STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055862	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Rose Care Center	1899 N Raymond Ave Pasadena, CA 91103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat resident with respect and dignity, and maintain privacy for three (3) of 18 sampled residents (Residents 1, 62, and 73) in accordance with the facility policy by failing to ensure: 1. Resident 1 was fed by Certified Nursing Assistant 1 (CNA 1) at the resident's eye level on 6/3/2025. 2. Licensed Vocational Nurse 4 (LVN 4) failed to knock on the door before entering Resident 62's room. 3. LVN 4 failed to knock on the door before entering Resident 73's room. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with the diagnoses including but not limited to metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), dementia (progressive brain disorder that slowly destroys memory and thinking skills), and type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel). During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 4/24/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating. During a review of Resident 1's care plan, revised 6/2/2025, the care plan indicated Resident 1 had an activity of daily living self-care performance deficit related to diagnosis Parkinson (progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), respiratory failure, muscle wasting, repeated falls, and osteoporosis (weakening of bones, leading to a decrease in bone density and an increased risk for fractures). The care plan interventions indicated Resident 1 required extensive assistance from one staff to eat. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/3/2025 at 8:22 AM in Resident 1's room with CNA 1, observed CNA 1 was standing at the bedside and feeding Resident 1 while the resident is in bed. CNA 1 stated Resident 1 needed assistance with feeding she was standing above Resident 1's eye level while feeding Resident 1. CNA 1 stated she was not supposed to stand above the resident's eye level and was supposed to sit while feeding Resident 1. During an interview on 6/5/2025 at 9:45 AM with the Director of Nursing (DON), the DON stated staff should be sitting down at the resident's eye level during feeding the residents. The DON stated at the resident's eye level, staff would be able to see if the resident was pocketing food or choking. The DON also stated being at eye level with the resident ensured residents did not feel intimidated by the staff and ensures residents feels they are treated with dignity and respect. 2. During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] and re-admitted on [DATE], with the diagnoses including but not limited to anoxic brain injury (occurs when the brain receives no oxygen at all), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), and type 2 diabetes mellitus. During a record review of Resident 62's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 62 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of the bed. During an observation on 6/5/2025 at 9:28 AM, with LVN 4 in front of Resident 62's room, LVN 4 entered Resident 62's room without knocking on the resident's door. During an interview on 6/5/2025 at 10:32 AM, with LVN 4, LVN 4 stated, facility staff need to knock on Resident 62's door before entering the resident's room to provide privacy just in case they are doing something inside the room and for their dignity. 3. During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was admitted to the facility on [DATE], with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), chronic respiratory failure and type 2 diabetes mellitus. During a record review of Resident 73's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 73 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed and chair/ bed - to chair transfer. During an observation on 6/5/2025 at 10:05 AM, with LVN 4 in front of Resident 73's room, LVN 4 entered Resident 73's room without knocking on the resident's door. During an interview on 6/5/2025 at 10:33 AM, with LVN 4, LVN 4 stated, to knock on Resident 72's door to respect their privacy and provide dignity on the residents. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 4:08 PM with Registered Nurse 2 (RN 2), RN 2 stated, It is important that staff knocks on the door before entering the resident's room to provide privacy to the residents, especially if they have visitors or they were doing something. It is also courtesy. If resident was not alert, we still have to knock on the door before entering because we still need to provide the residents' some privacy, and for their dignity. During a review of the facility's Policy and Procedure titled, Resident Rights, revised 10/1/2017, the policy indicated the facility must treat each resident with respect and dignity and care for each resident in a manner recognizing each resident's individuality.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate the needs of five (5) of 18 sampled residents (Residents 24, 69, 6, 42 and 72) by failing to ensure: 1. Resident 24's call light was answered timely. 2. Resident 69's call light was placed on the resident's side that did not have a contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). 3. and 4. Residents 6 and 42's call light was within reach. 5. Resident 72 had a tap call light (specialized nurse call device that is activated by pressure or touch on a soft pad) when the resident has a mitten restraint (a type of physical restraint, specifically a soft, large glove that covers a resident's hand, often used to prevent them from interfering with medical equipment). Findings: 1. During a review of Resident 24's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), Extended-Spectrum Beta-Lactamase (ESBL - It's an enzyme produced by some bacteria that makes them resistant to certain types of antibiotics), tracheostomy (a surgical procedure where an opening is created in the neck to directly access the trachea [windpipe] for breathing) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 24's care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) with focus on Risk for Falls, initiated 3/3/2025, the care plan indicated to attach call light within reach and encourage resident to use it for assistance as needed. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 5/20/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 24 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity, or, the assistance of 2 or more helps is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear but required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, assistance may be provided throughout the activity or intermittently) with oral hygiene. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/2/2025 at 8:56 AM, Resident 1 was observed in bed with call light within reach and watching television. Resident 1 stated the nurses would not answer her call light. During a concurrent observation and interview on 6/4/2025 at 8:28 AM, Resident 1 was observed activating the call light when the resident was coughing, turning red and was unable to talk. Certified Nursing Assistant 4 (CNA 4) came into the resident's room at 8:35 AM. During a concurrent interview and record review on 6/4/2025 at 3:10 PM with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Call System Communication, revised 10/24/2022, was reviewed. The DON stated nursing staff will answer call bells promptly, in a courteous manner and promptly means within 5 minutes. The DON also stated, It was not ok for the resident (Resident 24) to wait that long especially when she is coughing and turning red because in case of an emergency, the resident would need the facility's assistance. 2. During a review of Resident 69's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of anemia (a condition where the body does not have enough healthy red blood cells), gastrostomy, tracheostomy, and toxic encephalopathy (a neurological disorder caused by exposure to toxic substances, leading to brain dysfunction). During a review of Resident 69's MDS, dated 3/7/2025, the MDS indicated Resident 69 was severely impaired in cognitive skills for daily decision making. The MDS also indicated Resident 69 was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 69's care plan with focus on Moderate Risk for falls, revised 4/26/2024, the care plan indicated interventions included were to attach call light within reach and encourage resident to use it for assistance as needed. During an observation on 6/2/2025 at 8:24 AM in Resident 69's room, Resident 69 was observed sleeping in bed. Resident 69's right arm and hand were observed contracted. Resident 69's call light was observed on the side of the resident's right shoulder. During an interview on 6/5/2025 at 9:44 AM with Registered Nurse 2 (RN 2), RN 2 stated the call light should be on the resident's strong side and not the weak side. RN 2 added, Resident 69's right arm and hand was contracted so the call light should have been placed on the the left side. RN2 stated in case Resident 69 needs assistance, the resident can move and activate the call light so the staff can come and assist the resident. 3. During a review of Resident 6's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of anxiety (common emotion characterized by feelings of fear, worry, unease, and apprehension), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) type. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's care plan with focus on Bowel and Bladder Incontinence, revised 2/13/2025, the care plan indicated to keep call light within reach and answer promptly. During a review of Resident 6's care plan with focus on Activities of Daily Living (ADLs- activities such as bathing, dressing and toileting a person performs daily) Self-Care, revised 2/13/2025, the care plan indicated to encourage the resident to use bell to call for assistance. During a review of Resident 6's care plan with focus on Risk for falls, revised 2/13/2025, the care plan indicated to ensure the resident call light is within reach and encourage the resident to use it for assistance as needed. During a review of Resident 6's Minimum Data Set MDS - a resident assessment tool), dated 4/28/2025, the MDS indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated the resident was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a concurrent observation and interview on 6/2/2025 at 9:33 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 6's call light was observed on her roommate's bed. Resident 6 was observed yelling in bed stating she was itchy. Licensed Vocational Nurse 3 (LVN 3) stated Resident 6's call light was in her roommate's bed, and it was not within Resident 6's reach. During an interview on 6/5/2025 at 9:44 AM, RN 2 stated the call light should always be within reach of the resident. 4. During a review of Resident 42's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of muscle wasting and atrophy (the thinning, shrinking, or loss of muscle mass), depression (a common mental health condition characterized by a persistent feeling of sadness and loss of interest in activities) and anxiety. During a review of Resident 42's care plan with focus on ADL self-care, revised 5/12/2025, the care plan indicated to encourage the resident to use bell to call for assistance. During a review of Resident 42's MDS, dated [DATE], the MDS indicated the Resident 42was independent in cognitive skills for daily decision making, The MDS also indicated the resident required partial/moderate assistance with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene and chair/bed to chair transfer (the ability to transfer to and from bed to a chair (or wheelchair). During a concurrent observation and interview on 6/2/2025 at 10:03 AM, Resident 42 was observed sitting in a wheelchair in the resident's room. Resident 42 stated she wants to go to bed. Resident 42 also stated she cannot call for assistance because her call light was not within reach. Resident 42 stated the Certified Nursing Assistant (not identified) left her there. IPN walked into the resident's room and stated Resident 42's call light was not and should be within reach of the resident. During an interview on 6/25/2025 at 9:44 AM, RN 2 stated the staff needs to ensure when a resident is in a wheelchair that her call light is within reach so she would be able to call for assistance when needed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a review of Resident 72's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of tracheostomy, gastrostomy, pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and candidiasis (a fungal infection caused by a yeast). During a review of Resident 72's Order Summary, dated 3/14/2025, the order summary indicated apply bilateral hand mittens 24 hours due to pulling out medical devices. During a review of Resident 72's care plan with focus on bilateral hand mittens, revised 3/14/2025, the care plan indicated the resident needs a safe environment with adequate call light. During a review of Resident 72's MDS, dated [DATE], the MDS indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated the resident was dependent on oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 6/2/2025 at 8:40 AM, Resident 72 was observed with a mitten (restraint) on her right hand and a push button call light. Respiratory Therapist Director (RTD) stated the call light is not appropriate for the resident because she has a mitten on and would not be able to press the button to call for assistance. During an interview on 6/5/2025 at 9:44 AM, RN 2 stated a resident with a mitten should have a touch pad call light to call for assistance. RN 2 also stated the resident would be able to tap on the call light when calling for assistance. During a review of the facility's P&P titled Call System Communication, revised 10/24/2022, the P&P indicated the facility will provide a call system to enable residents to alert the nursing staff and should be accessible to the resident. The P&P also stated the call cords will be placed within resident's reach. During a review of the facility's P&P titled, Quality of Life Resident Rights, dated 5/1/2023, the P&P indicated the facility will provide care and services that ensure the resident's abilities in ADL do not diminish. The P&P also indicated each resident shall be care for in a manner that promotes and enhances the quality of life, dignity, respect and individuality.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a clean, comfortable and homelike (a place that feels like home) environment for five (5) of 11 sampled residents (Residents 26, 15, 78, 90 and 43) per facility policy by failing to ensure: 1. Resident 26's floor was clean and sanitary without any visible trash, dried brown smears by the commode, and brown clumps under the right side of the bed. 2. to 5. The facility's hot water temperatures were pleasurable and comfortable for Residents 15, 78, 90 and 43 for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). These deficiencies had the potential to negatively impact the quality of care, life and psychosocial well-being for Residents 26, 15, 78, 90 and 43. Findings: 1. During a review of Resident 26's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included anxiety disorder (a mental health disorder characterized by feeling of worry, or fear that are strong enough to interfere with one's daily activities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 3/9/2025, the MDS indicated Resident 26 had severe impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 26 was dependent (helper does all the effort) with toileting and required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing and putting on/taking off footwear, and personal hygiene. The MDS further indicated Resident 26 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and upper body dressing and required supervision (helper provides cues) with eating. During an observation on 6/2/2025 at 8:51 AM in Resident 26's room, Resident 26 was seen lying in bed asleep with the following waste and trash on the floor: a) Crushed crackers b) Used plastic glove c) Dried brown smear beside the commode inside the room d) [NAME] clumps under the right side of the resident's bed (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 10:31 AM, the Director of Nursing (DON) stated the facility had to make sure the residents' floors were kept clean and free of trash. The DON also stated leaving wastes and trash on the floor would be unsanitary for the residents in that room and the facility staff should have notified housekeeping to clean Resident 26's room. During an interview on 6/5/2025 at 11:16 AM, Licensed Vocational Nurse 5 (LVN 5) stated housekeeping should have been notified right away to clean and sanitize Resident 26's floor. LVN 5 also stated it would be unsanitary and not good for residents' mental and physical well-being when you leave wastes and trash on the resident's floor. LVN 5 further stated that the facility should provide a homelike environment for the residents. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rooms and Environment, revised November 1, 2017, indicated the facility was to provide residents with a safe, clean, and homelike environment. The P&P also indicated that the facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents comfort, independence, and personal needs and preferences. 2.During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (a sudden condition in which not enough oxygen passes from the lungs into the blood), muscle wasting (weakening, shrinking, and loss of muscle) and acute kidney failure (the sudden and rapid loss of kidney's ability to filter waste and balance fluid in blood). The admission Record also indicated Resident 15 was self-responsible (individual takes ownership of their health and well-being, making decisions and to maintain or improve their health status). During a review of Resident 15's MDS, dated 4/8/2025, the MDS indicated Resident 15 had moderately impaired cognitive skills. The MDS indicated Resident 15 was dependent with bathing, dressing, toileting hygiene and partial/moderate assistance with oral hygiene. During an interview on 6/2/2025 at 9:59 AM with Resident 15, Resident 15 stated there was no hot water available in the sink and shower for one week. Resident 15 also stated she has not showered in one week due to no hot water being available. 3. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), anxiety disorder and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 78's MDS dated 3/17/2025, the MDS indicated Resident 78 had moderately impaired cognitive skills. The MDS indicated Resident 78 required substantial/maximal assistance with bathing, toileting, personal and oral hygiene and partial/moderate assistance with eating. During an interview on 6/2/2025 at 10:05 AM with Resident 78, Resident 78 stated on 5/31/2025, he was offered to take a shower but was told by facility staff the water is cold and hot water is not available. Resident 78 also stated that same day, while receiving incontinence care, the nursing staff used cold water to clean him, causing him to shake. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was admitted to the facility on [DATE] with diagnoses that included difficulty in walking, muscle wasting and left hip pain. During a review of Resident 90's MDS, dated 4/6/2025, the MDS indicated Resident 90 had intact cognitive skills for daily decision making. The MDS indicated Resident 90 required partial/moderate assistance with showering/bathing, toileting hygiene and independent (no help needed to complete activity) with eating, oral and personal hygiene. During an interview on 6/2/2025 at 10:12 AM with Resident 90, Resident 90 stated during her shower on 6/1/2025, she got into the shower with the cold water but thought it would heat up during the shower and never did. Resident 90 also stated when she washed up this morning, the water was cold. During a concurrent observation on 6/2/2025 at 10:19 AM to 10:22 AM with the Maintenance Supervisor (MS), in the facility Shower room [ROOM NUMBER], the shower water temperature was 85.0 degrees Fahrenheit, after running for 4 minutes. During an observation on 6/2/2025 at 10:23 AM with MS in Room A, the sink water temperature reached the highest temperature of 72.5 degrees F. During a concurrent observation and interview on 6/2/2025 at 10:25 AM with MS in the facility Shower room [ROOM NUMBER], the temperatures for the water in two showers were both 71.6 degrees F. MS stated the water temperatures should be at 112 to 120 degrees F, with the lowest temperature at 110 degrees F. 5. During a review of Resident 43's admission Record, the admission Record indicated Resident 43 was originally admitted to the facility on [DATE] with diagnoses that included respiratory failure, COPD and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 43's MDS, dated 4/2/2025, the MDS indicated Resident 43 had intact cognitive skills. The MDS also indicated Resident 43 was dependent with bathing and partial/moderate assistance with oral, toileting and personal hygiene. During an interview on 6/3/2025 at 8:12 AM with Resident 43, Resident 43 stated on 6/1/2025, he wanted to shave but there was no hot water available and was told by facility staff the water is cold. Resident 43 stated during his bed bath on 6/2/2025, the water was cold. Resident 43 stated there were more occasions of not having comfortable water temperatures for bathing and hygiene care. During an interview on 6/5/2025 at 11:21AM with MS, MS stated it is important to make sure the water stays at the appropriate temperatures to make sure hot water is available for the residents to keep residents happy, comfortable and feel like they're at home. During a review of the facility's P&P titled, Water Temperatures, revised 6/1/2017, the P&P indicated the facility will ensure water is maintained at temperatures suitable to meet residents' needs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled Resident Rooms and Environment, revised 11/1/2017, the P&P indicated the facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the resident's comfort, independence, and personal needs and preferences. The P&P indicated the facility provides residents with a safe, clean, comfortable and homelike environment. The P&P also indicated facility staff aim to create a personalized, homelike atmosphere, paying close attention to comfortable temperatures.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure the Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder [MD] or intellectual disabilities [ID] are placed in facilities that can provide the appropriate care) Level II was completed for one (1) of three (3) sampled residents (Resident 40), as indicated in facility policy. This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 40. Findings: During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a mental disorder that involves persistent and excessive worry that can interfere with daily activities), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) and End Stage Renal Disease (ESRD- irreversible kidney failure). During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 40 with moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 40 was partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral, toileting and personal hygiene, bathing, dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating. The MDS also indicated Resident 40 was taking antipsychotic (used to manage psychosis) and antianxiety (used to reduce or treat the symptoms of anxiety) medications. During a review of Resident 40's Subject: Notice of PASRR Level I Screening Results letter, dated 3/26/2025, the letter indicated a serious mental illness (SMI) Level II Mental Health Evaluation was required for Resident 40. The letter also indicated the facility will be contacted within two (2) to four (4) days to set up an appointment for an evaluator to conduct the Level II Mental Health Evaluation for Resident 40. During a concurrent interview and record review on 6/4/2025 at 2:51 PM with Medical Records (MR), Resident 40's Subject: Notice of Attempted Evaluation letter, dated 3/29/2025, the letter indicated Resident 40's SMI Level II Mental Health Evaluation was not scheduled because facility staff were unresponsive to 2 or more separate attempts of communication within 48 hours of the Level I Screening. The letter also indicated the case is closed and the facility must submit a new Level I Screening to reopen the case. MR stated she is responsible for completing the PASARR follow ups for the residents and did not know Resident 40's case was closed because they were unable to reach the facility. MR stated she did not submit for a new Level I Screening and should have. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2025 at 12:07 PM with MR, MR stated PASARR is a prescreen of the residents so facility staff can know their cognitive level and mental health. MS stated not having the PASARR II Evaluation completed could affect the residents because they could have been seen by psychiatrist and/or psychologist to help with their medications or prescribe any medications that are needed. MS also stated a PASARR Level II is a concrete answer and will tell us more and what extra services may be needed. During a review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review (PASRR), revised 7/1/2023, the P&P indicated: A. The P&P purpose is to ensure all facility applicants are screened for mental illness and/or intellectual disability and to ensure coordination with the appropriate state agencies, if indicated. B. The PASRR Level II (an in-depth evaluation of the individual by a Level II Contractor) must be completed prior to admission. C. Recommendations from the PASRR Level II screening will be incorporated into the residents' care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop individualized resident-centered care plans (a care plan that prioritizes the unique health needs and desired outcomes of the resident) with measurable objectives, timeframe, and interventions for two (2) of 18 sampled residents (Resident 72, and 40): 1. Resident 72 did not have a care plan to address resident's incontinence (the inability to control the flow of urine or the passage of stool) needs. 2. Resident 40 did not have a care plan to address resident's fluid restriction diet and episode of significant weight loss of eight (8) pounds from 2/1/2025 to 3/2/2025. This deficient practice had the potential to result in delayed necessary care and services for Residents 72 and 40 which could result in harm and affect the residents' overall wellbeing. Findings: 1. During a review of Resident 72's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of tracheostomy (a surgical procedure where an opening is created in the neck to directly access the trachea [windpipe] for breathing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and candidiasis (a fungal infection caused by a yeast). During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 3/19/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident was dependent (helper does all of the effort, resident does none of the effort to complete the activity, or, the assistance of 2 or more helps is required for the resident to complete the activity) on oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 6/2/2025 at 12:16 PM with Certified Nursing Assistant 4 (CNA 4), CNA 4 was observed providing incontinence care to Resident 72. During a concurrent interview and record review on 6/4/2025 at 12:29 PM with Registered Nurse 1 (RN 1), Resident 72's care plans, dated 3/11/2025 to 4/15/2025 were reviewed. RN 1 stated the resident should have but does not have a care plan on bowel/bladder incontinence. RN 1 also stated the care plan is to ensure the staff meets the resident's incontinence needs since the resident is dependent on toileting needs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 11:35 AM with the Director of Nursing (DON), Resident 72's care plans, dated 3/11/2025 to 4/15/2025 were reviewed. The DON stated Resident 72 should have but does not have a care plan on bowel/bladder incontinence. The DON also stated it is important to have a care plan for the continuity of care and the implementation of the plan of care. 2. During a review of Resident 40's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a mental disorder that involves persistent and excessive worry that can interfere with daily activities), End Stage Renal Disease (ESRD- irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed). During a review of Resident 40's MDS dated 3/31/2025, the MDS indicated Resident 40 with moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 40 was partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral, toileting and personal hygiene, bathing, dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating. The MDS also indicated Resident 40 with a significant weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and is not on a physician-prescribed weight-loss regimen. During a review of Resident 40's Weights and Vitals Summary, the Weights and Vitals Summary indicated Resident 40 with the weights of 127.9 pounds on 2/1/2025 and 119.9 pounds on 3/2/2025, which indicated a weight loss of 8.9 pounds equaling 6.96%. During a review of Resident 40's Order Summary Report, dated 5/19/2025, the Order Summary Report indicated an order for fluid restrictions: 1000 milliliters (ml - a measurement of volume) per day; dietary 600 cubic centimeters (cc-unit of measurement), nursing 400cc. During a concurrent interview and record review on 6/5/2025 at 8:20 AM and 8:52 AM with Registered Nurse 1 (RN 1), Resident 40's medical chart was reviewed. The medical chart did not indicate a care plan for Resident 40's 1000ml fluid restriction and/or significant weight loss. RN 1 stated Resident 40 should have a care plan for his fluid restriction order and significant weight loss. During an interview on 6/5/2025 at 11:38 AM with the DON, the DON stated care plans are important because it lets staff know what interventions are ordered and in place for staff to follow and provide to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Dialysis Care, revised 11/1/2017, the P&P indicated the interdisciplinary team (IDT- a coordinated group of experts from several different fields) will ensure that the resident's care plan includes documentation of the resident's renal condition and necessary precautions and will be updated as needed. During a review of the facility's P&P titled, Assessment and Management of Resident Weights, revised 6/1/2017, the P&P indicated the IDT care plan will be updated to reflect individualized goals and approaches for managing the [significant] weight change (weight change of 5% in one (1) month, 7.5 % in three (3) months or 10% in six (6) months. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Care Planning, revised 10/24/2022, the care plan indicated each resident is to have a comprehensive person-centered care plan developed based on their individual assessed needs. The P&P also indicated each resident's comprehensive care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, any services that would be required, but not provided due to resident's right to refuse. The P&P also indicated a licensed nurse will initiate the care plan, and the plan will be finalized in accordance with resolution of current problems.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise the care plan for one (1) of 18 sampled residents (Resident 24) to address Resident 24's respiratory status for the discontinuance of ventilator (a medical device that provides mechanical ventilation, assisting or replacing a person's breathing when they are unable to do so adequately on their own) and current use of oxygen (a chemical element that is needed to survive) via tracheostomy (a surgical procedure where an opening is created in the neck to directly access the trachea [windpipe] for breathing). This deficient practice has the potential for a delay in the respiratory care and can cause complications associated with oxygen therapy for Resident 24. Findings: During a review of Resident 24's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), Extended-Spectrum Beta-Lactamase (ESBL - It's an enzyme produced by some bacteria that makes them resistant to certain types of antibiotics), tracheostomy and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 24's Physician Orders, dated 5/15/2025, the Physician Orders indicated four (4) liters (l - unit of measure) per minute of humidified oxygen (oxygen that has moisture) via oxygen concentrator (medical device that extracts oxygen from ambient air and delivers it to a resident) to tracheostomy continuously every shift. During a review of Resident 24's Minimum Data Set (MDS- a resident assessment tool), dated 5/20/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helps is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with oral hygiene. During a concurrent observation and interview on 6/4/2025 at 8:22 AM, the Respiratory Therapist (RT) was observed doing trach care (the procedures involved in maintaining a tracheostomy tube and the surrounding area to ensure proper breathing and prevent complications) for Resident 24. The RT stated Resident 24 is no longer on a ventilator because the resident was weaned off the ventilator while in the General Acute Care Hospital (GACH). (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 24's care plans, dated 2/28/2025 to 5/30/2025, and interview on 6/5/2025 at 11:18 AM, the Director of Nursing (DON) stated Resident 24's care plan with focus on Dependent on Ventilator, revised 4/2/2025, needs to be revised and updated. The DON stated Resident 24 is no longer on a ventilator and is currently on oxygen via tracheostomy. The DON also stated it is important to revise the care plan so the resident may receive the proper care, and the staff may implement the appropriate care. During a review of the facility's Policy and Procedure (P&P) titled Care Planning, revised 10/24/2025, the P&P indicated in the event the comprehensive care plan identified a change in the resident's goals or functioning, these changes will be incorporated into an updated summary. The P&P also indicated changes may be made to the comprehensive care plan on an ongoing basis for the duration of the resident's stay.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide incontinent care for one (1) of three (3) sampled residents (Resident 69) who was dependent on activities of daily living (ADLs- are activities related to personal care that include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating), in accordance with the facility's policy. This deficient practice had the potential for Resident 69 to develop skin issues/ complications. Findings: During a review of Resident 69's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of anemia (a condition where the body does not have enough healthy red blood cells), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), tracheostomy (a surgical procedure where an opening is created in the neck to directly access the trachea (windpipe) for breathing), and toxic encephalopathy (a neurological disorder caused by exposure to toxic substances, leading to brain dysfunction). During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2025, the MDS indicated Resident 69 was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 69 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity, or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 6/2/2025 at 8:24 AM, Resident 69 was observed sleeping in bed with a sign on the wall indicating two (2) changes per day. During an interview on 6/3/2025 at 2:10 PM, Certified Nurse Assistant 4 (CNA4) stated she would change the resident 2 times per shift. CNA 4 also stated every time she would change Resident 69, the resident's brief would be full of urine and the gown and bed linen would also be wet with urine. During an observation and interview on 6/4/2024 at 1:05 PM, CNA 4 was observed providing incontinence care for Resident 69. Resident 69 was observed with a brief full of urine, and the gown and bed linen were wet with urine as well. CNA 4 confirmed Resident 69's brief was full, and his gown and bed linen were also wet with urine. During a concurrent interview and record review on 6/5/2025 at 10:58 AM with the Director of Nursing (DON), the facility's Policy & Procedure (P&P) titled, Continence Management Guideline, revised 7/2017, was reviewed. The P&P indicated residents' incontinence pad/brief change every 2 to 4 hours. The DON stated the policy indicated pad/brief change every 2 to 4 hours, but it should also indicate as needed to ensure the resident was kept clean and dry. The DON stated Resident 69 needs to be changed more than twice a day to avoid issues on Resident 69's skin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Perineal Care, revised 6/1/2017, the P&P indicated to maintain cleanliness of the genital area, to reduce odor, and to prevent infection or skin breakdown.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and treatment for two (2) of 18 sampled residents (Resident 6 and 346) by failing to: 1. Reevaluate and treat Resident 6's wounds on her arms and legs. 2. Provide interventions after report of Resident 346'scomplaint of pain and episodes of confusion. These deficient practices had the potential to result to delay in the necessary care and treatment of Resident 6 and 346's which could negatively affect the residents' overall wellbeing. Findings: 1. During a review of Resident 6's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of anxiety (common emotion characterized by feelings of fear, worry, unease, and apprehension), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) type. During a review of Resident 6's care plan with focus on Self-Inflicted Scratch, dated 4/16/2025, the care plan indicated if skin tear occurs, treat per facility protocol and notify attending physician. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool), dated 4/28/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helps is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During an observation on 6/2/2025 at 9:33 AM, Resident 6 was observed moving around, scratching herself and stating she was itchy. Resident 6 was also observed with open wounds on her arms and legs that were bleeding. During an observation on 6/4/2025 at 10 AM, Resident 6 was observed scratching her open wounds on her arms and legs, which were bleeding. During a concurrent observation and interview on 6/4/2025 at 10:20 AM, Registered Nurse 1 (RN 1) stated if Resident 6's skin treatment was ineffective, the attending physician should have been notified. Resident 6 was observed scratching her wounds and was observed with bleeding wounds on her arms and legs. RN 1 stated Resident 6's treatment was ineffective because the resident was still scratching, and the scratching is causing the wounds to get deeper. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/2/2025 at 10:31 AM, Treatment Nurse (TN) stated resident has 2 ointments for her skin condition which were Clotrimazole (started on 5/9/2025) and Ketoconazole (started 4/2025). During a concurrent interview and record review of Resident 6's care plans, dated 1/24/2025 to 5/21/2025, RN 1 stated resident did not and should have had a care plan for her clotrimazole treatment order. RN 1 stated it is important to have a care plan to know what interventions to implement to help the resident reach their goal and for continuity of care. During an interview on 6/5/2025 at 11:25 AM, the Director of Nursing (DON) stated the bleeding and deepening of the wounds is considered a Change of Condition (COC) and the doctor would need to be notified. The DON also stated if the treatment is ineffective, the doctor should be updated. The DON stated Resident 6 did not and should have had a care plan for Clotrimazole. The DON stated having a care plan will ensure implementation and continuity of care for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Change of Condition, revised 6/1/2017, the P&P indicated the licensed nurse will notify the resident's attending physician when there is a need to alter treatment. P&P also indicated a licensed nurse will communicate any changes in required interventions to the Interdisciplinary Team (IDT - a group of professionals from different disciplines who collaborate to achieve a shared goal, often in fields like healthcare or research) members involved in the resident's care. During a review of the facility's P&P titled, Care Planning, revised 10/24/2022, the P&P indicated a culturally and trauma-informed care plan will be developed for each resident. The P&P also indicated the care plan includes measurable objectives and timetables to meet a resident medical, nursing, mental and psychological needs in the event when an identified change in the resident's goals or functioning. 2. During a review of Resident 346's admission Record, the admission Record indicated Resident 346 was admitted to the facility on [DATE] and re-admitted on [DATE], with the diagnoses including but not limited to left shoulder dislocation (an injury in which the upper arm bone pops out of the cup-shaped socket that's part of the shoulder blade), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), and urinary tract infection (UTI, an infection in the bladder/urinary tract) During a record review of Resident 346's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 346 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, shower/bathe self, lower body dressing, and putting on/ taking off footwear. The MDS also indicated Resident 346 needed supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) for oral hygiene, and personal hygiene. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 346's Care Plan (CP) for impaired cognitive function or impaired thought process related to dementia and impaired decision making, dated 4/19/2025, the CP indicated the staff interventions included were to monitor / document /report to MD any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness and mental status. During a record review of Resident 346's 15:45 Nurses' Progress Notes (NPN) dated 5/8/2025 at 3:45PM, the NPN indicated, LVN 2 received a call from Resident 346's FM 1 and FM 2. FM 1 and FM 2 expressed concerns that Resident 346 reported that she had fallen sometime in April 2024 and had complained of shoulder pain due to it. LVN 2 informed FM 1 and FM 2 that there was no fall incident that had occurred, but Resident 346 was observed to have episodes of confusion and had noticed Resident 346 dangling her legs over the bed and attempting to get out of bed. LVN 2 informed FM 1 and FM 2 that doctor will be notified per family request. During a concurrent observation and interview on 6/5/2025 at 12:36 PM with Resident 346, Resident 346 was lying on her bed with the head of the bed elevated 90 degrees and she was not wearing her sling on her left shoulder. Resident 346 stated her left shoulder hurts a little bit. Resident 346 stated, I remember that I had a fall then I passed out and I could not get up. It was during daytime, and it happened last year. My left shoulder hurt after that. There was a male person that helped me. I was going to the hospital, I do not remember if the nurses checked on me after falling. During an interview on 6/5/2025 at 2:43 PM with LVN 3, LVN 3 stated, If resident (Resident 346) had an altered mental status, we should have done neuro checks and 72-hour monitoring. We should also call the family. The family needs to know what was going on with the resident. LVN 3 also stated, We also need to do change of condition (COC, is a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) and developed a care plan. If these steps were not done for a resident's COC, the resident can have complications since we were not able to provide the appropriate care needed by the resident immediately. During a concurrent interview and record review on 6/5/2025 at 2:51 PM with LVN 3, the NPN dated 5/8/2025 was reviewed. LVN 3 stated, We should have done an assessment on Resident 346, called the doctor, do a COC, formulate or update the care plan and monitor the resident for risk of falling. During a concurrent interview and record review of Resident 346's medical records on 6/5/2025 at 2:56 PM with LVN 3, LVN 3 stated there was no COC formulated for an episode of confusion for Resident 346. LVN 3 stated there was no documentation that the staff called the doctor and assessed or monitored Resident 346. During an interview on 6/5/2025 at 2:57 PM with LVN3, LVN 3 stated if there was no COC, it means there were no interventions done by the nurses and the resident's condition could get worse. During a concurrent interview and record review on 6/5/2025 at 3:51 PM, with LVN 2, the NPN dated 5/8/2024 was reviewed. The NPN indicated Resident 346 claimed she had a fall incident earlier part of the week during her conversation with FM 2. LVN 2 stated, I called the MD (Medical Doctor), but I do not remember if the MD called us back. LVN 2 stated, I do not know what happened. LVN 2 stated she did not follow up the following day and she did not follow up with the other shifts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 3:53 PM, with LVN 2, the COC dated 5/8/2024 to 5/9/2024 was reviewed. LVN 2 stated there was no COC for Resident 346 after complaining of left shoulder pain from falling that was reported by the family members on 5/8/2024. During a concurrent interview and record review on 6/5/2025 at 3:54 PM, with LVN 2, the NPN dated 5/8/2024 to 5/11/2024 was reviewed. The NPN did not indicate monitoring for fall or episodes of confusion for Resident 346. LVN 2 stated there was no documentation for 72-hour monitoring for Resident 346 for fall risk or episodes of confusion. During a concurrent interview and record review on 6/5/2025 at 3:56 PM, with LVN 2, the COC dated 5/8/2024 was reviewed. LVN 2 stated, It appears that I did not do COC for the resident (Resident 346)'s fall and episode of confusion. Not having a COC meant we did not assess the resident (Resident 346) which could delay the care needed by the resident. During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification revised 6/1/2017, The P&P indicated, I. The Licensed Nurse will notify the resident's Attending Physician when there is an: A. Incident/accident involving the resident. B. An accident involving the resident which results injury and has the potential for requiring physician intervention. C. A significant change in the resident's physical, mental or psychosocial status, e.g., deterioration in health, mental or psychosocial status, life-threatening conditions or clinical complications. II. The Licensed Nurse will assess the resident's change of condition and document the observations and symptoms. VI. Documentation A. A Licensed Nurse will document the following: i. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date, time, and pertinent details of the incident and the subsequent assessment in the Nursing Notes. ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contacted. iv. Update the Care Plan to reflect the resident's current status. v. The incident and brief details in the 24-Hour Report. vi. If the resident is transferred to an acute care hospital, complete an inter-facility transfer form. vii. Complete an incident report per Facility policy. B. A Licensed Nurse will communicate any changes in required interventions to the IDT members involved in the resident's care. C. A Licensed Nurse will document each shift for at least seventy-two (72) hours. D. Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-Hour Report.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an intervention to prevent pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one (1) of 1 resident sampled for pressure ulcer care area (Resident 64) in accordance with the facility's policy and procedure by failing to: 1. Ensure Resident 64's low air loss mattress (LAL, mattress used for residents who are at risk for developing sores or already have pressure ulcer designed to circulate a constant flow of air for the management of pressure sores) was at a correct setting. 2. Develop a care plan to indicate Resident 64's risk for development of pressure ulcer. These deficient practices placed Residents 64 at risk for development of pressure ulcer. Findings: During a review of Resident 64's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (a condition caused by brain injury that results in a varying degree of weakness, stiffness, and a lack of control in one side of the body) following cerebral infarction (a medical condition that occurs when brain tissue dies due to a lack of blood flow and oxygen) and muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (a decrease in muscle mass, often due to an extended period of immobility). During a review of Resident 64's Braden Scale (a tool that predicts the risk for developing pressure ulcers) dated 12/12/2024, the Braden Scale indicated Resident 64 was very high risk for developing pressure ulcer. During a review of the Resident 64's Physicians order dated 12/14/2024 at 1:03 PM, the Physicians order indicated daily monitoring of function and proper setting (according to the residents' weight) of LAL mattress. During a review of the Resident 64's Physician's order dated 12/14/2024 at 1:05 PM, the Physicians order indicated daily use of LAL as treatment for skin management. During a review of Resident 64's Minimum Data Set (MDS- a resident assessment tool), dated 3/19/2025, the MDS indicated Resident 64 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 64 was dependent (helper does all the effort) oral, toileting, and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 64's weight summary, the weight summary indicated Resident 64's weight was 144.4 pounds taken on 5/2/2025. During an observation on 6/2/2025 at 9:39 AM, Resident 64 was asleep in bed with the LAL Mattress set at 350 pounds. During an interview on 6/4/2025 at 4:32 PM, Licensed Vocational Nurse 1 (LVN 1) stated LAL mattress was used for management and prevention of pressure ulcer. LVN 1 also stated Resident 64's mattress would be too hard, and the resident could develop pressure ulcer. During a review of Resident 64's medical record, the medical record did not indicate a care plan was developed on the resident's risk for the development of pressure ulcers. During a concurrent interview and record review with the Director of Nursing (DON) on 6/05/2025 at 9:56 AM, the DON stated Resident 64's LAL mattress should be set correctly based on the resident's weight to ensure the resident would not develop pressure ulcer and other skin issues. The DON also confirmed Resident 64 did not have a care plan on risk for the development of pressure ulcer. The DON stated Resident 64 should have a care plan to guide staff on what interventions to follow to prevent the resident from developing pressure ulcers. During a review of the facility's Policy and Procedure (P&P) titled, Support Surface Guidelines, revised 7/1/2017, the P&P indicated its purpose was to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. The P&P also indicated that the facility would implement measures to reduce tissue pressure that may include the use of support surfaces such as LAL mattresses. The P&P further stated that any individual at risk for developing pressure ulcers will be placed on a pressure reducing device as recommended. During a review of the facility's P&P titled, Care Planning, revised 10/24/2022, the care plan indicated each resident is to have a comprehensive person-centered care plan developed based on their individual assessed needs. The P&P also indicated each resident's comprehensive care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, any services that would be required, but not provided due to resident's right to refuse. The P&P also indicated a licensed nurse will initiate the care plan, and the plan will be finalized in accordance with resolution of current problems.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the correct foot orthosis (brace or support worn outside the body) was used to support, align, and protect the right foot for one (1) of two (2) residents (Resident 86) in accordance with the physician's order. This deficient practice had the potential for Resident 86 to develop right foot contractures (occurs when the muscles, tendons, joints, or tissues tighten or shorten causing a deformity) and increases the resident's risk of developing a pressure ulcer (injury to skin and underlying tissue resulting from prolonged pressure on the skin) on the right heel due to improper foot support. Findings: During a review of Resident 86's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (a decrease in muscle mass, often due to an extended period of immobility). During a review of Resident 86's History and Physical (H&P, a formal and complete assessment of the patients and their problems) dated 12/11/2024, the H&P indicated the resident had a hemorrhagic intraparenchymal stroke (a type of stroke where a blood vessel inside the brain leaks or bursts, causing bleeding into the brain tissues) with right sided weakness. During a review of Resident 86's Minimum Data Set (MDS, a resident assessment tool), dated 12/17/2024, the MDS indicated Resident 86 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 86 was dependent (helper does all the effort) with oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During a review of Resident 86's physicians order summary report dated 5/24/2025, the order summary report indicated an order for Restorative Nursing Aide (RNA- responsible for providing restorative and rehabilitation care for residents/patients to maintain or regain physical, mental, and emotional well-being) program for the resident's right lower extremity (RLE) using Pressure Relief Ankle Foot Orthosis (PRAFO, a medical device used to support and protect the foot and ankle) boot for 2 hours, three (3) times a week as tolerated. During a concurrent observation and interview on 6/4/2025 at 8:45 AM, Restorative Nursing Assistant 1 (RNA 1) checked the Physical Therapy (PT) cabinet outside the rehabilitation room where he stated they store the rest of the residents PRAFO boots but did not see one for Resident 86. RNA 1 stated Resident 86 PRAFO boot would be in the resident's closet. During a concurrent observation and interview on 6/4/2025 at 9:00 AM, Resident 86's did not have a PRAFO boot on her RLE and the resident gestured she had not been provided with the boot. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/4/2025 at 9:28 AM, RNA 1 confirmed Resident 86 did not have the PRAFO boot in her room after checking the resident's closet and bedside. RNA 1 stated he used the soft heel protector for Residents 86's right foot for the week of 5/25/2025 to 5/31/2025 since he could not find the residents PRAFO boot. RNA 1 also stated Resident 86 could end up with a foot drop (inability to lift the front part of the foot, leading to the foot hanging down) if they are not using the correct foot orthosis. During a review of Resident 86's Care Plan dated 5/26/2025, the Care Plan indicated the resident was on RNA services using RLE PRAFO for 2 hours, daily 3 times a week as tolerated with an approach plan to monitor for pain and discomfort while in use. During another interview with RNA 1 on 6/4/2025 at 2:25 PM, RNA 1 stated he should have looked for Resident 86's RLE PRAFO boot or ordered another one for the resident. RNA 1 also stated his RNA evaluation on the use of the RLE PRAFO boot for Resident 86 would be inaccurate because the resident was using the soft heel protector instead of the PRAFO boot. During an interview on 6/5/2025 at 10:10 AM, the Director of Nursing (DON) stated RNA 1 should have notified nursing and rehabilitation unit so they could look for Resident 86's RLE PRAFO boot and should have ordered a replacement if unable to find them. DON also stated Resident 86 should be provided with the PRAFO boot because the resident had the potential to develop contractures on the right foot. During a review of the facility's Policy and Procedure (P&P) titled, Splinting, revised 6/1/2017, the P&P indicated the facility uses splints (supportive device used to hold still an injured part of the body helping it to heal properly) to prevent contractures or decreased tone and to protect joint alignment. During a review of the manufacturers guide for PRAFO boot also known as Comfy Splints C-Boot Orthosis indicated that the splint is to be used to position the lower leg and support and position the ankle and foot. The manufacturers guide also indicated that the well-padded boot minimizes pressure areas, especially in the heel and is useful in treating immobility and neuromuscular impairment (a condition that affects the ability of your nerves to communicate with your muscle).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper hydration and nutrition maintenance for two (2) of 2 sampled residents (Residents 11 and 40) by failing to: 1. Provide a water pitcher and fluid at bedside for Resident 11. 2. Follow the significant weight loss policy for Resident 40, after an episode of significant weight loss. These failures had the potential to place Resident 11 at risk for dehydration (harmful reduction in the amount of water or fluids in the body) and Resident 40 for continued preventable weight loss, which could affect the residents' overall physical and psychosocial well-being. Findings: 1. During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was readmitted to the facility on [DATE], with the diagnoses including but not limited to metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), and acute kidney failure (when the kidneys suddenly become unable to filter waste products from the body). During a record review of Resident 11's Minimum Data Set (MDS, a resident assessment and tool), dated 5/5/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 11 was required partial/moderate assistance (helper does less than half the effort) for eating, oral hygiene, and personal hygiene. During a record review of Resident 11's care plan, revised 6/2/2025, the care plan indicated Resident 11 had a sacrococcyx (the fused sacrum and coccyx, or tailbone) stage 4 pressure injury (pressure injury is very deep, reaching into muscle and bone and causing extensive damage). The care plan intervention for staff was to encourage/offer fluids in between meals. During a record review of Resident 11's care plan, revised 6/2/2025, the care plan indicated Resident 11 had hypotension (low blood pressure) with an increased risk for confusion, dizziness, nausea/vomiting, and fainting. The care plan interventions for staff were to encourage adequate fluid intake and a healthy diet. During a record review of Resident 11's care plan, revised 6/2/2025, the care plan indicated Resident 11 required mechanical/manual chest wall oscillation therapy delivered by a respiratory therapist to aid in mobilizing and expelling mucus from the airway walls, improving respiratory function and reducing the risk of respiratory infections. The care plan intervention for staff was to ensure adequate hydration, as increased fluid intake helps thin mucus and aids in easier clearance during therapy sessions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/2/2025 at 9:22 AM in Resident 11's room, Resident 11 was lying in bed with no water pitcher or fluid at bedside. There was also a note above Resident 11's bed Please keep resident hydrated and reposition every 2 to 4 hours, thank you. Resident 11 stated there was no water and she needed water. Resident 11 lips appeared dry. During an observation on 6/2/2025 at 1:03 PM in Resident 11's room, a Certified Nursing Assistant (CNA) unidentified came out of Resident 1's room after assisting Resident 11 with feeding. There was no water or fluid left at the bedside. During an observation on 6/2/2025 at 3:22 PM in Resident 11's room, Resident 11 was sleeping in bed and there was no water pitcher or fluid at the bedside. During an observation on 6/3/2025 at 9:20 AM in Resident 11's room, there was no water pitcher or fluid at the bedside. During an observation on 6/3/2025 at 2:18 PM in Resident 11's room, there was no water pitcher or fluid at the bedside. During a concurrent observation and interview on 6/3/2025 at 3:01 PM in Resident 11's room with CNA 3, CNA 3 stated there was no water at Resident 11's bedside. CNA 3 stated water pitchers were left at the residents' bedside and staff needed to make sure the pitcher was filled with water. During a concurrent observation and interview on 6/3/2025 at 3:05 PM in Resident 11's room with the Director of Staff Development (DSD), DSD stated Resident 11's lips look a little bit dry. DSD stated there was not water at the bedside. During a concurrent interview and record review on 6/3/2025 at 3:14 PM of Resident 11's Physician Orders with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 11 was not placed on any fluid restrictions. LVN 5 stated Resident 11 should have a water pitcher with water at the bedside. LVN 5 stated there was a sign placed above Resident 11's bed to hydrate the resident. LVN 5 stated Resident 11's family came to the facility a few months ago and wanted the staff to ensure Resident 11 was getting water. During the same interview and record review on 6/3/2025 at 3:14 PM of Resident 11's care plan with LVN 5, LVN 5 stated Resident 11 had a stage 4 pressure injury, and an intervention was to encourage fluids between meals. LVN 5 stated Resident 11 had another care plan for respiratory issues and hypotension and both interventions included to encourage fluid intake. LVN 5 stated keeping Resident 11 hydrated was important for wound healing, to prevent hypotension and make sure Resident 11 had water. LVN 5 stated CNAs get busy, and they forget to bring water for Resident 11. LVN 5 stated this can lead to Resident 11 becoming dehydrated leading to poor wound healing, hyponatremia (abnormally low sodium levels in the blood), increased thirst, and seizures (burst of uncontrolled electrical activity between brain cells that can cause the body to shake uncontrollably). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025 at 4:49 PM with the Director of Nursing (DON), the DON stated residents with no fluid restrictions should have water at the bedside. The DON stated the facility wanted to ensure all residents had fluids and drank water. The DON stated when residents did not have water at the bedside the residents could get dehydrated. The DON stated dehydration could result in confusion and having dry lips, and dry skin. The DON stated nurses needed to check residents at least every two hours as needed for water at the bedside. During a record review of the facility's policy and procedure titled, Bedside Water Containers, dated 2023, the policy indicated each resident should have two complete water container sets for water at the bedside. Night shift staff will be responsible for collecting used water containers and replacing clean water containers, filled with fresh water and ice on a daily basis. 2. During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a mental disorder that involves persistent and excessive worry that can interfere with daily activities), End Stage Renal Disease (ESRD- irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed). During a review of Resident 40's MDS, dated 3/31/2025, the MDS indicated Resident 40 with moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 40 was partial/moderate assistance with oral, toileting and personal hygiene, bathing, dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating. The MDS also indicated Resident 40 with a significant weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months and is not on a physician-prescribed weight-loss regimen. During a review of Resident 40's Weights and Vitals Summary, the Summary indicated Resident 40 with the weights of 127.9 pounds on 2/1/2025 and 119.9 pounds on 3/2/2025, which indicated a weight loss of 6.96 %. During a concurrent interview and record review on 6/5/2025 at 8:52 AM with the Registered Nurse 1 (RN 1), Resident 40's medical chart was reviewed. Resident 40's medical record failed to indicate the completion of a change of condition (COC) assessment, medical doctor (MD) notification, registered dietician (RD) notification, a nutritional assessment and/or weekly weights for his significant weight loss on 3/2/2025. RN 1 stated there should have been a COC done, nursing progress notes that indicated the MD and RD were notified and a nutritional assessment completed because that is the facility's policy. RN 1 stated the policy was not followed because nursing and dietary were not made aware of the significant weight loss by the restorative nursing assistant once found. RN 1 also stated nursing staff were not able to ensure Resident 40's significant weight loss was monitored and treated effectively because they were not aware. During an interview on 6/5/2025 at 10:19 AM with the Dietary Supervisor (DS), the DS stated when a resident has a weight loss is 5% or more, DS should have interviewed the resident, for possible reasons for the weight loss, update any food preferences, and document in dietary progress notes for RD to review. DS stated it is important to complete an interview with the residents to make sure the residents are eating and that they like the food to prevent continued weight loss. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 11:38 AM the DON, DON stated when a resident experiences significant weight loss, nursing staff are to notify the doctor, complete a change of condition assessment, notify the dialysis center and inform the RD to assess the resident within 72 hours. DON stated these things were not done for Resident 40's significant weight loss and should have been done. DON also stated it is important to notify the doctor for new orders and interventions to be given, and ensure RD sees the resident so staff can follow the recommendations to prevent further weight loss. During a review of the facility's P&P titled Assessment and Management of Resident Weights, revised 6/1/2017, the P&P indicated with significant weight change management included: a. Significant weight change includes 5% in one (1) month b. The designated nurse supervisor or licensed nurse will report the weight change in the medical record and on the 24-hour Report, notify the physician and dietician of the significant weight changes and document the notification in the nurses' notes. c. The registered dietician will complete a nutritional assessment on all residents with a significant weight change and document the nutritional assessment and weight management recommendations in the medical record. d. The licensed nurse will notify the physician of the dietician's recommendations and notify the family, as indicated. e. Residents will be weighed at least weekly.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the fluid restriction (a diet which limits the amount of daily fluid consumption) order for one of one resident (Resident 40) who was dependent on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) as indicated on the physician's order. This failure resulted in Resident 40 not receiving fluid restrictions from 5/19/2025 through 6/3/2025, with the potential to cause fluid overload (having too much fluid in the body), or preventable health complications for Resident 40. Findings: During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder (a mental disorder that involves persistent and excessive worry that can interfere with daily activities), End Stage Renal Disease (ESRD- irreversible kidney failure) and dependence on renal dialysis. During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated 3/31/2025, the MDS indicated Resident 40 with moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 40 was partial/moderate assistance (helper does less than half the effort needed to complete the activity) with oral, toileting and personal hygiene, bathing, dressing and setup or clean-up assistance (helper helps only prior to or following the activity completion) with eating. During a review of Resident 40's medical chart, the medical chart indicated a telephone order dated 5/19/2025, for dialysis fluid restrictions: 1000 milliliters (ml - a measurement of volume) per day; dietary 600 cubic centimeter (cc-unit of measurement) and nursing 400cc. During an observation on 6/2/2025 at 12:32 PM at Resident 40's bedside, Resident 40's Resident 40 was observed receiving a lunch tray with 1 cup of red liquid and 1 additional cup of liquid. During a record review of Resident 40's Dietary Lunch Tray Card, dated 6/2/2025, the tray card indicated Resident 40 with a diet order of mechanical soft, no added salt and standing orders to receive 4 ounces (oz- a unit of measurement) of fruit juice and 1 cup of hot tea with lunch. The tray card did not indicate any ordered fluid restrictions for Resident 40. During an interview on 6/4/2025 at 9:58 AM with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated she was assigned to Resident 40 and is aware that Resident 40 is on fluid restriction but unable to recall the fluid restriction limit. LVN 6 stated Resident 40 receives fluids from the kitchen, and she encourages Resident 40 to drink 4 to 8 oz of water with medication administration. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 8:20 AM Registered Nurse 1 (RN 1), Resident 40's Physician's Orders were reviewed. The Physician Orders indicated an order of fluid restriction of 1000ml per day, ordered 5/19/2025. RN 1 stated Resident 40's fluid restriction was not started until 6/4/2025, and there were no active fluid restrictions being done for Resident 40 from 5/19/2025 to 6/3/2025. RN 1 stated Resident 40 needs to have the fluid restrictions order followed because he has kidneys (a pair of organs that filter waste materials and extra water out of the blood) that are not functioning properly and is at risk for fluid overload, possibly causing respiratory (relating to breathing) or heart issues including increased blood pressure and edema (swelling caused by excess fluid trapped in your body's tissues). During an interview on 6/5/2025 at 10:19 AM with the Dietary Supervisory (DS), DS stated nursing did not give her a fluid restriction order for Resident 40 until 6/4/2025 and there was no fluid restriction in place for Resident 40 until 6/4/2025. During an interview on 6/5/2025 at 11:38 AM with the director of Nursing (DON), DON stated Resident 40's fluid restriction of 1000ml was ordered 5/19/2025 but was not started by staff until 6/4/2025 because facility staff failed to activate the order in Resident 40's electronic chart. DON stated the order should have been started and followed on 5/19/2025 to prevent Resident 40 from having negative outcomes like fluid overload. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, revised 11/1/2017, the P&P indicated dialysis residents will have fluid restrictions as ordered by the physician, nursing and dietary staff will carefully organize the division and distribution of fluid. During a review of the facility's P&P titled, Diet Record Maintenance, revised 6/1/2017, the P&P indicated the facility will provide residents with meals that meet the nutritional and consistency requirements per physician orders. The P&P also indicated the dietary record system will contain and reflect the diet order on the resident's tray card.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide trauma-informed care (TIC, an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumas) for one (1) of 1 sampled resident (Resident 83) who was diagnosed with post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event) in accordance with the facility's policy. This deficient practice had the potential for Resident 83 to experience re-traumatization, (unintentionally causing harm through practices, policies, and/or activities that are insensitive to the needs of the residents) that could lead to severe psychosocial harm and negatively affecting Resident 83's quality of life. Findings: During a review of Resident 83's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included post traumatic PTSD and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 83's Social Service Assessment (a process where a social worker evaluates an individual's needs to determine the best support and resources to help them) dated 4/7/2025 timed at 12:48 PM, the Social Service Assessment indicated Resident 83 claimed to have PTSD with triggers that included being touched, loud noise and yelling. During a review of Resident 83's Minimum Data Set (MDS - a resident assessment tool) dated 4/13/2025, the MDS indicated Resident 83 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 83 required partial assistance (helper does less than half the effort) with toileting, shower, lower body dressing, and putting on/taking off footwear and required supervision (helper provides verbal cues) with oral and personal hygiene, and upper body dressing. The MDS further indicated Resident 83 had an active diagnosis of PTSD. During an interview on 6/3/2025 at 9:00 AM, Resident 83 stated she has PTSD that is triggered by loud noises and when someone stands over her. Resident 83 also stated she had witnessed robbery in the past which resulted to the PTSD. Resident 83 further stated she never had sat down with anyone in the facility to discuss about developing a care plan for her PTSD. During an interview on 6/3/2025 at 4:19 PM, Certified Nursing Assistant (CNA 6) stated she was unaware of Resident 83's PTSD diagnosis and its triggers. During an interview on 6/3/2025 at 4:27 PM, Registered Nurse 1 (RN 1) stated all the facility staff taking care of Resident 83 should know the residents PTSD triggers to prevent associated symptoms. During an interview on 6/4/2025 at 3:11 PM, Licensed Vocational Nurse 6 (LVN 6) stated the staff should know Resident 83's PTSD triggers to prevent anxiety behaviors. LVN 6 also stated she did not receive an in-service related to PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/4/2025 at 10:50 AM, multiple residents were transported by facility staffs around the facility's hallway by wheelchair accompanied by loud music playing in the background. Same activity was observed daily since 6/2/2025 around the same time. During another interview with Resident 83 on 6/5/2025 at 8:50 AM, Resident 83 stated that the loud music coming from outside her room everyday was too much and it triggers her PTSD and caused her migraine headaches. Resident 83 also stated she wanted to close her door each time they have this particular activity, but the social worker (resident unable to recall the name of the social worker) told her to keep the door open. During a concurrent interview and record review on 6/5/2025 at 10:21 AM, the Director of Nursing (DON) confirmed Resident 83 did not have a comprehensive care plan developed that addressed the residents PTSD and its triggers. The DON stated Resident 83 should have a care plan developed so the facility can come up with a plan to avoid PTSD triggers that could potentially cause repeat trauma to the resident. The DON confirmed the facility was doing Happy Feet activity everyday by letting the residents' go around the hall and allowed them to enjoy the music but also acknowledged that the loud music could trigger Resident 83's PTSD. During an interview on 6/5/2025 at 11:29 AM, the Director of Staff Development (DSD) confirmed LVN 6 did not receive an in-service on TIC/PTSD. The DSD stated training the facility staff on Trauma Informed Care was important for the staff to be aware of how to handle residents with PTSD. During a review of the facility's Policy and Procedure (P&P) titled Trauma Informed Care, dated June 4, 2025, indicated its purpose was to effectively address client's psychosocial issues, as it pertains to history of trauma and to treat the whole person, with histories of trauma, that recognizes the presence of trauma symptoms and acknowledges the role trauma played in their lives. The P&P also indicated that the facility shall identify triggers that can negatively affect residents' well-being and implement resources, activities, environment adjustments and plan of care in an attempt to reduce any unnecessary feelings/emotions related to past trauma with present interaction/situations in an attempt to maintain the resident's quality of life while a resident of the facility. The P&P further indicated that the facility will provide trauma informed training to employees upon hire and annually and Inter Disciplinary Team (IDT, comprised of team members from different disciplines working together, with a common purpose, to set goals, make decisions, and share resources and responsibilities) to develop a trauma informed plan of care to address issues surrounding past trauma as a way to prevent retraumatizing resident and creating a safe environment.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the Posted Nursing Hours for Direct Care Staff (Nurse Staffing Information) on 5/30/2025, 6/2/2025, 6/3/2025 and 6/4/2025 were accurate in accordance with the facility's policy and procedure. This deficient practice had the potential for residents and visitors to not be informed of the actual number of nurses providing direct care to the residents. Findings: During an observation on 6/2/2025 at 7:39 AM, the Nurse Staffing Information posted by the front lobby of the facility was dated 5/30/2025. During an observation on 6/3/2025 at 8:05 AM, the Nurse Staffing Information posted by the front lobby of the facility was dated 6/2/2025. During an interview on 6/4/25 at 4:46 PM, the Director of Staff Development (DSD) stated the Nurse Staffing Information should have the correct date, so the visitors, staff, and residents know how many staff per patient ratio are working that day. The DSD also stated before the assistant DSD leaves for the day she should have already anticipated how many staff they have for the next day. During an interview on 6/5/25 at 10:46 AM, the Director of Nursing (DON) stated the Nurse Staffing Information posted should be accurate so that the staff, visitors, residents or anyone who walks in the facility would know how many staff should be in the facility to provide care to the residents based on how many residents are in house. During a review of the Nurse Staffing Information, Nursing Staffing Assignment and Sign-in Sheet on 6/5/25 at 3:50 PM with the DSD, the DSD confirmed the Nurse Staffing Information posted did not accurately reflect the number of staff on the Nursing Staffing Assignment and Sign-in Sheet that were working for the following dates: 5/30/2025 - 11 PM to 7 AM shift in Subacute (a specialized unit within the skilled nursing facility that provides care to residents who are not acutely ill but require more intensive care than is typically offered in a regular nursing home) 6/2/2025 - 3 PM to 11 PM shift in Skilled Nursing Facility (SNF, a type of nursing home that provides specialized medical and rehabilitation care that is temporary and short term for people to recover and regain independence before returning home). 6/3/2025 - 7 AM to 3 PM shift for SNF 6/4/2025 - 7 AM to 3 PM shift for SNF During an interview on 6/5/25 at 4:15PM, the Administrator (ADM) stated the Nurse Staffing Information posted should be accurate to make sure we have the actual count of staff working and to ensure residents are being cared for appropriately depending on the census and acuity. (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility Policy and Procedure (P&P) titled, Nursing Department - Staffing, Scheduling, and Postings, revised October 24, 2022, the P&P indicated that the nurse staffing information will be posted daily and will include the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for residents' care per shift. The policy also indicated that the information posted will be in a prominent place readily accessible to staff, residents, and visitors.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services for three (3) of 11 sampled Residents (Residents 48, 73, and 76) by failing to ensure: 1. Resident 48 received Marinol (a cannabinoid, a man-made form of cannabis [marijuana is an herbal form of cannabis] used to treat loss of appetite in people with acquired immunodeficiency syndrome [disease in which there is a severe loss of the body's immunity, greatly lowering the resistance to infection and malignancy] and to treat severe nausea and vomiting caused by cancer chemotherapy) medication two times daily from 5/6/2025 to 5/13/2025 (8 days, total of 15 missed doses). 2. Resident 73's medications were administered timely in accordance with the physician's order. a. Apixaban (a medication used to help prevent strokes or blood clots in people who have atrial fibrillation [a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes]) twice daily. b. Spironolactone (a medication used to treat build-up of fluid in your body) twice daily. c. Finasteride (a medication that treats the symptoms of an enlarged prostate) twice daily. d. Bethanechol (a medication that stimulates your bladder to help you urinate) twice daily. This deficient practice had the potential to result in Resident 48 to experience a decrease in appetite and possible weight loss due to poor appetite and for Resident 73 to experience irregular heartbeat, fluid retention, urinary retention, and decline in overall health status. 3. Resident 76 medications were not left at the resident's bedside table. This deficient practice had the potential for medication errors and accidental administration of the medications to another resident. Findings: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and recurrent major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a record review of Resident 48's Minimum Data Set (MDS, a resident assessment and tool), dated 5/5/2025, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making were severely impaired. The MDS indicated Resident 48 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for eating, toileting hygiene, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer. The MDS also indicated Resident 48's mood interview had poor appetite or overeating for seven (7) to 11 days (half or more of the days). During a record review of Resident 48's Order Summary Report (OSR), dated 2/15/2025, the order Summary Report indicated Megestrol Acetate (Megace, a medication used to treat serious weight loss caused by certain health conditions) Oral Suspension 400 milligrams (mg, unit of measurement)/milliliter (ml, unit of volume): Give ten ml by mouth two (2) times a day for poor appetite. During a review of Resident 48's Medication Regimen Review (MRR, consists of a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) recommendation titled, Note to Attending Physician/Prescriber, dated 4/25/2025, the MRR Note to Attending Physician/Prescriber indicated Resident 48 was currently on Megestrol (Megace, a medication used to treat serious weight loss caused by certain health conditions). The MRR recommendation was to discontinue Megace and start Marinol 2.5 mg twice a day with meals due to an increased risk for thromboembolic phenomena (a situation where a blood clot breaks off travels through the bloodstream and block a blood vessel which can lead to tissue damage, organ damage, or death), edema (swelling caused by too much fluid trapped in the body's tissues), hyperglycemia (high blood sugar), and adrenal suppression (occurs when the adrenal glands [glands located on top of kidneys] don't make enough of certain hormones) for continued Megace usage. During a record review of Resident 48's OSR, dated 5/6/2025, the OSR indicated Marinol oral capsule 2.5 mg: Give one (1) capsule by mouth 2 times a day for vomiting give with meals. During a record review of Resident 48's Medication Administration Record (MAR, a medical record used by healthcare providers to document the administration of a medication or treatment) for the month of May 2025, the MAR indicated Marinol oral capsule 2.5 mg: Give one capsule by mouth two times a day for vomiting give with meals start date 5/6/2025 at 5:15 PM. The MAR indicated Resident 48 missed one dose on 5/6/2025 and missed 2 doses on days 5/7/2025 through 5/13/2025. During a record review of Resident 48's Nursing Notes, dated 5/6/2025 to 5/13/2025, the Nursing Notes indicated Marinol oral capsule 2.5 mg medication was not available and was waiting delivery from the pharmacy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 48's Nursing Notes, Physician Order Summary Report, and MAR on 6/5/2025 at 9:39 AM with the Director of Nursing (DON), the DON stated from 5/6/2025 through 5/13/2025 Resident 48 did not and should have received the Marinol medication. The DON stated the nursing notes indicated licensed nurses were awaiting the pharmacy to deliver the medication. The DON stated the pharmacy delivered medications within a 24-hour period. The DON stated when the medication was not available for delivery the licensed nurses should have and did not notify the doctor within a 24-hour period. The DON stated Resident 48 was not administered Marinol for a total of 8 days. The DON stated Resident 48 needed the ordered medication Marinol to increase her appetite due to her poor appetite. During a record review of the facility's policy and procedure (P&P) titled, Medication - Administration, revised 6/1/2017, the policy indicated medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. During a record review of the facility's P&P titled, Provider Pharmacy Requirements, dated 1/2022, the policy indicated the provider pharmacy agrees to perform the following pharmaceutical services including but not limited to providing routine and timely pharmacy service as contracted and emergency pharmacy service 24 hours per day, seven days per week. All other new medication orders are received and available for administration as soon as possible on the next routine delivery, unless indicated otherwise by facility staff 2. During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was admitted to the facility on [DATE], with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), atrial fibrillation, and urinary retention (a condition in which you cannot empty all the urine from your bladder) During a record review of Resident 73's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 73 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed and chair/ bed - to chair transfer. During a record review of Resident 73's Order Summary Report OSR, the OSR indicated the following medications: a) Apixaban 5 milligrams (mg, unit of weight), give 1 tablet via gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) two (2) times a day for atrial fibrillation, dated 7/18/2024. b) Bethanechol 50 mg, give 1 tablet via G-tube 2 times a day for urinary retention, dated 7/18/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Rose Care Center	1899 N Raymond Ave Pasadena, CA 91103

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) Finasteride 5 mg, give 1 tablet via G-tube 1 time a day for urinary retention, dated 1/2/2025. d) Spironolactone 25 mg, give 1 tablet via G-tube 2 times a day for COPD, dated 5/12/2025. During a record review of Resident 73's Medication Administration Record (MAR), dated from 6/1/2025 to 6/30/2025, the MAR indicated Resident 73 was scheduled to receive four medications at 9 AM: 1. Spironolactone 25 mg 2. Finasteride 5 mg 3. Apixaban 5 mg 4. Bethanechol 50 mg During an observation of the medication administration on 6/5/2025 at 10:18 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 administered the following medications: a) Apixaban 5 mg, give 1 tablet via G-tube 2 times a day for atrial fibrillation. b) Bethanechol 50 mg, give 1 tablet via G-tube 2 times a day for urinary retention. c) Finasteride 5 mg, give 1 tablet via G-tube 1 time a day for urinary retention. d) Spironolactone 25 mg, give 1 tablet via G-tube 2 times a day for COPD. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 10:26 AM with LVN 4, LVN 4 stated, all the medications she administered were scheduled at 9 AM. the medications can be given 1 hour before and 1 hour after 9AM. LVN 4 administered Resident 73's medications at 10:18 AM and finished at 10:24 AM. During an interview on 6/5/2025 at 10:26 AM with LVN 4, LVN 4 stated, The medications for urinary retention were administered late, it means resident (Resident 73) may not be able to urinate on normal schedule. The spironolactone was also late, resident may have fluid retention and the apixaban was also late which may affect resident's heartbeat and blood clotting. During a review of the facility's P&P, titled, Administering Medications, revised on 6/1/2017, the P&P indicated the following: I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. V. Medications may be administered one hour before or after the scheduled medication administration time. Nursing Staff will keep in mind the seven rights of medication when administering medication: A. The right medication B. The right amount C. The right resident D. The right time E. The right route F. Right indication G. Right outcome (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 76's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had intact cognitive skills for daily decision making. The MDS also indicated Resident 76 was dependent) with lower body dressing and putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting, shower, and upper body dressing. The MDS further indicated Resident 76 required setup assistance (helper sets up; resident completes activity) with eating and oral hygiene. During a concurrent observation and interview on 6/2/2025 at 8:07 AM, Resident 76 was lying in bed with a medication cup containing 2 white round medications left on top of the bedside table. Resident 76 stated she told the nurse providing the medications (unable to remember the name of the nurse) that she was refusing to take them. During a review of Resident 76's Nursing admission Assessment, dated 5/30/2025, and signed by Registered Nurse 1 (RN 1), the Nursing admission Assessment indicated Resident 76 did not request to self-administer her medications. During an interview on 6/5/2025 at 10:35 AM, the DON stated no medications should be left at the residents' bedside to ensure the medications would not be accidentally taken by another resident. The DON also stated the licensed staff should have taken the medications back and documented Resident 76 refusal in the MAR. During an interview on 6/5/2025 at 11:18 AM, Licensed Vocational Nurse 5 (LVN 5) stated it was not acceptable to leave Resident 76's medications at the bedside table. LVN 5 also stated the licensed staff should witness the resident take the medications instead of leaving them at the bedside since the resident could take the medications later which could potentially cause an overdose if not spaced out. LVN 5 further stated, the licensed staff should have labeled Resident 76's medication cup, kept it in a locked medication cart, offer the medications 3 times to the resident and then discard the medications safely in the medication room if the resident still refused to take them. During a review of the facility's P&P titled, Medication - Administration, revised June 1, 2017, indicated that the facility provides practice standards for safe administration of medications for residents in the facility. The policy also indicated that medications will not be left at the bedside.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Medication Regimen Review (MRR, consists of a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) for one (1) of five (5) residents (Resident 48) was conducted monthly for the months of February 2025 and March 2025. This deficient practice had the potential for Resident 48 to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a record review of Resident 48's Minimum Data Set (MDS, a resident assessment and tool), dated 5/5/2025, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making were severely impaired. The MDS indicated Resident 48 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for eating, toileting hygiene, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer. The MDS also indicated Resident 48 was taking high risk drug medications such as antipsychotic (medication that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking), antianxiety (medication used to treat symptoms such as feelings of fear, dread, uneasiness, and muscle tightness), antidepressant (medication primarily used to treat depression and other mental health conditions), and an anticoagulant (medicine that help prevent blood clots). During a record review of the MRR for the month of February 2025, the MMR failed to indicate a review was done for Resident 48's medication regimen. During a record review of the MRR for the month of March 2025, the MMR failed to indicate a review was done for Resident 48's medication regimen. During an interview on 6/5/2025 at 8:46 AM with the Director of Nursing (DON), the DON stated all residents in the facility should be included in the MRR. The DON stated the importance of conducting MRR for residents were identify potential medication interactions, ensure medications were appropriate for residents' diagnosis and treatments, determine if any medications should be discontinued and assess whether any adjustments or recommendations were needed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 9:01 AM with the DON, the monthly MRRs for February and March 2025 were reviewed. The DON stated Resident 48's medications were not and should have been included in the February 2025 and March 2025 MRRs. The DON stated the consultant pharmacist would send the MRR via email with all the medications reviewed. The DON stated she did not check to make sure all residents in the facility were included in the MRR. The DON stated the facility missed 2 months of MRR for Resident 48. During a review of the facility's policy and procedure titled, Drug Regimen Review, revised 11/1/2017, the policy indicated the pharmacist will review each resident's medication regimen at least once a month to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one (1) of five (5) residents (Resident 48), was free of unnecessary medication by failing to clarify the order indication (a specific reason or medical condition that justifies the use) for Marinol (a cannabinoid, a man-made form of cannabis [marijuana is an herbal form of cannabis] used to treat loss of appetite in people with acquired immunodeficiency syndrome [disease in which there is a severe loss of the body's immunity, greatly lowering the resistance to infection and malignancy] and to treat severe nausea and vomiting caused by cancer chemotherapy). This deficient practice had the potential to result in a lack of monitoring the intended indication for Marinol use. Findings: During a review of Resident 48's admission Record, the admission Record indicated Resident 48 was initially admitted to the facility on [DATE] and readmitted on [DATE], with the diagnoses including but not limited to encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and recurrent major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 48's Medication Regimen Review (MRR, consists of a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) recommendation titled, Note to Attending Physician/Prescriber, dated 4/25/2025, the Note to Attending Physician/Prescriber indicated Resident 48 was currently on Megestrol (Megace, a medication used to treat serious weight loss caused by certain health conditions). The MRR recommendation was to discontinue Megace and start Marinol 2.5 milligram (mg, unit of measurement) twice a day with meals due to an increased risk for thromboembolic phenomena (a situation where a blood clot breaks off travels through the bloodstream and block a blood vessel which can lead to tissue damage, organ damage, or death), edema (swelling caused by too much fluid trapped in the body's tissues), hyperglycemia (high blood sugar), and adrenal suppression (occurs when the adrenal glands [glands located on top of kidneys] don't make enough of certain hormones) for continued Megace usage. During a record review of Resident 48's Minimum Data Set (MDS, a resident assessment and tool), dated 5/5/2025, the MDS indicated the resident's cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making were severely impaired. The MDS indicated Resident 48 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for eating, toileting hygiene, sit to lying, lying to sitting on side of bed and chair/bed-to-chair transfer. The MDS also indicated Resident 48's mood interview had poor appetite or overeating for seven (7) to 11 days (half or more of the days). During a record review of Resident 48's Order Summary Report, dated 5/6/2025, the report indicated Marinol oral capsule 2.5 milligrams (mg, unit of measurement): Give one capsule by mouth two (2) times a day for vomiting give with meals. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025 at 9:23 AM with the Director of Nursing (DON), Resident 48's MRR and Order Summary Report were reviewed. The DON stated Resident 48 was taking Megace for poor appetite. The DON stated Megace was discontinued and replaced with Marinol after the MRR. The DON stated the current order indicated Resident 48 was taking Marinol for vomiting, however the indication was incorrect and should have indicated for poor appetite. DON stated Resident 48 was not vomiting. The DON stated the licensed nurse needed to clarify Resident 48's order for Marinol. The DON stated Resident 48's Marinol needed to include the proper indication for her diagnosis, so staff were aware of what the medication's indication. During the same interview on 6/5/2025 at 9:48 AM with the DON, the DON stated Marinol's indication was vomiting, and Resident 48 was not vomiting. The DON stated the licensed nurse should have and did not notify the doctor either to add parameters to hold the medication since resident was not vomiting based on the indication for the medication. The DON stated the licensed nurses should have clarified the indication of the Marinol based on Resident 48's diagnosis. During a record review of the facility's policy and procedure titled, Physician Orders, revised 5/1/2019, the policy indicated medication orders will include the condition/diagnosis for which the medication is ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five (5) percent (%). Four (4) medications errors (the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order/ manufacturer's specifications / accepted professional standards and principles) out of 33 opportunities (observed administered medications) for error and yielded a facility medication rate of 12.12% for one (1) of five (5) sampled residents (Resident 73) observed during medication administration (med pass):. Resident 73 did not receive the following medications timely in accordance with the physician's order: a. Apixaban (a medication used to help prevent strokes or blood clots in people who have atrial fibrillation [a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes]) twice daily. b. Spironolactone (a medication used to treat build-up of fluid in your body) twice daily. c. Finasteride (a medication that treats the symptoms of an enlarged prostate) d. Bethanechol (a medication that stimulates your bladder to help you urinate) twice daily. This deficient practice had the potential to result in harm to Resident 73 by not administering medications as prescribed by the physician in order to meet the resident's medication needs. Findings: During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was admitted to the facility on [DATE], with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), chronic respiratory failure (a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide), atrial fibrillation, and urinary retention (a condition in which you cannot empty all the urine from your bladder) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 73's Minimum Data Set (MDS, a resident assessment and tool), dated 4/25/2025, the MDS indicated the resident's cognitive skills (ability to understand and make decisions) for daily decision making were severely impaired. The MDS indicated Resident 73 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed and chair/ bed - to chair transfer. During a record review of Resident 73's Order Summary Report OSR, the OSR indicated the following medications: a) Apixaban 5 milligrams (mg, unit of weight), give 1 tablet via gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) two (2) times a day for atrial fibrillation, dated 7/18/2024. b) Bethanechol 50 mg, give 1 tablet via G-tube 2 times a day for urinary retention, dated 7/18/2024. c) Finasteride 5 mg, give 1 tablet via G-tube 1 time a day for urinary retention, dated 1/2/2025. d) Spironolactone 25 mg, give 1 tablet via G-tube 2 times a day for COPD, dated 5/12/2025. During a record review of Resident 73's Medication Administration Record (MAR), dated from 6/1/2025 to 6/30/2025, the MAR indicated Resident 73 was scheduled to receive four medications at 9 AM: 1. Spironolactone 25 mg 2. Finasteride 5 mg 3. Apixaban 5 mg 4. Bethanechol 50 mg During an observation of the medication administration on 6/5/2025 at 10:18 AM with Licensed Vocational Nurse 4 (LVN 4), LVN 4 administered the following medications: a) Apixaban 5 mg, give 1 tablet via G-tube 2 times a day for atrial fibrillation. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) Bethanechol 50 mg, give 1 tablet via G-tube 2 times a day for urinary retention. c) Finasteride 5 mg, give 1 tablet via G-tube 1 time a day for urinary retention. d) Spironolactone 25 mg, give 1 tablet via G-tube 2 times a day for COPD. During an interview on 6/5/2025 at 10:26 AM with LVN 4, LVN 4 stated, all the medications she administered were scheduled at 9 AM. the medications can be given 1 hour before and 1 hour after 9AM. LVN 4 administered Resident 73's medications at 10:18 AM and finished at 10:24 AM. During an interview on 6/5/2025 at 10:26 AM with LVN 4, LVN 4 stated, The medications for urinary retention were administered late, it means resident (Resident 73) may not be able to urinate on normal schedule. The spironolactone was also late, resident may have fluid retention and the apixaban was also late which may affect resident's heartbeat and blood clotting. During a review of the facility's P&P, titled, Administering Medications, revised on 6/1/2017, the P&P indicated the following: I. Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. V. Medications may be administered one hour before or after the scheduled medication administration time. Nursing Staff will keep in mind the seven rights of medication when administering medication: A. The right medication B. The right amount C. The right resident D. The right time E. The right route F. Right indication G. Right outcome

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide one (1) of two (2) sampled residents (Resident 21) with meals that accommodated the resident's food preferences. This deficient practice had the potential to result in decreased meal intake and can lead to weight loss and malnutrition (a condition that occurs when a person's body doesn't get the right amount of nutrients it needs to function properly). Findings: During a review of Resident 21's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included severe protein calorie malnutrition and muscle wasting and atrophy (a decrease in muscle mass, often due to an extended period of immobility). During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2025, the MDS indicated Resident 21 had moderate impairment in cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 21 was dependent (helper does all the effort) with toileting and personal hygiene, shower, upper and lower body dressing. During a review of Resident 21's progress notes dated 5/27/2025, the progress notes indicated Resident 21 was changed to dysphagia mechanical soft, thin liquids diet and did not indicate what was Resident 21's food preferences. During a review of Resident 21's medical record, the medical record did not indicate a Nutritional Quarterly Progress Evaluation (method used to assess a person's nutritional status and progress towards their nutrition-related goals) which included the food preferences of Resident 21 after the resident was started on oral diet on 5/27/2025. During an interview on 6/3/2025 at 9:50 AM, Resident 21 stated she did not like the food being served because they did not look good, and they tasted bad and terrible. Resident 21 also stated she had told everyone (resident unable to name the staffs she spoke to) she wanted three (3) hashbrowns, a tomato sauce, and eggs for breakfast but nothing was ever done, and dietary people never came to ask for her food preferences. During a concurrent interview and record review on 6/03/25 at 3:12 PM, the Dietary Director (DD) confirmed Resident 21's did not have a Nutritional Quarterly Progress Evaluation done after 4/10/2025. The DD stated Residents 21's food preferences should be honored to prevent weight loss and to ensure the resident was happy. During an interview on 6/05/25 at 10:41 AM, the Director of Nursing (DON) stated the facility should provide whatever food preference Resident 21 likes because that was one of the resident's rights. (continued on next page)

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Golden Rose Care Center	1899 N Raymond Ave Pasadena, CA 91103

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2025 at 11:14 AM, Licensed Vocational Nurse 5 (LVN 5) the facility staff should have told the dietician, speech therapist and notify Resident 21's physician about her food choices and preferences. LVN 5 also stated the facility should honor Resident 21's choices but still ensure residents safety. During a review of the facility's Policy and Procedure (P&P) titled Resident Preference Interview revised June 1, 2017, indicated that the dietary manager or designee will utilize the dietary questionnaire to determine food preferences for residents consuming oral diets. The P&P also indicated that the dietary department would provide residents with meals consistent with their preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure by failing to: a. Label open foods in the kitchen with item name and 'use by' date (the last date recommended for the use of the product) or open date. b. Discard expired foods in the kitchen. These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization. Findings: During a concurrent observation in the kitchen and interview with the Dietary Supervisor (DS) on 6/2/2025 at 7:50 AM, the kitchen was observed with food items not labeled to indicate the food item names, open date, and use by date. The DS stated all food items were supposed to be labeled with food item name, use by date, and food must be discarded when expired. DS stated. the following were found in the kitchen's cooking station, dry storage, refrigerator and/or freezer: a. Clear container of beets in refrigerator labelled use by date of 6/1/2025. b. One opened tub of cottage cheese with use by date of 5/30/2025. c. One opened gallon container of buttermilk ranch dressing with no open and use by date. d. Four bags of corn tortillas with use by dates of 4/29/2025, 4/29/2025, 5/12/2025, and 5/28/2025. e. One opened four-pound jar of peanut butter with no open and use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DS stated the cottage cheese, buttermilk ranch dressing, and peanut butter were opened but was not and should have been labeled with the name of the food item and dated the item with an open or use by date in order to know when to discard the food. DS stated all expired food items should have been thrown away. DS stated all food items should have been labeled with the item name along with a use by date to know when the food items were going to expire. DS stated the importance of having an expiration date on the food items was to prevent serving expired foods to the residents. DS stated serving expired food items to the residents would get the residents sick by causing food poisoning. During a record review of the facility's policy and procedure titled, Food Storage, revised 6/1/2017, the policy indicated label and date all food items. During a review of the 2022 FDA 2022 Food Code 2022, 3-501.18 titled, Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition, indicated time/temperature control safety refrigerated foods must be consumed, sold, or discarded by the expiration date. https://www.fda.gov/media/164194/download?attachment

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage were properly disposed and contained. This deficient practice had the potential to attract pests and rodents. Findings: During an observation on 6/2/2025 at 8:28 AM with the Dietary Supervisor (DS), there were four (4) trash dumpsters overfilled with trash and the lids were not closed. All 4 trash dumpsters were filled, stacked with bags of trash high above the brim of the receptacle. A concurrent interview with the DS, the DS stated the lids to the trash cans need to be closed and not left open. DS attempted to close the lid of the trash dumpster however the lid could not be fully close due to the bags of trash in the dumpster. During a follow up interview on 6/5/2025 at 12:37 PM with DS, DS stated proper trash disposal was needed to prevent pest infestation (a destructive insect or other animal that attacks crops, food, livestock, etc.) and contamination. During a review of the U.S. Food and Drug Administration (FDA) Food Code 2022, dated 1/18/2023, indicated proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. During a review of the facility's policy and procedure titled, Garbage and Trash Can Use and Cleaning, revised 11/1/2017, the policy indicated food waste will be placed in covered garbage and trash cans.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for six (6) of 18 sampled residents (Residents 72, 69, 24, 62, and 73) in accordance with the facility's policy and procedure when: 1. and 2. Certified Nursing Assistant 4 (CNA 4) failed to change gloves and perform hand hygiene (cleaning hands with the use of alcohol-based hand rubs containing 60%-95% alcohol or hand washing with soap and water) after providing incontinence care (assistance provided due to the inability to control the release of urine or stool) to Residents 72 and 69. 3. Respiratory Therapist Director (RTD) failed to change gloves and perform hand hygiene after touching Resident 24's personal items during tracheostomy (a surgical procedure where an opening is created in the neck to directly access the trachea [windpipe] for breathing) care (cleaning the trach the site, changing dressings, suctioning the tube to remove secretions, and potentially replacing or cleaning the inner cannula). 4. CNA 5 failed to doff (take off) Personal Protective Equipment (PPE- protective clothing, goggles, or other garments to prevent or minimize exposure to and spread of infection or illness) and perform hand hygiene before exiting Room B. 5. Licensed Vocational Nurse 4 (LVN 4) failed to change gloves and perform hand hygiene in between task during Resident 62's medication administration. 6. LVN 4 failed to change gloves and perform hand hygiene in between task during medication administration to Resident 73. These deficient practices had the potential to result in the spread of bacteria, viruses and pathogens (harmful microorganisms) to Residents, visitors and staff with the potential to negatively affect Residents 72, 69, 24, 62 and 73's physical and/or psychosocial well-being. Findings: 1. During a review of Resident 72's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following diagnoses of tracheostomy (a surgical procedure where an opening is created in the neck to directly access the trachea [windpipe] for breathing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and candidiasis (a fungal infection caused by a yeast). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 3/19/2025, the MDS indicated Resident 72 was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity, or the assistance of 2 or more helpers is required for the resident to complete the activity) on oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 6/3/2025 at 2:16 PM, CNA 4 was observed providing incontinence care to Resident 72. CNA 4 did not change gloves and did not perform hand hygiene after providing peri-care (involves cleaning the genital and anal areas) to Resident 72. CNA 4 was then observed using the same set of gloves when CNA4 touched Resident 72's bed sheets and the Resident 72's body. 2. During a review of Resident 69's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of anemia (a condition where the body does not have enough healthy red blood cells), gastrostomy, tracheostomy, and toxic encephalopathy (a neurological disorder caused by exposure to toxic substances, leading to brain dysfunction). During a review of Resident 69's MDS, dated 3/7/2025, the MDS indicated Resident 69 was severely impaired in cognitive skills for daily decision making. The MDS also indicated Resident 69 was dependent with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 6/4/2025 at 1:05 PM, CNA 4 was observed providing incontinence care to Resident 69. CNA 4 did not change gloves and did not perform hand hygiene after providing peri-care to Resident 69. CNA 4, was then observed using the same set of gloves when CNA4 touched Resident 69's bed sheets, bed remote, and the resident's body. During an interview on 6/4/2025 at 1:27 PM, CNA 4 stated she should have removed her gloves, performed hand hygiene and changed gloves prior to touching Resident 69's bed sheets, bed remote, and body to prevent the spread of infection. During an interview on 6/4/2025 at 2:57 PM, the Infection Preventionist Nurse (IPN) stated CNAs are supposed to change their gloves and perform hand hygiene after gloves are soiled with urine and feces because it can be transmitted (spread) to the resident's body and surfaces. 3. During a review of Resident 24's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), Extended-Spectrum Beta-Lactamase (ESBL - It's an enzyme produced by some bacteria that makes them resistant to certain types of antibiotics), tracheostomy and gastrostomy. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 24's MDS, dated 5/20/2025, the MDS indicated Resident 24 was severely impaired in cognitive skills for daily decision making. The MDS also indicated Resident 24 was dependent on toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear but required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with upper body dressing and required supervision/touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, assistance may be provided throughout the activity or intermittently) with oral hygiene. During a concurrent observation and interview on 6/4/2025 at 3:20 PM, RTD was observed providing trach care to Resident 24. RTD was then observed touching Resident 24's cell phone and television remote. RTD was then observed using the same set of gloves when RTD prepared a drape (a sterile sheet used to create a sterile field during surgical procedures with the purpose of preventing the spread of infection) on the bedside table and touched the surface of the drape. RTD (using the same set of gloves) was then observed putting the speaking valve on top of the drape and was about to put it back on the resident. RTD stated he was not supposed to touch Resident 24's cell phone and television remote and then use the same set of gloves to prepare and set up the drape. RTD also stated that can spread infection to the resident. During an interview on 6/4/2025 at 3:48 PM, IPN stated RTD should have changed his gloves and performed hand hygiene after touching the resident's phone and television remote because it can transmit microorganisms to the trach area. 4. During a concurrent observation and interview on 6/3/2025 at 10:35 AM, CNA 5 was observed coming out of Room B with PPEs on and putting dirty linen into the linen cart across the hallway. CNA 5 stated she should not have worn her PPEs in the hallway because it can spread infection. During an interview on 6/4/2025 at 2:57 PM, IPN stated the CNA cannot come out of the resident's room with PPE's on because it can contaminate the hallway. IPN also stated the CNAs are supposed to doff PPE's and perform hand hygiene prior to exiting resident's room. 5. During a review of Resident 62's admission Record, the admission Record indicated Resident 62 was admitted to the facility on [DATE] and re-admitted on [DATE], with the diagnoses including but not limited to anoxic brain injury (occurs when the brain receives no oxygen at all), chronic respiratory failure (a condition in which your blood does not have enough oxygen or has too much carbon dioxide), and type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a record review of Resident 62's MDS dated 4/24/2025, the MDS indicated Resident 62's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 62 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, and lying to sitting on side of the bed. During an observation on 6/5/2025 at 9:30 AM, with LVN 4 inside Resident 62's room, LVN 4 pulled the curtain, touched Resident 62's bed sheets, gown then disconnected Resident 62's gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach) feeding connection to the Tube Feeding machine while wearing the same gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/5/2025 at 9:32 AM, with LVN 4 inside Resident 62's room, LVN 4 touched the tube feeding machine, put on her stethoscope, then injected 5 cubic centimeters (cc- unit of measurement) of air in the flush syringe while auscultating (listening to the internal sounds of the body, usually using a stethoscope [a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a piece placed upon the area to be examined]) Resident 62's abdomen then checked the gastric residual volume (GRV, refers to the amount of fluid remaining in the stomach after a meal or during tube feeding) on Resident 62's G-Tube then started medication administration using same gloves. During an interview on 6/5/2025 at 10:29 AM with LVN 4, LVN 4 stated, I should have changed gloves for infection control. There was an increased risk of introducing bacteria to the Resident's G-Tube. The Resident might not have signs and symptoms right away but within a couple of days, he might have infection. 6. During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was admitted to the facility on [DATE], with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), chronic respiratory failure and type 2 diabetes mellitus. During a record review of Resident 73's MDS dated 4/25/2025, the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 73 was dependent for oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of the bed and chair/ bed - to chair transfer. During an observation on 6/5/2025 at 10:06 AM with LVN 4, inside Resident 73's room, LVN 4 pulled the curtain, arranged the bed sheets, then disconnected Resident 73's tube feeding machine without changing gloves. During an observation on 6/5/2025 at 10:07 AM with LVN 4 inside Resident 73's room, LVN 4 injected 5 cubic centimeters (cc- a unit of measurement) of air on the flush syringe, put on her stethoscope then auscultated Resident 73's abdomen then checked the G-tube residual using the same gloves. During an observation on 6/5/2025 at 10:08 AM, with LVN 4 inside Resident 73's room, LVN 4 connected the flush syringe on Resident 73's G-Tube then flush 30 milliliters (ml- a unit of measurement) of water without changing her gloves. During an interview on 6/5/2025 at 10:31 AM with LVN 4, LVN 4 stated, I forgot to change my gloves. I should have changed gloves because of infection control. During an interview on 6/5/2025 at 3:59 PM with the Infection Preventionist Nurse (IPN), IPN stated, It is not okay that staff did not change their gloves when they touched the curtains and then do the medication administration. The staff should have set up their area and then changed gloves because they can introduce bacteria to the residents and resident can have infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, Personal Protective Equipment, revised 7/1/2023, the policy indicated Facility staff wear gloves whenever blood, body fluids, secretions, excretions, mucous membranes, and/ or non- intact skin are touching. The P&P also indicated gloves are used only once and are discarded into the appropriate receptacle located in the room in which the procedure is being performed, and hands are washed before and after the removing of gloves. During a review of the Policy and Procedure (P&P) titled Infection Prevention and Control Program, revised 10/24/2022, the P&P indicated to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. During a review of the facility's P&P titled Hand Hygiene revised 2/20/2025, the P&P indicated to perform hand hygiene after contact with the resident and/or body fluids and environmental surfaces. The P&P also indicated the use of gloves does not replace hand hygiene procedures and hand hygiene is always the final step after removing and disposing of personal protective equipment.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the antibiotic stewardship program protocols for prescribing the appropriate antibiotics (medication used to treat or prevent some types of bacterial infection) was followed for one (1) of two (2) sampled residents (Resident 25) prior to the administration of the resident's antibiotic therapy. This deficient practice had the potential for Resident 25 to be prescribed inappropriate antibiotics and increased the risk for developing antibiotic-resistant organisms (bacteria that are not controlled or killed by antibiotics). Findings: During a review of Resident 25's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following diagnoses of pneumonia (an infection/inflammation in the lungs), sepsis (a life-threatening blood infection), urinary tract infection (UTI- an infection in the bladder/urinary tract), Extended Spectrum Beta Lactamase (ESBL - It's an enzyme produced by some bacteria that makes them resistant to certain types of antibiotics) Resistance. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool), dated 6/3/2025, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 25 was dependent (helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear. During a review of Resident 25's Physician's Order, dated 5/28/2025, the Physician's Order indicated meropenem (an antibiotic used to treat a variety of infections) intravenous (IV - administered into the vein) solution reconstituted 1 gram (g - unit of measure), use 1 gram IV every eight (8) hours for pneumonia until 6/5/2025. During a review of Resident 25's Surveillance Data Collection Form, dated 5/28/25, indicated Resident 25 only met criteria 1. There was no indication for Resident 25 to receive antibiotic since resident only met one criterion. During a concurrent interview and record review on 6/5/2025 at 12:45 PM with the Infection Preventionist Nurse (IPN), the surveillance data collection form, dated 5/28/2025, was reviewed. The IP Nurse stated all three (3) criteria must be met for antibiotic therapy to be initiated. The IP Nurse also stated there was no documentation that indicated the doctor was notified, after Resident 25 only met criteria 1 on the surveillance data form. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and control, revised 12/1/2021, the P&P indicated the IPN will review the infection control surveillance form and surveillance data collection form initiated by licensed nurse and determine if the infection meet the associated infection. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During a review of Resident 86's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included dependence on supplemental oxygen, tracheostomy (plastic tube inserted into a hole made in the neck to help a person breath), and aphonia (loss of voice). During a review of Resident 86's MDS, dated 12/17/2024, the MDS indicated Resident 86 had moderate impairment in cognitive skills for daily decision making. The MDS also indicated Resident 86 was dependent with oral, toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. During an observation on 6/2/2025 at 9:32 AM, Resident 86 was in bed sleeping with her call pad on the left side hanging by the side of the bed away from the resident. During an interview on 6/4/2025 at 9 AM, Resident 86 gestures and nods that she uses the call pads to call the staff for help. During an interview on 6/5/2025 at 9:59 AM, RN 1 stated the call pad is used by Resident 86 to call for help. RN 1 also stated residents in the subacute unit (a specialized unit within the skilled nursing facility that provides care to residents who are not acutely ill but require more intensive care than is typically offered in a regular nursing home) are mostly non-verbal (inability to use words to communicate) because of the tracheostomy tube and they need to have that call pad within reach to inform staff when they needed help. RN 1 further stated Certified Nursing Assistants (CNAs), Licensed Vocational Nurses (LVNs) and Registered Nurses (RNs) in subacute should make rounds and ensure the residents call lights are within the residents' reach. During a review of the facility's Policy and Procedure (P&P) titled, Communication - Call System, revised 10/24/2022, the P&P indicated the facility will provide a call system to enable residents to alert the nursing staff from their beds and call cords will be placed within the resident's reach in the resident's room with a purpose to provide a mechanism for residents to promptly communicate with nursing staff. The P&P further stated that an adaptive call bell (flat pad, call cord, hand bell, etc.) will be provided to a resident per the resident's needs. Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within the resident's reach (arm's length) for two (2) of 18 sampled residents (Resident 23 and 86) as indicated on the facility's call system policy. This deficient practice had the potential for Residents 23 and 86 to be unable to call the facility staff for assistance especially during an emergency, which could lead to an injury or harm. Findings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055862	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Rose Care Center	1899 N Raymond Ave Pasadena, CA 91103

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a review of Resident 23's admission Record, the admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities) and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 5/21/2025, the MDS indicated Resident 23 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making but he was usually understood in his ability to express ideas and wants and understood verbal content from others. The MDS also indicated Resident 23 was dependent (helper does all effort needed to complete activity) with toileting, bathing, dressing and partial/moderate assistance (helper does less than half the effort needed to complete the activity) with eating, oral and personal hygiene. The MDS also indicated Resident 23 is dependent for rolling left to right in bed, moving from a lying to sitting position, sitting to lying position and was unsafe with walking and picking up objects from the floor. During a concurrent observation and interview on 6/2/2025 at 10:55 AM with Certified Nursing Assistant 2 (CNA 2) at Resident 23's bedside, Resident 23's call light was observed on the floor, on the right side of the resident's bed. CNA 2 stated Resident 2's call light should have been clipped to the bed and in reach for Resident 23. CNA 2 also stated the call light is supposed to be accessible to the residents because it is their first line of help when needed. During an interview on 6/5/2025 at 9:07 AM with the Registered Nurse 1 (RN1), RN 1 stated staff are to make sure call lights are in reach of residents, especially for nonverbal and residents who cannot walk. RN 1 also stated it was important to make sure call lights are in reach because to prevent falls, address their needs and staff are unable to ensure needs are being met if call lights are not within their reach or working. During an interview on 6/5/2025 at 11:38 AM the Director of Nursing (DON), [NAME] stated it is important that call lights are within the reach of residents when they need help and assistance, they can press that button and staff become aware. DON also stated if residents do not have a call light in reach, staff does not know what they need and will not be able to give the proper care.