

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 promote healing, and prevent development and worsening of pressure ulcer/injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) for two (2) of 2 sampled residents (Resident 19 and 71), reviewed for pressure ulcer and skin condition in accordance with the facility's policy and procedure by: Failing to ensure Resident 19's low air loss mattress (LAL - a specialized medical bed surface featuring inflatable air chambers with tiny, perforated holes with airflows to wick away moisture and regulate skin temperature for preventing and healing the skin and the underlying tissue damage) air pressure setting was set up according to the resident's body weight. Failing to ensure Resident 71's LAL mattress air pressure setting was set according to the resident's weight and the weekly skin assessments were completed for Resident 71's pressure ulcer after 6/17/2026. This deficient practice had the potential to cause discomfort, friction, and worsening to Resident 19 and Resident 71's pressure ulcers. Findings: 1. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 19's diagnoses included type 2 diabetes mellitus with foot ulcer (a patient with chronically high sugar level in the blood stream who has developed an open sore or wound on their foot), encounter for attention to gastrostomy (a medical procedure that creates a small, artificial opening through the abdomen directly into the stomach, it allows for the insertion of a feeding tube [G-tube] to safely deliver liquid nutrition, fluids, and medications, and dysphagia oral pharyngeal phase [difficulty initiating a swallow, where food or liquid cannot move properly from the mouth to the top of the esophagus]). During a review of Resident 19's Minimum Data Set (MDS, resident assessment tool), dated 5/29/2026, the MDS indicated Resident 19 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, and sitting to lying. During a review of Resident 19's weight from the vital sign section of the point click care system (an electronic health record [HER] and healthcare software platform designed specifically for the senior care, long-term care, and post-acute care industries. It acts as a central system for nursing homes (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
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and assisted living facilities to manage patient records, medications, and billing) dated 6/6/2026, it indicated Resident 19 weighed 113 pounds. During a review of Resident 19's Care Plan on low air loss mattress for wound management, initiated on 2/19/2026, the Care Plan indicated Resident 19's low air loss mattress is set according to resident weight, comfort and manufacture setting, monitoring the air pressure setting and functionality of the mattress. During an observation on 7/7/2026 at 12:56 PM in Resident 19's room, observed Resident 19's low air loss mattress machine's setting was at the range of between 280 pounds to 320 pounds. During an interview on 7/9/2026 at 2:16 PM with Wound Care Nurse 1 (WCN 1), WCN 1 stated Resident 19 LAL's air mattress setting was supposed to be set according to Resident 19's body weight, which was 113 pounds. WCN 1 also stated it is very important to set the LAL's air pressure according to resident's body weight and monitor the air pressure setting to make sure the LAL maximizes the mattress's pressure redistribution, protects vulnerable skin, and prevents existing wounds from worsening or causing discomfort. During a concurrent interview and record review on 7/9/2026 at 3:22 PM with Maintenance Manager (MM), LAL mattress model menu (undated) was reviewed. The LAL mattress menu indicated LAL mattress setting should be in accordance with the resident's weight. MM stated Resident 19's LAL mattress model menu instruction for the setting of the machine is to set the LAL's mattress according resident's weight for optimal comfort and support. During an interview on 7/9/2026 at 4:56 PM with the Director of Nursing (DON), the DON stated it is important to set the LAL's air pressure according to resident's body weight and monitor the air pressure setting per the LAL mattress menu's instruction to maximize the LAL mattress's pressure redistribution, protects vulnerable skin, and prevents existing wounds from worsening or causing discomfort to Resident 19. During a review of the facility's Policy and Procedure (P&P) titled, Support Surface Guidelines, revised 5/1/2026, the P&P indicated the purpose is to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. The P&P indicated the Facility will implement measures to reduce tissue pressure that include frequent repositioning, protective devices and the use of support surfaces such as Pressure Reducing Support Surface (Pressure Redistribution Support Surface) and an example of which is low-air-loss mattresses. 2. During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (the partial or complete wasting away, degeneration, or decrease in size of a body part, tissue, or organ), pressure ulcer of sacral (bone at the end of the spine) region, pressure ulcer of other site, pressure ulcer of left heel and pressure-induced deep tissue (the internal structural layers beneath the skin and superficial fat) (purple or maroon localized (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) services and care were provided as indicated on the physician's order and facility policy for two (2) of 2 sampled residents (Residents 9 and 70) reviewed for dialysis by failing to ensure:1. Resident received dialysis treatment on 5/7/2026, 6/9/2026, at 6/13/2026.2.a. Resident 70 received dialysis treatment on 6/13/2026 and 6/20/2026.2.b. Resident 70, who was on fluid restrictions, was not provided with a water pitcher at bedside.These deficient practices have the potential for Residents 9 and 70 to experience life threatening complications such as dangerous waste and fluid buildup, resulting to difficulty breathing, heart problems, hospitalization, and death. Findings: 1.During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included metabolic encephalopathy (brain dysfunction caused by a chemical imbalance, organ failure, or lack of nutrients in the body), dependence on renal (kidneys) dialysis, and end stage renal disease (permanent kidney failure when the kidneys can no longer filter waste and extra fluid from the blood to keep a person alive). During a review of Resident 9's Minimum Data Set (MDS- a resident assessment tool), dated 6/14/2026, the MDS indicated Resident 9 was assessed having severely (never/rarely made decisions) impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 9 required partial/moderate assistance (helper does less than half the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and personal hygiene. The MDS also indicated Resident 9 was dependent (helper does all of the effort) with rolling left and right, sit to lying, sit to stand, and toilet transfer. The MDS further indicated Resident 9 was on dialysis. During a review of Resident 9's Order Summary Report, dated 7/10/2026, the Order Summary Report indicated a physician order, with a start date of 6/8/2026, for dialysis Tuesday, Thursday, Saturday with chair time of 6 AM. Resident will be picked up between 5:15 AM and 5:30 AM. During a review of Resident 9's Progress Note, dated 5/7/2026, at 6:49 AM, the Progress Note indicated that Resident 9 was unable to go to dialysis appointment due to no escort. It also indicated communication with Dialysis Center 1 (DC 1) if Resident 9's dialysis could be rescheduled at later time but no available chair time. During a review of Resident 9's Progress Note, dated 6/9/2026, at 5:04 AM, the Progress Note indicated that Resident 9 was unable to go to dialysis due to no escort. It also indicated communication with DC 1 for an inquiry on availability on 6/9/2026 but there was no available chair time for the resident. The Progress Notes further indicated the dialysis appointment was scheduled for the next day, 6/10/2026 at 5 AM and on Thursday on Resident 9's regular chair time. (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 9's Progress Note, dated 6/13/2026, at 5:31 AM, the Progress Note indicated that Resident 9 was unable to go to dialysis due to no escort. It also indicated communication with DC 1 for an inquiry on availability for 6/13/2026 but there was no available chair time for the Resident until Monday and was requested to call back later in the day to reschedule chair time. During a concurrent interview and record review on 7/8/2026, at 4:24 PM, with Case Manager (CM), Resident 9's Progress Notes were reviewed. CM stated that on 5/7/2026, 6/9/2026, and 6/13/2026, Resident 9 needed to be accompanied by an escort to his dialysis appointments because he was only getting courtesy rides by his insurance. CM stated Resident 9's escort was either a Certified Nursing Assistant (CNA) or an Activity Staff. CM stated an escort was required to go with Resident 9 because the courtesy ride was an Uber (company that provides on-demand transportation services through a mobile app, allowing people to request rides from nearby drivers) and not an ambulance. CM stated Resident 9 did not go to dialysis on 5/7/2026, 6/9/2026, and 6/13/2026 because he did not have an escort. During a follow up interview on 7/9/2026, at 8:41 AM, with DSD and ADSD, ADSD stated that Resident 9 did not go to dialysis on 5/7/2026 because of a miscommunication and CNA 4 was not assigned and informed on 5/6/2026 that he was going to escort Resident 9 to his dialysis appointment on 5/7/2026. During the same interview on 7/9/2026, at 9:15 AM, with DSD and ADSD, ADSD stated that Resident 9 did not go to dialysis on 6/9/2026 because he was readmitted back to the facility on 6/8/2026. ADSD stated CM did not clearly communicate Resident 9's dialysis pick up time with DSD and ADSD. ADSD stated she and DSD misunderstood Resident 9's pick up time and chair time and thought Resident 9's chair time was actually his pick up time. ADSD stated that CNA 5 was informed on 6/8/2026 that he was assigned to escort Resident 9 to dialysis at 6 AM on 6/9/2026. ADSD stated there was no escort available when Resident 9's Uber came to pick him up at 6 AM because CNA 5 did not arrive at the facility until 7 AM. During the same interview on 7/9/2026, at 9:15 AM, with DSD, DSD stated there were a lot of miscommunications regarding Resident 9's escort for dialysis and needed to review the text messages. After reviewing her text messages, DSD stated that on 6/8/2026, they were not informed of Resident 9's readmission until he physically arrived at the facility at 7:49 PM. DSD stated they were not notified that Resident 9 needed an escort to his dialysis appointment until 8:28 PM and by that time there did not have any staff available to accompany Resident 9 to his dialysis appointment on 6/9/2026. DSD stated Resident 9 missed his dialysis appointment on 6/9/2026 because facility was not able to arrange an escort for him on 6/8/2026. During an interview on 7/9/2026, at 9:48 AM, with DSD and ADSD, both DSD and ADSD stated Resident 9 did not go to dialysis on 6/13/2026 because CNA 5 was not informed that he was assigned to escort Resident 9 to his dialysis appointment that day. DSD stated it was important to assign an escort to residents ahead of time, so dialysis appointments are not missed. DSD stated escort assignments should be communicated and confirmed with CNAs and AS to prevent miscommunications. DSD stated it was important for dialysis residents to keep their dialysis (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 (the observed or identified preparation or administration of medication or biologicals which is not in accordance with the prescriber's order/manufacture's specifications/accepted professional standards and principles) rate was less than five (5) percent (%). Two (2) medication errors out of 25 opportunities (observed administered medications) for error which yielded a facility medication error rate of 8 % for one (1) of 8 (eight) sampled residents (Resident 56) observed for medication administration (med pass). These deficient practices had the potential to result in harm to Resident 56 by not administering medications as prescribed by the physician in order to meet Resident 56's medication needs. Findings: During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), gastroparesis (a condition where the stomach empties food too slowly, despite there being no physical blockage), and gastrostomy (G-Tube- a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) malfunction. During a review of Resident 56's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 56 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 56 is dependent (helper does all of the effort, resident does none) with oral/toileting/personal hygiene, upper/lower body dressing, and shower/bathe self. The MDS indicated Resident 56 had a G-Tube. During a review of Resident 56's Order Summary Report, dated 7/10/2026, the Order Summary report indicated the following physician orders: Bethanechol (medication used to treat urinary retention) 25 milligrams (mg- unit of measurement for weight), to give 1 tablet via G-tube three times a day for bladder emptying, with a start date of 12/5/2025. Multivitamin (a supplement), give 1 tablet via G-tube one time a day for supplement, with a start date of 3/23/2026. Flush enteral tubing (g-tube- a soft, flexible plastic tube used to deliver liquid nutrition, fluids, or medications directly into the stomach) with at least 5 to 15 milliliters (ml- unit of measurement for liquid) of water in between each medication, with a start date of 7/5/2026. During a review of Resident 56's Care Plan, revised on 2/26/2026, the Care Plan indicated Resident 56 had a gastrostomy tube secondary to dysphagia (difficulty or discomfort in swallowing). Resident 56's Care Plan intervention indicated to use 10 ml of water to mix with crushed meds. During an observation of the medication preparation, on 7/9/2026, at 4:42 PM, LVN 4 crushed the following medications and placed them in medication cups: Bethanechol 25 mg 1 tablet Multivitamin 1 tablet LVN 4 transferred Resident 56's bethanechol and multivitamin medications from the medicine cups in a large clear plastic cup (5 ounces (oz- unit of measurement for weight and liquid volume) or approximately 148 ml). LVN 4 added approximately 50 ml of water in each clear plastic cup and swirled each cup to mix the medication with the water. LVN 4 grabbed another clear plastic cup and poured approximately 120 ml (3/4 full) of water into the clear plastic cup. LVN 4 entered Resident 56's room to administer the medications. During a concurrent observation and interview, on 7/9/2026, at 4:48 PM, with LVN 4 of medication administration, LVN 4 administered Resident 56's Bethanechol and multivitamins via G- Tube. LVN 4 drew up the remaining contents of water (approximately 50 ml) from the clear plastic cup and flushed Resident 56's G-tube. LVN 4 reconnected Resident 56's G-tube feeding and exited the room. LVN 4 stated she did not measure the amount of water she added to (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 56's bethanechol and multivitamin medication. LVN 4 stated, LVN 4 did not flush Resident 56's G-tube with 5 to 15 ml of water in between each medication and did not flush Resident 56's G-tube with 20-30 ml of water after administering Resident 56's medications. During an interview on 7/9/2026, at 5:14 PM, with LVN 4, LVN 4 stated she flushed Resident 56's G-tube with the remaining water in the clear plastic cup after administering Resident 56's medications. LVN 4 further stated she did not know that she had to flush Resident 56's G-tube with 10 ml of water in between medications. During an interview on 7/10/2026, at 10:40 AM, with LVN 1, LVN 1 stated licensed nurses should use the medication cup when adding water to dilute the medication because it had measurements, which help ensure the correct amount of water is added to the medications per the physician's order. LVN 1 stated the clear plastic cup should not be used when mixing the medications with water because it could hold around 150 ml of water and the medication can end up getting mixed with too much water. LVN 1 stated crushed medications should be mixed with approximately 10 ml of water before administering the medication in the G-tube. LVN 1 stated licensed nurses should follow the residents' physicians order and care plan on flushing the G-tube during medication administration. During an interview on 7/10/2026, at 1:04 PM, with the Director of Nursing (DON), the DON stated crushed medications should be mixed with approximately 10 ml of water before administering the medication through the G-tube and not more than 10 ml. The DON stated licensed nurses should flush the G-tube with 20 to 30 ml of water before and after medication administration and not more than 30 ml of water. The DON stated licensed nurses should measure the amount of water that is flushed and mixed with the medications. The DON stated giving the Resident too much water through the G-tube can cause stomach discomfort. The DON stated licensed nurses should follow the physicians order and the care plan for the safety of the resident. During a review of the facility's policy and procedure (P&P), titled, Medication-Administration, revised 6/1/2017, the P&P indicated:Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.The resident's MAR (Medication Administration Record) will be reviewed for allergies and/or special considerations for administration including accepted professional standards and principles. During a review of the facility's P&P, titled, Feeding Tube-Administration of Medication, revised 6/1/2017, the P&P indicated:Medications are administered appropriately and safely when the resident has a feeding tube in place and medication are delivered through the feeding tube.Dilute medication according to resident's administration orders making sure that medications are dissolved completely prior to administration.Check for tube placement by gently inserting 15 cc of air into the tube via the piston syringe (a type of syringe used to safely administer medications directly into a feeding tube) and auscultating (listening) the resident's abdomen about 3 inches (unit of measurement) below the sternum with the stethoscope.Medication must be given separately, flush with 5 cc of warm water in between each medication.Flush with 30 cc of water after the final medication is administered.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were properly stored as indicated on the facility's policy and procedure (P&P) by failing to ensure: 1. One (1) of four (4) medication carts (MC- med cart) were not left unattended and locked on 7/8/2026 and during medication administration on 7/9/2026. This deficient practice had the potential for unauthorized access to medications by staff and visitors which could lead to medication overdose (taking a toxic or poisonous amount of a drug or medicine), unauthorized use, adverse reactions (any unexpected or dangerous reactions to a drug), or harmful drug interactions (a reaction between two or more drugs or between a drug, and a food, beverage, or supplement). 2. To defrost (become free of accumulated ice) two of three medication refrigerators (Medication Refrigerators 1 and 2). This deficient practice had the potential to affect the temperature quality of Medication Refrigerators 1 and 2, which might affect the efficacy (the power or capacity of a drug, treatment, or action to produce a desired or intended result) of the refrigerated medications for the residents. 1. During a concurrent observation and interview on 7/8/2026, at 1:27 PM, MC 1 was left unattended and unlocked. Medications of residents were observed inside the first and second drawers of MC 1. Licensed Vocational Nurse 2 (LVN 2) stated he did not lock MC 1 before stepping away from it. During an observation in the resident rooms' hallway on 7/9/2026, at 4:51 PM, LVN 4 did not lock MC 1 before entering a resident's room. During an observation in the resident room hallway on 7/9/2026 at 4:51 PM, LVN 4 was observed failing to lock MC 1 before entering a resident's room. During an observation in the resident room hallway on 7/9/2026 at 5:01 PM, LVN 4 was observed failing to lock MC 1 before entering a resident's room. During an interview on 7/9/2026, at 5:18 PM, with LVN 4, LVN 4 stated she forgot to lock MC 1 before she entered the residents' rooms. LVN 4 stated it was important to lock the MC to prevent residents and staff from accessing the medications inside the MC. During an interview on 7/10/2026 at 12:15 PM with LVN 2, LVN 2 stated that licensed nurses administering medications should ensure the MC was locked before walking away to prevent unauthorized residents, staff, and visitors from accessing the medications inside. LVN 2 stated unauthorized staff or visitors could steal and distribute medications. LVN 2 further stated residents could accidentally take the medications and experience a drug interaction, adverse reaction, or overdose, which could result in hospitalization or death. During an interview on 7/10/2026, at 1:11 PM, with the Director of Nursing (DON), the DON stated MCs in the facility should not be left unlocked and unattended. The DON stated if left unlocked and unattended, residents can have access and take the medications which could lead to hospitalization. The DON stated the policy for medication storage was not followed. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's policy and procedure (P&P), titled, Medication Storage in the Facility, dated, 1/2022, the P&P indicated: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. During a concurrent observation of Medication Refrigerator 1 and interview with Registered Nurse Supervisor 1 (RNS 1) on 7/10/2026 at 11:06 AM, RNS 1 verified that Medication Refrigerator 1 was filled with built up ice. RNS 1 stated that this was not acceptable because it may affect the temperature of the entire fridge and affect the efficacy of the residents' refrigerated medications. During a concurrent observation of Medication Refrigerator 2 and interview with Licensed Vocational Nurse 1 (LVN 1) on 7/10/2026 at 11:11 AM, LVN 1 stated that almost half of the freezer compartment in Medication Refrigerator 2 was filled with built up ice. LVN 1 stated the refrigerator should have been defrosted because it can impact the temperature quality of refrigerator. During a concurrent observation of Refrigerator 2 and interview with RNS 2 on 7/10/2026 at 11:19 AM, RNS 1 verified that almost half of the freezer compartment in Medication Refrigerator 2 was filled with built up ice. RNS 2 was unable to state and provide documented evidence when the last time Medication Refrigerators 1 and 2 were defrosted. During a review of Facility's P&P titled, Medication Storage in the Facility, revised in January 2018, the P&P indicated medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the dietary menu (a planned food program designed to meet the nutritional needs of residents) and ensure to use the correct measuring scoop (a food serving utensil used to measure even portions) on 7/9/2026 for the lunch meal servings of beans and brown rice provided to 32 of 78 residents. This failure resulted in inconsistent portion sizes and had the potential to cause the 32 affected residents to receive inadequate nutritional intake, placing them at risk for not meeting daily dietary requirements, which could lead to weight loss. Findings: During a review of the facility's Summer Menus, dated 7/9/2026, the Summer Menu indicated for staff to follow the following recipes: 1. Ranch style beans- use #12 scoop (a food serving utensil that measures one third [1/3] of a cup portion) for the controlled carbohydrate diet (CCHO - a diet of set or equal amounts of carbohydrates at meals to help stabilize blood glucose levels) and regular diet (no dietary restrictions) lunch serving portion. 2. [NAME] rice- use #12 scoop for the renal diet (a specialized diet for residents with kidney disease that limits sodium [salt], potassium, phosphorus, and protein) and low fat/cholesterol diet lunch serving portion. During an observation on 7/9/2026 from 11:38 AM to 12:48 PM with the Dietary Supervisor (DS), in the facility kitchen, [NAME] 1 was observed: 1. Using the #8 measuring scoop (a food serving utensil that measures one half of a cup portion) to scoop the ranch style beans and serve on residents' plates. 2. Using an unmeasured (not having a known size or amount) scoop to scoop brown rice and serve on residents' plates. During a concurrent interview and record review on 7/9/2026 at 12:48 PM with the DS and [NAME] 1, the Summer Menus, dated 7/9/2026 were reviewed. The DS and [NAME] 1 confirmed the menu indicated to use a #12 scoop for the ranch style bean serving portion and a #12 scoop for the brown rice serving portion. [NAME] 1 stated she used the wrong sized scoops for the ranch style beans and the brown rice and should have followed the scoop sizes indicated on the menu. The DS stated staff are to follow the recipe and provide residents with the exact portion sizes indicated to ensure residents get the right nutrition to maintain and improve their health. During a review of the facility's Diet Type Report, printed 7/10/2026, the Diet Type Report indicated the following: 16 residents with a prescribed CCHO diet and solid texture (the physical consistency and structure of foods and liquids). 12 residents with a prescribed regular diet and solid texture. 3 residents with a prescribed renal diet and solid texture. 1 resident with a prescribed low fat/cholesterol diet and solid texture. During a review of the facility's Policy & Procedure (P&P) titled, Therapeutic Diets, revised 6/1/2027, the P&P indicated the facility will provide therapeutic diets to residents that meets nutritional guidelines, the correct equipment is available for the preparation and serving of therapeutic diets and that food portions served are equal to the written portion sizes. During a review of the facility's P&P titled, Dietary Department - General, the P&P indicated the dietary department is responsible for establishing a program that meets the nutritional needs of the residents. The P&P also indicated the primary objectives of the dietary department include preparation and provision of nutritionally adequate, attractive, well-balanced meals that are consistent with physician's orders and accommodates residents' allergies, intolerances and preferences.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the dietary staff failed to ensure food was served at an appetizing and proper temperature on 7/9/2026 during lunch as indicated on the facility Policy & Procedure (P&P). This deficient practice had the potential to result in rapid growth of bacteria that can cause foodborne illness (any illness resulting from eating contaminated/spoiled foods) and had the potential to result in insufficient meal intake and weight loss for 56 residents. Findings: During a concurrent observation and interview on 7/9/2026 at 1:09 PM with the Dietary Supervisor (DS), the Dietary Supervisor (DS) was observed taking the temperatures on the test meal tray (an ordered meal used to evaluate food temperatures, palatability [tastiness], and tray accuracy) that included a pork loin, ranch style beans and southern style green beans. The temperature readings for the pork, beans and green beans were 116 degrees Fahrenheit (F- a method of measuring temperature). The DS stated the food temperatures should be more than 140 degrees F. The DS stated the food items were too cold. During an interview on 7/10/2026 at 3:31 PM with the Dietary Supervisor (DS), the DS stated dietary staff should make sure the served food is at a temperature above 140 degrees F to ensure it is safe for residents to eat. During a review of the facility's P&P titled, Food Temperatures, reviewed 1/1/2026, the P&P indicated foods prepared and served in the facility will be served at proper temperatures to ensure food safety. The P&P also listed the required serving temperature to be greater than 140 degrees F for meat, entrees, and vegetables.		

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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 ensure proper food handling and food storage practices in accordance with the facility's policy and procedure (P&P) by failing to ensure: 1. Food was stored appropriately in the refrigerator and dry storage. 2. Dietary staff maintained sanitary measures during the preparation and serving of food during tray line. These deficient practices have the potential to result in pathogen (germ) exposure to residents, which could place 56 residents consuming food by mouth at risk for developing foodborne illness (caused by food contaminated with bacteria) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever) and can lead to other serious medical complications and hospitalization. Findings: 1. During a concurrent observation and interview on 2/10/2025 at 7:58 AM in the facility kitchen with the Dietary Supervisor (DS), the following food items were observed in the dry storage and refrigerator: a. One (1) bag of cocoa powder stored in a partially closed bag inside of a cardboard box. b. Refrigerated container of pumpkin labeled with an expiration date of 7/5/2026. The DS stated all foods should be stored according to the policy. During a review of the facility's P&P titled, Food Storage, dated 1/1/2026, the P&P indicated food items will be stored, thawed and prepared in accordance with good sanitary practice. The P&P also indicated for opened products to be placed in storage containers with tight fitting lids in dry storage. 2. During an observation on 7/9/2026 from 11:38 AM to 12:48 PM, in the facility kitchen, DS failed to change disposable gloves or perform hand hygiene after intermittently leaving the cooking area and using his gloved hand to open the refrigerator door and touch his personal clothing before returning to prepare cornbread and handle cooking and serving utensils. During an interview on 7/9/2026 at 1 PM with the DS, the DS stated that he should have changed his gloves and performed hand hygiene after touching his clothing and the refrigerator door handle. The DS stated that food should be prepared and served in a sanitary manner to prevent residents from getting sick and to reduce the risk of foodborne illness. During a review of the facility's P&P titled, Dietary Department - General, the P&P indicated the dietary department will maintain standards for sanitation and safety. The P&P also indicated [dietary] staff should maintain wearing intact disposable gloves in good condition that are changed appropriately to reduce the spread of infection.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to follow proper food storage practices in accordance with its policy and procedure (P&P) by failing to ensure one of one resident refrigerator temperature was 41 degrees Fahrenheit (F- a method of measuring temperature) or less. This deficient practice had the potential to result in food borne illness (any sickness that is caused by the consumption of foods or beverages that are contaminated with certain infectious or noninfectious agents) to the residents. Findings: During a concurrent observation and interview on 7/7/2026 at 9:06 AM with the DS in the facility Activity/Dining Room, the resident refrigerator was observed to have a temperature of 51 degrees F. The DS stated the refrigerator temperature should be maintained at 41 degrees F or below to keep food safe for residents to eat. The DS stated the food items in the residents' refrigerator were brought in by the residents' family and/ visitors. During a review of the facility's P&P titled, Refrigerator/Freezer Temperature Records, dated 1/1/2026, the P&P indicated refrigerator temperature must be 41 degrees F or below.		

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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 staff failed to provide the necessary infection control measures and services for seven (7) of 7 sampled residents (Residents 56, 32, 88, 73, 82, 2 and 95) reviewed for infection control and oxygen use in accordance with the facility's policy and procedure (P&P) by failing to ensure: Licensed Vocational Nurse 4 (LVN) performed hand hygiene (the process of cleaning the hands to remove germs, dirt, and microorganisms by washing with soap and water or using an alcohol-based hand sanitizer [hand sanitizer]) after removing her soiled gloves during medication administration for Residents 56, 32, 88, and 73. Resident 82, 2, and 95's indwelling catheter (a tube inserted into the bladder to help drain urine) drainage bags (a bag used to collect urine from an indwelling catheter) and/or tubing were not touching the floor. Resident 56's respiratory equipment was stored in a clean and sanitary manner to prevent contamination. These deficient practices had the potential to put Residents 56, 32, 88, 73, 82, 2 and 95 at higher risk for healthcare associated infections and potential spread of infections in the facility. Findings: a. During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), gastroparesis (a condition where the stomach empties food too slowly, despite there being no physical blockage), and gastrostomy (G-Tube- a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) malfunction. During a review of Resident 56's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 56 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 56 is dependent (helper does all of the effort, resident does none) with oral/toileting/personal hygiene, upper/lower body dressing, and shower/bathe self. The MDS indicated Resident 56 had a G-Tube. During a review of Resident 56's Care Plan, revised on 11/17/2025, the Care Plan indicated Resident 56 was on enhanced barrier precautions related to G-tube and secondary to history of candida auris positive on 11/5/2025. Resident 56's Care Plan interventions included hand hygiene, practice good infection control (example: proper hand hygiene), and cleaning hands including before entering and when leaving the room. During a review of Resident 56's Order Summary Report, dated 7/10/2026, the Order Summary report indicated a physician order, with a start date of 3/28/2026, for enhanced barrier precautions (EBP- an infection control measure used in long-term care facilities to prevent the spread of multidrug-resistant organisms [MDRO]) secondary to indwelling (an invasive device left inside the body) medical device (G-tube) and history of MDRO Candida Auris (a multidrug- resistant yeast infection). b. During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses that included Parkinsonism (a ground of neurological disorders that cause motor symptoms like tremors, slowed movement, and muscle (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stiffness), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 88's MDS, dated [DATE], the MDS indicated Resident 88 was assessed having severely impaired cognitive skills for daily decision making. The MDS indicated Resident 88 required supervision or touching assistance with eating and rolling left and right. The MDS indicated Resident 88 required partial/moderate assistance (helper does less than half the effort) with sit to lying, and lying to sitting on side of the bed. The MDS indicated Resident 88 required substantial/maximal assistance (helper does more than half the effort) with toileting/personal hygiene, upper/lower body dressing, shower/bathe self, and tub/shower transfer. c. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), cerebral infarction (when the blood supply to part of the brain is blocked or reduced), and schizophrenia (a mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others). During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 32 required partial/moderate assistance with eating. The MDS indicated Resident 32 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, upper/lower body dressing, sit to lying, and chair/bed-to-chair transfer. d. During a review of Resident 73's admission Record, the admission Record indicated Resident 73 was admitted to the facility on [DATE] with diagnoses that included unspecified injury of head, urinary tract infection (UTI- an infection in any part of the urinary system), and paranoid schizophrenia. During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73 had intact memory and cognitive skills for daily decision making. The MDS indicated Resident 73 required supervision or touching assistance with eating. The MDS indicated Resident 73 required substantial/maximal assistance with toileting/personal hygiene, shower/bathe self, upper body dressing, and sit to lying. The MDS further indicated Resident 73 was dependent with lower body dressing and putting on/taking off footwear. During an observation on 7/9/2026, at 4:31 PM, LVN 4 put on a gown and gloves and entered Resident 56's room. LVN 4 checked Resident 56's blood pressure with a blood pressure monitor, removed her gown and gloves and exited Resident 56's room without performing hand hygiene. During an observation on 7/9/2026, at 4:42 PM, LVN 4 put on new gloves, prepared Resident 56's bethanechol (a medication used to treat urinary retention) and multivitamin medications. LVN 4 removed her gloves and did not perform hand hygiene. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1899 N Raymond Ave Pasadena, CA 91103	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/9/2026, at 4:46 PM, LVN 4 replaced her gloves and put on a gown and re-entered Resident 56's room. LVN 4 checked Resident 56's G-tube for placement and administered Resident 56's medications through the resident's G-tube. LVN 4 removed her gown and gloves, exited Resident 56's room and charted the administered medications in the computer. LVN 4 did not perform hand hygiene after removing her gloves and before charting Resident 56's medications in the computer. During an observation on 7/9/2026, at 4:51 PM, LVN 4 took out the blood glucose monitor (BGM- a device used to measure the residents' current blood sugar level) from the medication cart drawer, put on gloves, and checked Resident 88's blood sugar. After LVN 4 checked Resident 88's blood sugar, LVN 4 removed her gloves, exited Resident 88's room. LVN 4 did not perform hand hygiene after removing her gloves and before exiting Resident 88's room. During an observation on 7/9/202, at 4:57 PM, LVN 4 put on gloves and prepared Resident 88's gabapentin (a medication used to treat seizure, nerve related pain) medication. LVN 4 removed and replaced her gloves, entered Resident 88's room and administered Resident 88's medication. LVN 4 removed her gloves, exited Resident 88's room and charted the administered medication in the computer. LVN 4 did not perform hand hygiene after removing her gloves and before charting Resident 88's medication on the computer. During an observation on 7/9/2026, at 5:01 PM, LVN 4 put on gloves and crushed Resident 32's risperidone (medication used to treat schizophrenia), mixed the crushed risperidone with apple sauce. LVN 4 poured Resident 32's Prostat (a protein supplement) into another medicine cup then LVN 4 removed her gloves, did not perform hand hygiene and donned (put on) new gloves. LVN 4 entered Resident 32's room and administered Resident 32's medications. During an observation on 7/9/2026, at 5:05 PM, LVN 4 removed her gloves, exited Resident 32's room without performing hand hygiene and charted the administered medications in the computer. During an observation on 7/9/2026, at 5:08 PM, LVN 4 put on gloves and prepared resident 73's Seroquel (medication used to treat schizophrenia) and fenofibrate (medication used to lower cholesterol [fat-like substance that can build up in the blood vessels]) medications. LVN 4 then removed her gloves, did not perform hand hygiene and donned new gloves. LVN 4 entered Resident 73's room and administered the resident's medications, removed her (LVN 4) gloves and exited Resident 73's room and charted the administered medications in the computer. LVN 4 did not perform hand hygiene after removing her gloves and before charting Resident 73's medications in the computer. During an interview on 7/9/2026, at 5:18 PM, LVN 4 stated she did not perform hand hygiene before she put on her gloves and after she removed her soiled/ used gloves. LVN 4 did not give a reason why hand hygiene was not performed. LVN 4 stated facility staff were supposed to perform hand hygiene before putting on and after removing gloves for infection control. During an interview on 7/10/2026, at 12:15, with LVN 2, LVN 2 stated facility staff should perform hand hygiene after removing gloves and when leaving the residents' room. LVN 2 stated not using the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alcohol- based hand sanitizer or washing the hands after removing the gloves or leaving the residents' room can cause contamination and spread infection in the facility. During an interview on 7/10/2026 at 2:18 PM with Infection Prevention Nurse (IPN), the IPN stated facility staff should always use hand sanitizer and wash their hands after removing their gloves. IPN stated staff must at least use hand sanitizer if hand washing was not possible at the time. IPN stated facility staff's hands can sweat while wearing gloves, which can promote bacterial growth and contaminate equipment and infect the residents and in the facility. IPN stated infections can cause residents to get sick and lead to hospitalization. During a review of the facility's P&P, titled, Hand Hygiene, revised 2/20/2025, the P&P indicated: The facility will ensure that all individuals use appropriate hand hygiene while at the facility. Facility staff follows the hand hygiene procedures to help prevent the spread of infections to other staff, residents, and visitors. Alcohol-based hand hygiene products can and should be used to decontaminate hands: Immediately upon exiting a resident occupied area (example: before exiting into a communal area such as a corridor) regardless of glove use. After removing personal protective equipment (PPE- a barrier precaution which includes use of gloves, gown, mask, face shield, shoe covers, head covers, respirators, etc. when you anticipate contact with blood or body fluids or other communicable toxins or agents) Hand hygiene is always the final step after removing and disposing of personal protective equipment. 2. a. During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included immunodeficiency, urinary tract infection, and abnormalities of gait and mobility. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 82 required substantial/maximal assistance with oral/toileting hygiene, personal hygiene, shower/bathe self, sit to stand, and toilet transfer. The MDS indicated Resident 82 had an indwelling catheter. During a review of Resident 82's Order Summary Report, dated 7/10/2026, the Order Summary Report indicated a physician order, with a start date of 6/30/2026, for indwelling catheter 16 French (FR - the standard sizing scale) with 10 cubic centimeter (cc- unit of measurement for volume) bulb connect to straight drainage every shift related to obstructive and reflux uropathy (blockage in the body that makes it difficult or impossible to urinate). During a concurrent observation and interview, on 7/7/2026, at 11:48 AM, in Resident 82's room, Resident 82 was asleep in bed with Certified Nursing Assistant 6 (CNA 6) sitting on a chair next to the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's bed. Resident 82's indwelling catheter drainage bag was touching the floor. CNA 6 stated Resident 82's drainage bag should not touch the floor and should be placed in a basin to prevent it from touching the floor. During an interview on 7/10/2026, at 12:51 PM, with the Director of Nursing (DON), the DON stated it was important for the residents' indwelling catheter drainage bag to not touch the floor to prevent urinary tract infections. The DON stated drainage bags should be placed in a basin if the bed needed to be at a low level to prevent the bag from touching the floor. The DON stated the policy for indwelling catheter care was not followed. During a review of the facility's P&P, titled, Catheter- Care of, revised 5/1/2026, the P&P indicated: The facility will prevent catheter-associated urinary tract infections while ensuring that residents are not given indwelling catheters unless medically necessary. Collection bags should always be kept below the level of the bladder, including during transport, avoiding contact with the floor. Take care to ensure the collection bag does not touch the floor at any time. 2 b. During a record review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) affecting the right dominant side, dysphagia (difficulty swallowing), carcinoma of the penis (an external organ in the male reproductive and urinary system) and urine retention (the inability to completely empty your bladder). During a review of Resident 2's admission MDS, dated [DATE], the MDS indicated Resident 2 had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 2 required dependent assistance with eating, dressing, shoe/bathing self, oral, personal and toileting hygiene. The MDS also indicated Resident 2 had an indwelling catheter. During a review of Resident 2's Order Summary Report, dated 7/9/2026, the Order Summary Report indicated an indwelling catheter 16 FR with 10cc bulb may connect to drainage bag every shift carcinoma in SITU (CIS- diagnosis identifies abnormal, pre-cancerous cells that remain exactly where they first formed and have not invaded surrounding tissues), ordered 6/11/2026. During an observation on 7/7/2026 at 10:12 AM at Resident 2's bedside, Resident 2's indwelling catheter drainage bag was observed touching the floor. 2 c. During a review of Resident 95's admission Record, the admission Record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (cancer) of prostate (a male reproductive gland), obstructive and reflex uropathy. During a review of Resident 95's Physician's Order, dated 7/6/2026, the Physician's Order indicated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indwelling foley catheter 16FR with 10cc bulb connect to straight drainage every shift for diagnoses obstructive uropathy. During a review of Resident 95's admission MDS, dated [DATE], the MDS indicated Resident 95 had severely impaired cognitive skills for daily decision making. The MDS also indicated Resident 95 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity) with eating, oral and personal hygiene and substantial/maximal assistance with toileting hygiene. The MDS also indicated Resident 95 had an indwelling catheter. During an observation on 7/7/2026 at 10:34 AM at Resident 95's bedside, Resident 95's indwelling catheter drainage bag was observed touching the floor. During an interview on 7/9/2026 at 9:44 AM with Infection Preventionist Nurse (IPN), the IPN stated indwelling catheter care included ensuring the catheter drainage bag and tubing are not touching the floor. IPN stated collection bags should be placed in a basin to create a barrier between the bag and floor and if a collection bag or catheter is found touching the floor, it needs to be changed. IPN also stated the indwelling catheter tubing and collection bag that has touched the floor can cause the resident to get infections including UTI. During a concurrent interview and record review on 7/10/2026 at 2:22 PM with the DON, the facility's P&P titled, Catheter- Care of, revised 5/1/2026, the P&P indicated the [indwelling catheter] collection bag does not touch the floor at any time. The DON stated the facility policy does not say the indwelling catheter should not touch the floor but should because that is the facility standard of practice. The DON stated the indwelling catheter and collection bag are to not touch the floor to ensure it is free of contamination that can lead to the risk of infections for the residents. 3. During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), type 2 DM and shortness of breath. During a review of Resident 56's Order Summary Report, dated 12/5/2025, the Order Summary Report indicated oxygen at 2 liters per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed due to increased secretions every 24 hours. During a review of Resident 56's annual MDS, dated [DATE], the MDS indicated Resident 56 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 56 required dependent assistance with oral, personal and toileting hygiene, dressing, and shower/bathing self. During a concurrent observation and interview on 7/7/2026 at 9:53 AM with Restorative Nurse Assistant 1 (RNA 1) at Resident 56's bedside, a plastic bag containing an oxygen mask (a medical or (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	emergency device worn over the nose and mouth to transfer oxygen from a storage source directly to the lungs) with tubing (a small plastic tube, used for providing supplemental oxygen) (connected to a device on the nightstand) was observed on the floor under the resident's bed. RNA 1 stated the bag and respiratory equipment (oxygen mask and tubing) was under the bed, touching the floor and must have fallen [from the nightstand]. RNA 1 was then observed picking the plastic bag and equipment from the floor, removing the oxygen mask and tubing out of the plastic bag and then placing the oxygen mask into a second plastic bag already stored in a nightstand drawer. RNA 1 stated he did not need to discard the oxygen mask and tubing, just the plastic bag. During an interview on 7/9/2026 at 10:03 AM with IPN, IPN stated Resident 56's respiratory equipment and plastic bag are to be stored in the bedside drawer and not on the floor. IPN stated all respiratory equipment, and bag should have been discarded because it became contaminated once it was on the floor. IPN further stated it was important to maintain infection control and clean respiratory equipment to prevent respiratory infections including pneumonia (an infection/inflammation in the lungs). During an interview on 7/10/2026 at 2:11 PM with the DON, the DON stated RNA 1 should have informed a licensed nurse or respiratory therapist that the respiratory equipment and plastic bag was on the floor so it could have been discarded and new equipment provided instead of placing it in Resident 56's drawer. The DON stated if the contaminated equipment was used, Resident 56 had a potential for respiratory infections. During a review of the facility's P&P titled, Oxygen Administration, dated 1/1/2026, the P&P indicated for infection control all oxygen tubing, masks and cannulas (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) will be changed weekly and when visibly soiled and oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 1/1/2026, the P&P indicated the facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide privacy for one (1) of 1 sampled resident (Resident 1) reviewed for dignity by failing to keep the curtains drawn on 7/8/2026 while the resident was receiving care as indicated on the facility's policy. This deficient practice resulted in Resident 1 being visible to the other residents and visitors in the room, which had the potential for loss of dignity and self-esteem. Findings: During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), encounter to attention to tracheostomy (a surgically created opening through the front of the neck into the windpipe), and second degree burn (affects the outer and middle layers of skin, causing blisters, severe pain, redness, and swelling) of face. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/7/2026, the MDS indicated Resident 1 had severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear and personal hygiene. During an observation on 7/8/2026 at 2:44 PM in Room A, Resident 1 was observed in Bed B receiving emergency medical services from paramedics (a highly trained healthcare professional who specializes in emergency medical care) and assigned facility staff due to a report of chest pain. The bedside curtain between Bed B and Bed A was not drawn, and the resident in Bed A and her visitor were observed watching Resident 1. The visitor of the resident in Bed C was also observed peeking through the bedside curtain that was drawn between Bed B and Bed C. The Infection Prevention Nurse (IPN) was observed near the foot area of Bed A. Paramedics were observed conducting assessments, including taking vital signs and performing an electrocardiogram (EKG, which is a test that measures the heart's electrical activity using electrodes placed on the chest, arms, and legs, which records these natural impulses as wavy lines on paper or a screen) During an interview on 7/8/2026 at 5 PM with IPN, IPN stated that she should have asked the visitor of Room A's bed to step outside the room while Resident 1 in bed B was receiving emergency care from the paramedics. During an interview on 7/10/2026 at 7:56 AM with the Director of Nursing (DON), the DON stated all residents should be treated with respect and dignity. The DON stated providing privacy while rendering care to residents should be practiced. The DON stated that on 7/8/2026, facility had to call 911 (universal emergency telephone number) for Resident 1 for complaints of chest pain. The DON stated Resident 1's Licensed Vocational Nurse, Registered Nurse, and Respiratory therapist should be in the room to assist the paramedics in rendering emergency service to Resident 1. The DON stated the IPN who was in the room should have made sure that Resident 1 was not being observed by other residents and visitors in the room. During a review of the Facility's policy and procedure (P&P) titled, Privacy and Dignity, revised 5/1/2026, the P&P indicated the facility respects resident's private space and property. The P&P indicated staff focuses on residents as when providing care and services. The P&P also indicated residents are afforded a right to privacy and confidentiality as part of the admission agreement and the resident is informed of these rights during the admission process.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure the call light (a handheld medical device that allows residents to easily contact staff for assistance) was within resident's reach for one (1) of two (2) sampled residents (Resident 2), reviewed for accommodation of needs, as indicated on the care plan and facility policy. This failure had the potential for Resident 2 to have unmet needs unmet and inadequate assistance, which could negatively affect the resident's care and overall wellbeing. Findings: During a record review of Resident 2's admission Record, the admission Record indicated Resident was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) affecting the right dominant side, dysphagia (difficulty swallowing), carcinoma of the penis (an external organ in the male reproductive and urinary system), and urine retention (the inability to completely empty the bladder). During a review of Resident 2's admission Minimum Data Set (MDS- a resident assessment tool), dated 6/15/2026, the MDS indicated Resident 2 had moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 2 was dependent (helper does all the effort) with eating, dressing, shoer/bathing self, oral, personal and toileting hygiene. During a review of Resident 2's Care Plan for At Risk for Falls related to Confusion, Gait/Balance Problems., dated 6/12/2026, the Care Plan indicated the staff interventions were to ensure Resident 2's call light is within reach and working, and that Resident 2 required a prompt response to all requests for assistance. During a concurrent observation in Resident 2's room and interview on 7/7/2026 at 10:12 AM with Resident 2, Resident 2's call light was observed out of Resident 2's reach. Resident 2 stated he needed help turning in bed. Resident 2 was then observed trying to reach his call light twice and stated he was unable to reach the call light to call for assistance. During a concurrent observation in Resident 2's room and interview on 7/7/2026 at 10:18 AM with Certified Nurse Assistant 2 (CNA 2), Resident 2's call light was observed out of reach. CNA 2 stated Resident 2's call light was out of his reach and should not be. During a concurrent interview and observation in Resident 2's room on 7/9/2026 at 9:44 AM with the Infection Preventionist Nurse (IPN), Resident 2 stated he needed assistance with water. The IPN instructed Resident 2 to press his call light for assistance. Resident 2 then stated he cannot reach his call light. Resident 2's call light was observed out of reach, positioned on the bed frame. The IPN stated Resident 2's call light was out of reach and should not be. The IPN also stated the call lights needed to remain within reach of the residents for safety, to prevent falls, and to ensure staff can promptly respond to residents' needs. During an interview on 7/10/2026 at 2:29 PM with the Director of Nursing (DON), the DON stated it was important to ensure call lights were in the reach of residents to prevent accidents, injuries, and so that residents can notify staff when they need assistance. The DON further added if call lights are not within resident's reach, staff will not be able to meet their needs. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights- Accommodation of Needs, dated 1/1/2025, the P&P indicated the facility ensures to provide an environment and services that meet the residents' individual needs. During a review of the facility P&P titled, Communication- Call System, dated 5/1/2026, the P&P indicated the facility is to provide residents with a mechanism to promptly communicate with nursing staff. The P&P also indicated call cords will be placed within the resident's reach in the resident's room.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the Notice of Medicare Non-Coverage (a form issued by the facility to indicate Medicare-covered services are ending) for one of three sampled residents (Resident 87) reviewed for Beneficiary Notification was signed by the responsible party. This failure had the potential to result in Resident 87 not being able to exercise the right to file an appeal. Findings: During a review of Resident 87's admission Record, the admission Record indicated Resident 87 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 87's diagnoses included encephalopathy (disease of the brain from damage or malfunction), cognitive communication deficit (difficulty with communication process and organized thoughts effectively), and dementia (group of symptoms affecting loss of memory, language, problem-solving and other thinking abilities). The record indicated Resident 87's has two individuals listed as the resident's responsible parties. During a review of Resident 87's History and Physical (H&P) form, dated 8/4/25, the H&P indicated Resident 87 does not have the capacity to understand and make decisions. During a review of Resident 87's Minimum Data Set (MDS- a resident assessment tool), dated 5/1/2026, the MDS indicated Resident 65 was severely impaired with cognitive skills (the ability to think and reason) for daily decision making and required extensive assistance (helper does more than half the effort) with staff for activities of daily living. During a review of Resident 87's Notice of Medicare Non-Coverage, dated 5/7/2026, the notice indicated Resident 87 received and understood the notice by signing it with her signature. During an observation on 7/10/2026 at 9:50 AM in Resident 87's room, Resident 87 was awake in bed, but did not respond to questions. During an interview on 7/10/2026 at 9:52 AM with Certified Nurse Assistant 1 (CNA1), CNA 1 stated Resident 87 has dementia and is unable to comprehend or respond to attempts at communication. During an interview on 7/10/2026 at 10:12 AM with Business Office Staff (BOS) 1, BOS 1 stated Resident 87 does not have the mental capacity to make an informed decision and sign a legal document. BOS 1 also stated the facility should contact Resident 87's responsible party for signature, and if no one is available then the document should be marked as unable to complete. During an interview on 7/10/2026 at 3 PM with the Administrator (ADM), the ADM stated Resident 87 does not have the mental capacity to make decisions, and the signature is invalid. ADM stated the facility should have contacted Resident 87's responsible party or family member to complete the document. During a review of the facility's undated policy and procedures (P&P) titled, Form Instruction for the Notice of Medicare Non-Coverage, the P&P indicated the facility need to contact resident's representative when the resident is not competent to sign the form.		

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NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to provide privacy and confidentiality (safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the Resident and/or the individual's surrogate or representative) for two (2) of 25 sampled residents (Resident 88 and 32) when Resident 88 and 32's electronic medical records were left exposed by leaving the computer on and unattended during medication administration on 7/9/2026. This deficient practice violated Resident 88 and 32's right to privacy and confidentiality. Findings: 1. During a review of Resident 88's admission Record, the admission Record indicated Resident 88 was admitted to the facility on [DATE] with diagnoses that included Parkinsonism (a group of neurological disorders that cause motor symptoms like tremors, slowed movement, and muscle stiffness), type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 88's Minimum Data Set (MDS- a resident assessment tool), dated 6/11/2026, the MDS indicated Resident 88 was assessed having severely (never/rarely made decisions) impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 88 required supervision or touching assistance with eating and rolling left and right. The MDS indicated Resident 88 required partial/moderate assistance (helper does less than half the effort) with sit to lying, and lying to sitting on side of the bed. The MDS also indicated Resident 88 required substantial/maximal assistance (helper does more than half the effort) with toileting/personal hygiene, upper/lower body dressing, shower/bathe self, and tub/shower transfer. During an observation on 7/9/2026, at 4:51 PM, of Licensed Vocational Nurse 4 (LVN 4) outside of Resident 88's room, LVN 4 removed the blood glucose monitor (BGM- a device used to measure the residents current blood sugar level) and Resident 88's gabapentin (a medication used to treat seizure, nerve related pain) medication from the medication cart (med cart) drawer and placed them on top of the med cart. LVN 4 verified the Resident 88's medication orders on the computer placed on top of the med cart. LVN 4 did not turn off the computer and left the computer unattended with Resident 88's medical records showing on the screen, then LVN 4 and entered Resident 88's room to check the resident's blood sugar and administered Resident 88's gabapentin medication. 2. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood), cerebral infarction (when the blood supply to part of the brain is blocked or reduced), and schizophrenia (a mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others). During a review of Resident 32's MDS, dated [DATE], the MDS indicated Resident 32 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 32 required partial/moderate assistance with eating. The MDS indicated Resident 32 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, upper/lower body dressing, sit to lying, and chair/bed-to-chair transfer. During an observation of LVN 4 outside of Resident 32's room, on 7/9/2026, at 5:01 PM, LVN 4 removed Resident 32's Prostat (a protein supplement) and risperidone (a medication used to treat schizophrenia) medications and placed them in individual cups on top of the med cart. LVN 4 verified Resident 32's medication orders on the computer on top of the med cart and (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered Resident 32's room. LVN 4 did not turn off the computer and left the computer unattended outside the resident's room when LVN 4 administered Resident 32's medications. During an interview on 7/9/2026, at 5:18 PM, with LVN 4, LVN 4 stated she forgot to close (pull down the screen) the computer or sign off from the computer on top of med cart before she entered Resident 88 and 32's rooms to administer the residents' medications. LVN 4 stated it was important to close the computer to prevent other people from accessing Resident 88 and 32 information. LVN 4 stated not closing the computer or not signing out and leaving the residents' information unprotected was a Health Insurance Portability and Accountability Act (HIPAA- a federal law designed to protect sensitive resident health information from unauthorized disclosure and theft) violation. During an interview on 7/10/2026, at 12:15 PM, with LVN 2, LVN 2 stated licensed nurses administering medications should close the computer or sign out from the computer before walking away from the med cart. LVN 2 stated it was important for licensed nurses to ensure resident information was protected and not left exposed to unauthorized people. During an interview on 7/10/2026, at 1:11 PM, with the Director of Nursing (DON), the DON stated staff did not follow the policy to protect Resident 88 and 32's health information on 7/9/2026. The DON stated LVN 4 did not protect Resident 88 and Resident 32's health information when LVN 4 left the computer on with the residents' health information showing and unattended before walking into the residents' rooms. During a review of the facility's policy and procedure (P&P), titled, Disclosure of Public Health Information (PHI), revised 6/1/2017, the P&P indicated: Facility Staff will keep medical records secure and confidential. Care should be taken to keep a medical record shielded and inaccessible to other residents or to the general public.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the environment for one (1) of two (2) residents (Resident 56), in the environment task, was clean and free of dirt in accordance with the facility's policy and procedure (P&P) titled, Resident Rooms and Environment. This failure had the potential to negatively affect Resident 56's quality of life. Findings: During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), gastroparesis (a chronic digestive disorder where the stomach takes too long to move food into the small intestine), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) 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 56's annual Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 56 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 56 required dependent (helper does all the effort) assistance with oral, personal and toileting hygiene, dressing, and shower/bathing self. During an observation on 7/7/2026 at 9:53 AM at Resident 56's bedside, dried tan and brown spots were observed on Resident 56's gastrostomy tube pump (G- Tube pump an electronic or battery-powered medical device designed to deliver liquid nutrition, hydration, or medications directly into a resident's stomach), the floor, floor mat (a cushioned floor pad designed to help prevent injury should a person fall) and nightstand table. During a concurrent observation and interview on 7/9/2026 at 9:58 AM with Infection Preventionist Nurse (IPN) at Resident 56's bedside, the previously observed dried tan and brown spots were observed on Resident 56's G-Tube pump, floor, floor mat and nightstand table. IPN stated Resident 56's environment was visibly dirty and there was dried enteral feeding [Glucerna] that dripped and spilled on the G-Tube pump, floor, floor mat and ran down Resident 56's nightstand. IPN stated Resident 56's environment is to be clean and sanitary, and this should have been cleaned up. During an interview on 7/10/2026 at 2:27 PM with the Director of Nursing (DON), the DON stated the residents' environments should always be clean and free from dirt to ensure quality of care and homelike environment. During a review of the P&P titled, Resident Rooms and Environment, dated 1/1/2026, the P&P indicated the facility will provide 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 the cleanliness and order.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled resident (Resident 25) reviewed for restraints (any device, medication, or physical method used to restrict a patient's freedom of movement or access to their body) was free from physical restraints (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body; cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body) in accordance with the facility's policy and procedure (P&P), titled Restraints. This deficient practice had the potential to result in limiting Resident 25's mobility and may cause injury. This also had the potential for Resident 25 not to be treated with respect and dignity with the use of restraints. Findings: During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry) and dependence on ventilator (a medical device to help support or replace breathing) status. During a review of Resident 25's Quarterly Minimum Data Set (MDS - a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 25 had severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 25 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 25 was dependent (helper does all of the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During a review of Resident 25's Order Summary Report, dated 7/9/2026, indicated an order of may have left hand mitten (a large, soft, padded glove used in healthcare to cover a patient's hands) due to attempting to pull out life sustaining tubes (medical devices that keep a person alive by delivering oxygen, liquid food, or hydration when the body cannot do so on its own), ordered on 3/26/2026, order transcribed by Registered Nurse Supervisor 2 (RNS 2). During an observation on 7/8/2026 at 9:19 AM, in Resident 25's room, Resident 25 was observed with left hand mitten. During a concurrent observation and interview on 7/9/2026 at 1:05 PM, Resident 25 was observed with no left-hand mitten, and no nursing staff at bedside. MDS Registered Nurse (MDSRN) stated Resident 25 did not and should have a hand mitten on the resident's left hand. During an interview on 7/9/2026 at 1:07 PM, with RNS 2, with the presence of MDSRN, RNS 2 stated Resident 25's left hand mitten is not placed because they only apply it on as needed basis. During a concurrent record review and interview on 7/9/2026 at 1:23 PM with MDSRN, Resident 25's medical records dated from 3/26/2026 to 7/9/2026. MDSRN stated Resident 25's left hand mitten order was transcribed by RNS 2, and the order can be understood as as needed because it was ordered may have left hand mitten. RNS 2 stated the staff will only apply the left hand mitt as needed, MDSRN added probably when Resident 25 seems agitated. MDSRN stated Resident 25 did not have a restraint assessment prior to use of hand mitten and Resident 25 should have a restraint assessment. MDSRN was not able to provide documentation of the restraint assessment for Resident 25 from 3/26/2026 to 7/9/2026. MDSNRN stated he had seen Resident 25 with a left-hand mitten restraint from 3/26/2026 to 7/9/2026. MDSRN stated there is no documented evidence that Resident 25 is being observed or checked every 30 minutes while the resident is on restraint and it should have been done per the facility's policy and procedure for use of restraints. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDSRN added there should be an order to observe Resident 25 every 30 minutes, and it should reflect on Resident 25's Treatment Administration Record (TAR). During an interview with the Director of Nursing (DON) on 7/9/2026 at 7:38 AM, the DON stated, she had seen Resident 25 with left hand mitten from 3/26/2026 to 7/9/2026. The DON stated that prior to use of hand mitten, RNS 2 should complete a restraint assessment for the use of hand mitten because it can be a form of physical restraint. The DON stated, hand mitten is a device that limits hand movement, and that means it is considered as a restraint. The DON stated restraints like Resident 25's left hand mitten should not be used as as needed. During a review of facility's Policy and Procedure (P&P), titled Restraints, revised in 5/1/2026, the P&P indicated facility will ensure that restraints will not be imposed for purposes of discipline or convenience. The P&P indicated the facility will not use restraints on a prn (as needed) or as necessary basis. The P&P indicated an assessment will be completed by a Registered Nurse prior to the application of any device that restricts movement or access to one's body. The assessment will be repeated quarterly thereafter. The P&P also indicated that a resident placed in a restraint will be observed at least every 30 minutes by nursing staff.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate assessment and documentation of the Minimum Data Set (MDS, a resident assessment tool) for three (3) of 25 sampled residents (Resident 13, 25 and 86) in accordance with the facility's policy and procedure (P&P) by failing to ensure the MDS reflected: Resident 13's weight of 103 pounds (lbs) on 3/5/2026 and 101 lbs on 6/5/2026. Resident 25 reflected the resident's active diagnosis of psychiatric/mood disorder (a mental health condition where your persistent emotional state, your mood, is severely disrupted). Resident 86's basal cell carcinoma (BCC- the most common type of skin cancer) skin lesions. This deficient practice had the potential for the facility to not develop and implement an individualized care plan (a document that outlines the facility's plan to provide personalized care to a resident that includes measurable objectives, interventions and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs), which could negatively affect Residents 13, 25, and 86's care and overall well-being. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included metabolic encephalopathy (a brain dysfunction caused by an underlying chemical process problem), protein calorie malnutrition (body lacks both enough energy calories and protein), dementia (a group of symptoms affecting loss of memory, language, problem-solving and other thinking abilities). During a review of Resident 13's medical record, dated 3/5/26, the record indicated Resident 13's documented weight was 103 lbs. During a review of Resident 13's significant change MDS, dated [DATE], the MDS indicated Resident 13's documented weight was 117 lbs. The MDS indicated Resident 13 had moderate impaired (rarely makes decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making, and need assistance from another person to complete any activities. During a review of Resident 13's medical record, dated 6/5/26, the record indicated Resident's 13's documented weight as 101.0 pounds. During a review of Resident 13's quarterly MDS, dated [DATE], the MDS indicated Resident 13's documented weight as 117 pounds. (MDS quarterly assessment) During an interview on 7/9/2026 at 9:17 AM, with MDS Registered Nurse (MDSRN, a registered nurse who specializes in evaluating and documenting the health, daily function, and care needs of residents), MDSRN stated his responsibility is to gather and ensure the accuracy of the MDS assessment. MDSRN stated Resident's 13 MDS documented weight on 3/6/2026 and 6/4/2026 did not reflect the resident's correct weight at the time of assessment. MDSRN stated inaccurate (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation can result in missed identification of significant changes in health status and can affect the accuracy of care plans and interventions. The MDSRN stated consequently Resident 13 may not receive timely nutritional support or medical attention, potentially increasing the risk of complications. 2. During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry) and dependence on ventilator (a medical device to help support or replace breathing) status. During a review of Resident 25's Psychiatric Notes (official medical records written by a mental health professional after a patient visit), the Psychiatric Notes, dated 5/2/2026, indicated Resident 25 has a past psychiatric history of dementia and anxiety. It also indicated a diagnosis of depression (a serious mood disorder that causes persistent sadness and a lack of interest in life). During a review of Resident 25's Quarterly MDS, dated [DATE], the MDS indicated Resident 25 had severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 25 had episodes of feeling or appearing down, depressed or hopeless, trouble falling or staying asleep or sleeping too much, feeling tired or having little energy, and trouble concentrating on things, such as reading newspaper or watching television. The MDS indicated Resident 25 required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated Resident 25 was dependent (helper does all of the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. In addition, the MDS indicated Resident 25 has a diagnosis of dementia. During a concurrent record review and interview on 7/9/2026 at 1:25 PM with MDS Registered Nurse (MDSRN), Resident 25's medical records dated from 5/2/2026 to 6/1/2026 were reviewed. MDSRN stated Resident 25's psychiatrist note dated 5/2/2026, indicated a diagnoses dementia, anxiety and depression. MDSRN stated the diagnoses of anxiety and depression were not and should have been reflected in the MDS on 6/1/2026. MDSRN stated that accurate MDS is important for the facility to develop a resident centered care plan. During an interview on 7/10/2026 at 7:44 AM with the Director of Nursing (DON), the DON stated it was important for the MDS to be accurate to ensure the development and implementation of an individualized resident care plan. 3. During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses that included BCC of skin of unspecified parts of face, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dysphagia (difficulty swallowing). During a review of Resident 86's Skin Weekly Assessment 1.1, dated 6/17/2026, the Skin Weekly Assessment indicated upon admission, Resident 86 had facial BCC lesions with granulation (a new (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	connective tissue; beefy red) and necrotic (dead, non-functioning; brown, black, leather, scab-like) tissue present. During a review of Resident 86's admission MDS, dated [DATE], the MDS indicated Resident 86 had intact cognitive skills for daily decision making. The MDS also indicated Resident 86 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) with toileting hygiene, dressing, shower/bathing self, and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and personal hygiene. During a concurrent interview and record review on 7/10/2026 at 12:25 PM with the MDSRN, Resident 86's admission MDS, dated [DATE], the MDS indicated that no ulcers, wounds and skin problems were present. The MDSRN stated Resident 86 had facial cancer lesions at the time this assessment was completed and open lesions should have been reflected on the MDS. The MDSRN stated Resident 86's MDS was not accurate and per facility policy should be. The MDSRN stated the MDS needs to be accurate to ensure residents receive proper care and care planning. The MDSRN stated an inaccurate MDS can result in an inaccurate or incomplete care plan. During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument (RAI- a standardized clinical system used in long-term care settings to evaluate a resident's health status, functional capabilities, and care needs) Process, dated 1/1/2026, the P&P indicated the RAI is used in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified. The P&P also indicated all information recorded within the MDS Assessment must reflect the resident's status at the time of the ARD.		

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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 interview and record review, the facility failed to develop a care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) to address one (1) of 1 resident (Resident 71) pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). This failure had the potential for Resident 71 to receive care that was not personalized to meet the specific needs for his pressure injuries, which could negatively affect his overall wellbeing. Findings: During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] with diagnoses that included muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (the partial or complete wasting away, degeneration, or decrease in size of a body part, tissue, or organ), pressure ulcer of sacral region (bone at the end of the spine), pressure ulcer of other site, pressure ulcer of left heel and pressure-induced deep tissue damage (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) of right hip. During a review of Resident 71's Skin Observation Checks, dated 6/14/2026, the Skin Observation Check indicated Resident with the following pressure injuries: Left heel; unstageable (a pressure ulcer/injury whose true depth and severity cannot be measured because dead tissue blocks the view) Sacrum; unstageable Right hip trochanter (hip); suspected deep tissue injury Right upper back; stage 2 (partial-thickness loss of skin, presenting as a shallow open sore or wound) Vertebrae (upper mid [right]) (one of the bones that make up the spinal column); stage 2 During a review of Resident 71's admission Minimum Data Set (MDS - a resident assessment tool), dated 6/17/2026, the MDS indicated Resident 71 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 71 required substantial/maximal assistance (helper does more than half the effort) with shower/bathing self and toileting hygiene, partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene, and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating. The MDS also indicated Resident 71 had one or more unhealed pressure ulcers/injuries. During a concurrent interview and record review on 7/10/2026 at 12:32 PM with Minimum Data Set Registered Nurse (MDSRN), Resident 71's medical record, dated 6/13/2026 through 7/10/2026, was reviewed. Resident 71's medical record did not indicate a developed care plan to address Resident 71's pressure ulcer on right upper back, right mid back and right hip. MDSRN stated Resident 71 did not have a developed care plan for his right upper and mid back and hip but should pressure ulcer. MDSRN stated each pressure ulcer should have a specific care plan that addresses the specific treatments and care for that wound to make sure accurate and proper care was planned and provided. MDSRN also stated a care plan was important because it is the plan that all departments collaborate on to provide better and consistent care for the residents, anticipate needs and any possible complications and to help avoid complications in general with their health. During an interview on 7/10/2026 at 2:45 PM with the Director of Nursing (DON), the DON stated Resident 71 should have a developed care plan for each pressure ulcer to ensure proper steps and care are planned and provided for the resident. The DON further stated Resident 71's pressure ulcer may not receive the proper care, and the resident could have complications without a developed care plan. During a review of the facility's Policy & Procedure (P&P) titled, Care Planning, dated 1/1/2026, the P&P indicated a purpose to ensure that a (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1899 N Raymond Ave Pasadena, CA 91103	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs. The P&P also indicated each resident's comprehensive care plan will describe the interventions and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial (the connection of mental and emotional well-being [psychological] and your interactions with other people or society [social] well-being.		

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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 ensure a care plan was updated and revised for one (1) of two (2) sampled resident (Resident 81), reviewed for urinary tract infections (UTI- a common bacterial infection occurring in any part of the urinary system which included the kidneys, bladder, uterus, and urethra), after Resident 81 was ordered Ceftriaxone (an antibiotic [a powerful, life-saving medication used to treat and prevent bacterial infections] used to treat severe bacterial infections) on 7/8/2026. This deficient practice had the potential to result in lack of interventions necessary to prevent worsening of UTI and had the potential to affect the provision of necessary care and services for Resident 81. Findings: During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (tissue death in the brain typically caused by blockage or narrowing of the blood vessels), resistance to multiple antibiotics (when a disease-causing bacteria develops the ability to survive and grow in the presence of multiple, structurally different antibiotic medications), and urinary tract infection. During a review of Resident 81's Minimum Data Set (MDS- a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 81 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 81 required partial/moderate assistance (helper does less than half the effort) with upper body dressing, personal hygiene, sit to lying, and rolling left and right. The MDS indicated Resident 81 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower/bathe self, and lower body dressing. During a review of Resident 81's Order Summary Report, dated 7/10/2026, the Order Summary Report indicated a physician order, with a start date of 7/8/2026, for ceftriaxone sodium solution 1 gram (gm- unit of measurement for weight), use 1 gram intravenously one time a day for UTI for 5 days. During a review of Resident 81's Situation, Background, Assessment, Recommendation Communication Form (SBAR- a communication tool that provides important information during critical situations), dated 7/8/2026, the SBAR Communication Form indicated Resident 81 had a change in condition and was positive for proteus mirabilis (a bacteria from the digestive tract or environment) from his urine culture (a test that grows and identifies bacteria in a urine sample to diagnose a UTI). The SBAR Communication Form indicated Resident 81's physician ordered to discontinue Keflex (an antibiotic) and to start Rocephin (brand name of ceftriaxone) 1 gm intravenously (IV- the administration of medications directly into a vein) every day (qd) for five days. During an interview on 7/7/2026, at 9:47 AM, with Resident 81, Resident 81 stated he had a bladder infection (UTI) and was taking oral antibiotics. Resident 81 stated he could not remember the name of the antibiotic. During a concurrent interview and record review on 7/10/2026, at 2:25 PM with Infection Prevention Nurse (IPN), Resident 81's Care Plan for antibiotic therapy dated 7/7/2026 was reviewed. IPN stated Resident 81 had a UTI and was ordered to take Keflex 500 mg by mouth on 7/6/2026 for the resident's UTI symptoms of abdominal pain and pain while urinating. IPN stated on 7/8/2026, Resident 81's urine culture came back positive for proteus mirabilis and Resident 81's Keflex was discontinued and changed to Ceftriaxone 1 gm once daily IV. IPN stated Resident 81's care plan for antibiotic therapy was not revised after Resident 81 was ordered to start Ceftriaxone. IPN stated Resident 81's care plan for antibiotic therapy should have been revised to indicate what antibiotic Resident 81 was currently receiving and include the specific side effects of the medication. IPN (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated it was the responsibility of the licensed nurses involved in Resident 81's care to revise and update the care plan. During an interview on 7/10/2026, at 3:45 PM, with the Director of Nursing (DON), the DON stated Resident 81's care plan should have been updated when the resident's Keflex was discontinued and Ceftriaxone was ordered on 7/8/2026. The DON stated Resident 81's care plan should include side effects to monitor, assess, and report to the physician. The DON stated the policy for care plan revision was not followed. During a review of the facility's policy and procedure, titled, Care Planning, revised 6/12/2025, the policy and procedure indicated that the Interdisciplinary Team (IDT- a group of healthcare professionals who work together to help people receive the care they need) will revise the Comprehensive Care Plan as needed at the following intervals: as dictated by changes in the resident's condition, to address changes in behavior and care, and other times as appropriate or necessary.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of quality for two (2) of two sampled residents (Resident 62 and Resident 33) by failing to: Complete a quarterly smoking assessment for Resident 62 as indicated in the facility's policy and procedure (P&P). Conduct an elopement (unauthorized departure-when a resident with cognitive impairment leaves a safe care facility without notifying staff) and wandering (aimless or disoriented roaming) assessment for Resident 33 as indicated in the P&P. This deficient practice had the potential to result in Resident 62 and 33 not receiving the necessary interventions which could lead to accidents, elopement, and harm. Findings: 1. During a review of Resident 62's admission Record, the admission Record indicated Resident 62 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included acute and chronic respiratory failure with hypercapnia (the inability of the lungs to properly eliminate carbon dioxide causing a dangerous acid buildup in the blood), chronic obstructive pulmonary disease with acute lower respiratory infection (a progressive lung disease causing airflow blockage and breathing-related issues), and nicotine dependence (addiction to the chemical found in tobacco products). During a review of Resident 62's Minimum Data Set (MDS- a resident assessment tool), dated 6/17/2026, the MDS indicated Resident 62 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 62 required supervision or touching assistance with oral/personal hygiene and wheeling his manual wheelchair 50 and 150 feet (ft.- unit of measurement for distance). The MDS indicated Resident 62 required partial/moderate assistance (helper does less than half the effort) with upper body dressing. The MDS also indicated Resident 62 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, lower body dressing, and putting on/taking off footwear. The MDS further indicated Resident 62 was currently using tobacco. During a concurrent observation and interview on 7/8/2026, at 1:22 PM, around the facility's smoking area, Resident 62 was observed smoking while sitting on his wheelchair. Resident 62 was supervised by an unknown facility staff and the Minimum Data Set Nurse 1 (MDS 1). Resident 62 stated he kept his own cigarettes and lighter and did not need to wear protective clothing while smoking. During a concurrent interview and record review on 7/8/2026, at 2:51 PM with Registered Nurse Supervisor 1 (RNS 1), Resident 62's Smoking Assessments from 4/20/2022 to 7/1/2026 were reviewed. RNS 1 stated Resident 62 has been a smoker since his admission to the facility on 4/20/2022. RNS 1 stated Resident 62 had a history of non-compliance regarding the facility's smoking policy and the resident's plan of care. RNS 1 stated Resident 62's Smoking Assessments were completed only on the following dates: 4/20/2022, 7/28/2022, 2/2/2023, 6/15/2023, 2/19/2024, 3/30/2024, 1/17/2025 and 7/1/2026. RNS 1 stated Resident 62's Smoking Assessment was not completed quarterly. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/10/2026, at 1:16 PM, with the Director of Nursing (DON), the DON stated a smoking assessment should be done upon admission, quarterly and as needed for residents who smoke in the facility. The DON stated it was important that a smoking assessment was done quarterly and as needed to assess the residents' ability to smoke safely. The DON stated the results of the smoking assessment were presented to the interdisciplinary team (IDT- a group of healthcare professionals who work together to help residents receive the care they need) to assess and review the effectiveness of the resident's current smoking care plan and interventions. The DON stated the facility's smoking policy was not followed. During a review of the facility's P&P, titled, Smoking, revised on 3/24/2023, the P&P indicated: The facility will respect Resident/employee choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. All smokers shall be assessed related to smoking safety at the time of admission and then at least quarterly as outlined by OBRA (Omnibus Budget Reconciliation Act of 1987-the baseline of care, patient's rights, and safety regulations that all Medicare and Medicaid-certified nursing homes must legally follow) assessment timeframes. The Licensed Nurse will provide the Smoking Assessment for review by IDT. 2. During a review of Resident 33's admission Record, the admission Record indicated Resident 33 was initially admitted to the facility on [DATE]. Resident 33's diagnoses included unspecified dementia (a decline in mental ability that is severe enough to interfere with daily life), unspecified severity, with other behavioral metabolic encephalopathy (brain dysfunction caused by chemical imbalances or toxins in the body), and anxiety disorder unspecified, (fear characterized by behavioral disturbances) (emotion characterized by feelings of tension, worried thoughts and physical changes). During a review of Resident 33's Minimum Data Set (MDS, resident assessment tool), dated 4/8/2026, the MDS indicated Resident 33 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 33 needed supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for oral and personal hygiene. Resident 33 needed partial or moderate assistance, (helper does less than half the effort) with toilet hygiene, shower/bathe self, upper and lower body dressing, and putting on/taking off footwear. Resident 33 just needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for eating. The MDS also indicated Resident 33 has no wandering behavior. During an observation on 7/7/2026 at 11:47 AM, in Resident 33's room, Resident 33 was observed with a plastic, black bracelet on her left wrist. Resident 33 stated she did not know that it was for. During a review of Resident 33's Physician Orders, dated 5/25/2026, the Physician's Order indicated to apply wander guard (an electronic safety system used in care facilities to prevent residents with cognitive impairments, such as dementia, from wandering into unsafe areas or leaving the premises) (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to prevent resident from going out of the facility unassisted. Monitor presence of wander guard every shift on left wrist. During a record review of Resident 33's Medical Record, the Medical Record did not have an elopement assessment conducted for Resident 33. During an interview on 7/9/2026 at 11:16 AM with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated she observed Resident 33 walking out of the front door a few times back in the month of May 2026. LVN 5 then told supervisor about Resident 33's wandering out of the main entrance. LVN 5 stated Resident 33 was wearing a wander guard since then. LVN 5 stated she did not know anything about the elopement or wandering assessment. During an interview on 7/9/2026 at 11:16 AM with the Registered Nurse Supervisor 1 (RNS1), RNS 1 stated she had not done any specific elopement or wandering assessment on Resident 33. RNS 1 stated LVN 5 reported to her about Resident 33's wandering out to the front entrance on 5/25/2026. RNS 1 stated she then called the physician for a wander guard order for Resident 33. During an interview on 7/9/2026 at 11:32 AM with the Director of Nursing (DON), the DON stated an elopement or wandering assessment is conducted upon admission, readmission, quarterly, and upon identification of significant change in condition in accordance with the facility's policy. The DON stated the elopement or wandering assessment is vital to determine if a resident requires a wander guard device and so the staff can provide interventions to prevent elopement if the resident is at risk. During a review of the facility's Policy and Procedure (P&P) titled, Elopement & Wandering, reviewed 4/24/2026, the P&P indicated the purpose is to enhance the safety of residents of the Facility. The Licensed Nurse, in collaboration with the Interdisciplinary Team (IDT, a group of professionals with diverse, complementary areas of expertise who collaborate to solve complex problems or achieve shared goals), will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition according to the Resident Assessment Instrument (RAI, a standardized, federally mandated system used in Medicare and Medicaid-certified nursing homes and long-term care facilities to assess the health, functional capacity, and clinical needs of each resident)guidelines to determine their risk of wandering/elopement. See EDP & Form A & Wandering/Elopement Risk Assessment. The resident's risk for elopement and preventative interventions will be documented in the resident's medical record and will be reviewed and re-evaluated by the IDT upon admission, readmission, quarterly, and upon change in condition according to the RAI guidelines.		

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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 and interview, the facility failed to provide oral care for one (1) of one (1) sampled residents (Residents 19) reviewed for activities of daily living (ADL, basic, routine tasks that individuals perform to maintain daily functioning) as indicated on the facility policy. Resident 19 was observed with white, crusted substance around the mouth on 7/7/2026 and 7/8/2026. This deficient practice had the potential to cause dry mouth, infection mouth soreness, discomfort, and reduction in Resident 19's overall quality of life. During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Resident 19's diagnoses included type 2 diabetes mellitus with foot ulcer (a patient with chronically high sugar level in the blood stream who has developed an open sore or wound on their foot), encounter for attention to gastrostomy (a medical procedure that creates a small, artificial opening through the abdomen directly into the stomach, it allows for the insertion of a feeding tube [G-tube] to safely deliver liquid nutrition, fluids, and medications, and dysphagia oral pharyngeal phase (difficulty initiating a swallow, where food or liquid cannot move properly from the mouth to the top of the esophagus). During a review of Resident 19's Minimum Data Set (MDS, resident assessment tool), dated 5/29/2026, the MDS indicated Resident 19 was severely impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, shower/bath self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, and sitting to lying. During an observation on 7/7/2026 at 11:47 AM in Resident 19's room, Resident 19 was noted to have a white, crusted substance present around the mouth. During an interview on 7/9/2026 at 1:56 PM, Certified Nurse Assistant 1 (CNA 1) stated it was very important to provide oral care to dependent residents to keep their mouth clean and prevent white, crusted substance in the residents' mouth, prevent infection and to maintain their overall dignity. During observations on 7/8/2025 at 1:32 PM in Resident 19's room, Resident 19's was noted to have a white, crusted substance present around the mouth. During an interview on 7/9/2026 at 4:13 PM, Certified Nurse Assistant 3 (CNA 3) stated CNA only require providing oral care once a day. But CNA 3 stated it was very important to provide oral care to dependent residents to keep their mouth clean and prevent white, crusted substance in the residents' mouth, prevent infection and to maintain their overall dignity. During a review of Resident 19's Care Plan on ADL, initiated on 5/31/2025, the Care Plan indicated Resident 19 requires maximum assistance by 1 staff with personal hygiene and oral care. The staff interventions included were to help to brush Resident 19's teeth and provide oral care. During an interview on 7/9/2026 at 2:16 PM with Licensed Vocational Nurse 1(LVN 1), LVN 1 stated CNAs were expected to provide oral care to Resident 19 each shift. The LVN 1 further stated that it is very important to provide oral care to dependent residents to prevent serious infections such as aspiration pneumonia (lung infection that occurs when a person inhales [aspirates] something other than air-such as food, liquid, saliva, or stomach contents-into the lungs, leading to inflammation and infection of the air sacs), other infections, and oral diseases, and to maintain the resident's overall dignity. During an interview on 7/9/2026 at 4:16 PM with the Director of Nursing (DON), the DON stated there was no specific policy for oral care for the dependent residents. DON stated the facility uses Dental Services as a guide for residents' oral care. During a review of the facility's Policy and Procedure (P&P) titled, Dental Services, revised 5/1/2026, the P&P indicated the purpose is to provide residents with oral care to maintain hygiene and dignity.If resident (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is unable to perform self-oral care, provide privacy, place emesis basin in front of resident, and proceed to brush teeth.		

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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 interview and record review, the facility failed to ensure one (1) of two (2) sampled residents (Resident 86), in the general care area, received: Weekly skin assessments for the resident's basal cell carcinoma (BCC- the most common type of skin cancer) lesions (an area of abnormal or damaged tissue caused by injury, infection, or disease) per facility Policy and Procedure (P&P). A follow up oncology (a branch of medicine dedicated to the diagnosis, treatment, and study of cancer) appointment was carried out in accordance with Resident 86's physician order and the facility and General Acute Hospital 1 (GACH 1) discharge instructions. These failures had the potential for Resident 86 to receive inadequate care, negatively impacting the resident's physical, mental and psychosocial (mental and emotional well-being [psychological] and interactions with other people or society [social] wellbeing). Findings: 1. During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses that included BCC of skin of unspecified parts of face, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and dysphagia (difficulty swallowing). During a review of Resident 86's Skin Weekly Assessment 1.1, dated 6/17/2026, the Skin Weekly Assessment indicated upon admission, Resident 86 had facial BCC lesions with granulation (a new connective tissue; beefy red) and necrotic (dead, non-functioning; brown, black, leather, scab-like) tissue present. During a review of Resident 86's admission MDS, dated [DATE], the MDS indicated Resident 86 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 86 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, partial/moderate assistance (helper does less than half the effort) with toileting hygiene, dressing, shower/bathing self, and supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and personal hygiene. During a concurrent interview and record review on 7/10/2026 at 10:03 AM with the Director of Nursing (DON), Resident 86's electronic medical record, dated 6/16/2026 through 7/10/2026, was reviewed. The electronic medical record did not indicate completed weekly skin assessments for Resident 86's facial BCC lesions for the weeks of 6/21/2026 through 6/27/2026, 6/28/2026 through 7/4/2026 and 7/5/2026 through 7/10/2026. The DON stated Resident 86 did not have completed weekly skin assessments documented in the resident's chart after 6/17/2026 but should. During an interview on 7/10/2026 at 10:07 AM with the Medical Records Director (MRD), the MRD stated Resident 86's medical record did not have any weekly skin assessments completed after 6/17/2026. During an interview on 7/10/2026 at 2:35 PM with the DON, the DON stated it was important to ensure weekly skin assessments were done to assess and see if the ulcers were improving or if they are declining, if the treatments are effective or if new orders are needed for treatment so that proper care and treatment can be provided. 2. During a review of Resident 86's GACH 1 discharge instructions, dated [DATE], the Discharge Instructions indicated for a follow up with oncology outpatient. During an interview on 7/9/2026 at 10:54 AM with the Social Services Director (SSD), the SSD stated upon admission, any follow up appointments need to be carried out through a physician's order and [referral] authorization (the formal approval granted by a health insurance plan allowing a resident to visit a specialist or receive specific medical services) to see the specialist. During a continued interview and concurrent record review on 7/9/2026 at 10:56 AM with the SSD, Resident 86's Order Summary Report, dated 7/9/2026, was reviewed. The Order Summary (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report indicated Resident 86 may have outpatient oncology follow up, ordered on 6/16/2026. SSD stated Resident 86 had an oncology follow-up order, but no appointment date/time were documented as scheduled. SSD further stated she could not provide any information regarding any follow-up actions done, including authorization, and had not done any follow-up actions to coordinate any oncology appointments for Resident 86. During an interview on 7/9/2026 at 11:26 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated he was assigned to provide Resident 86 care and was unaware of the resident's need and physician's order for a follow-up oncology appointment. During an interview on 7/10/2026 at 3:30 PM with the SSD, the SSD stated prior to 7/10/2026, there was no coordination to schedule an oncology appointment for Resident 86 and there should have been once Resident 86 was admitted at the facility and when it was ordered to ensure appointments form outside doctors are done in a timely manner. During an interview on 7/10/2026 at 3:37 PM with Case Manager (CM), CM stated she was not aware that Resident 86 had an oncology follow-up order and was not informed by nursing or social services staff and had not arranged any authorization or requests for an oncology appt prior to today [7/10/2026]. CM stated it was important to follow up with appointments so that residents receive the care they need for their health issues. During a review of the facility's P&P titled, Referrals to Outside Services, dated 1/1/2025, the P&P indicated the facility will provide residents with outside services as required by physician orders or the care plan. The P&P indicated the Director of Social Services coordinates the referral to outside agencies/programs to fulfill resident needs for services not offered by the facility. The P&P also indicated the Director of Social Services of the designee will coordinate with nursing staff to ensure that the Attending Physician's order and referral to outside provider is documented in the resident's medical record. During a review of the facility's P&P titled, Wound Management, dated 5/1/2026, the P&P indicated a resident with a wound will receive necessary treatment and services to promote healing, prevent infection and prevent current wounds from worsening. The P&P also indicated wound documentation will occur at a minimum of weekly until the wound is healed and the documentation will include wound measurements, appearance of wound base, drainage amount and characteristics, appearance of wound edges, and presence of pain. The P&P further indicated Licensed Nurses will document effectiveness of current treatment in the resident's medical record on a weekly basis.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a one (1) to 1 sitter (1:1 sitter- a healthcare worker who provides constant, individualized supervision to a single patient) was provided for 1 of 1 sample resident (Resident 11), reviewed for accidents, as recommended by Resident 11's interdisciplinary team (IDT - a coordinated group of experts from several different fields), indicated in Resident 11's care plan (a document that outlines the facility's plan to provide personalized care to a resident based on the resident's needs) and as ordered by the physician. This failure had the potential for Resident 11 to experience preventable falls, injury or accident hazards. Findings: During a review of Resident 11's admission Record, the admission Record indicated Resident 11 was originally admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), fracture (a partial or complete break) of femur (thigh bone), muscle wasting (weakening, shrinking, and loss of muscle) and atrophy (the partial or complete wasting away, shrinking, or decline of a body part, organ, or tissue). During a review of Resident 11's Fall Risk (Morse) Assessment, dated 5/26/2026, the Fall Risk Assessment indicated Resident 11 with fall risks that included overestimating or forgetting ambulation (walking) limits and weak gait (a manner of walking, stepping, or running). During a review of Resident 11's DT Post Fall Review, dated 6/2/2026, the IDT Post Fall Review indicated Resident had an unwitnessed fall on 5/26/2026 and was observed attempting to self-transfer and getting in/out of bed prior to fall. The IDT Post Fall Review indicated the recommendation for Resident 11 to have a 1:1 sitter. During a review of Resident 11's Care Plan Risk for Falls, revised 6/2/2026, the Care Plan indicated the intervention of a 1:1 sitter. During a review of Resident 11's Minimum Data Set (MDS- a resident assessment tool), dated 6/3/2026, the MDS indicated Resident 11 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 11 required dependent (helper does all the effort) assistance with toileting hygiene, shower/bathing self and chair to bed transfer (the ability to move to and from a bed to a chair/wheelchair). The MDS also indicated Resident 11 was substantial/maximal assistance (helper does more than half the effort) with oral and personal hygiene. During a review of Resident 11's Physician's Orders, dated 7/9/2026, the Physician's Orders indicated may have 1:1 sitter. During a concurrent observation and interview on 7/9/2026 at 9:58 AM with Infection Preventionist Nurse (IPN) at Resident 11's bedside, Resident 11 was observed lying in bed, with no 1:1 sitter or staff at bedside. IPN stated Resident 11 was alone and unsupervised and should have a 1:1 sitter at bedside because the resident was at risk for falls. During a continued observation and interview on 7/9/2026 at 9:58 AM with the IPN and Restorative Nurse Assistant 1 (RNA 1), RNA 1 was observed providing care to another resident behind a closed privacy curtain. RNA 1 stated he was supposed to be the 1:1 sitter for Resident 11 but was assisting another resident so RNA 1 did not provide 1:1 supervision to Resident 11 at that time. RNA 1 stated Resident 11 was left unsupervised and should not have been. During a concurrent interview and record review on 7/10/2026 at 2:06 PM with the Director of Nursing (DON), the facility's Policy & Procedure (P&P) titled, Sitters, dated 1/1/2026, was reviewed. The P&P indicated the purpose was to assist residents who need additional supervision and sitter's sole responsibility is to provide companionship to a resident including sitting at the bedside and conversing with the resident, notifying staff if resident attempts to get out of bed unassisted and the sitter will notify the facility staff when taking a break or when the sitter will be away from the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident. The P&P failed to indicate a sitter cannot leave a resident unattended. The DON stated the policy did not specifically state that a sitter cannot leave a resident unattended but should because staff know it is implied when the policy indicated when the sitter has to notify staff when they will be away from the resident. The DON stated Resident 11 should not have been left unattended and without any staff at bedside for her safety. The DON also stated it was important for Resident 11 to have a continued 1:1 sitter to prevent her from transferring out of bed unassisted and to help prevent another fall. During a review of the facility's P&P titled, Fall Management Program, dated 5/1/2026, the P&P indicated the facility will provide the highest quality care in the safest environment for residents in the facility with the purpose to prevent resident falls and minimize complications associated with falls. The P&P indicated nursing staff will develop a care plan with interventions to reduce the risks of falls and the care plan interventions will be implemented.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure competencies and skills sets to provide nursing and related services were completed for two (2) of five (5) sampled nursing staff in accordance with the facility assessment and policy and procedures (P&P). This deficient practice had the potential to result in an increased risk for improper care provided to the residents which could negatively affect the residents' overall wellbeing. Findings: During a concurrent review and interview on 7/10/2026 at 2:22 PM with the Director of Staff Development (DSD), Certified Nurse Assistant 4's (CNA 4) employee records were reviewed. The DSD stated CNA 4 was hired on 4/1/2026. The DSD stated the facility form titled, CNA Master Competency Worksheet, is used to evaluate the competency of the CNAs' skills upon hire. The DSD stated the skills competency log includes, but was not limited to, evaluating CNAs on activities of daily living, infection control, measurements and weights, positioning, and vital signs. The DSD verified that CNA 4's CNA Master Competency Worksheet, dated 5/1/2026, was incomplete and not conducted correctly. The DSD stated she checked off some of the checklists without validating CNA 4's skills. The DSD stated CNA 4's skills should have been observed and validated to ensure CNA 4 was competent in providing care to the residents. During a concurrent review and interview on 7/10/2026 at 2:36 PM with the DSD consultant, CNA 5's employee records were reviewed. The DSD consultant stated CNA 5 was hired on 5/20/2026. The DSD consultant verified that CNA 5's CNA Master Competency Worksheet, dated 6/4/2026, was incomplete and was not conducted correctly. The DSD consultant stated some of CNA 5's skills were checked off on the need improvement column, and no documented evidence of revalidation of skills. During a concurrent review of CNAs 4 and 5's CNA Master Competency Worksheet form and interview on 7/10/2026 at 2:39 PM with the DSD consultant, she stated the DSD did not indicate the method of validation for the competency skills that were checked off for both CNAs 4 and 5. The DSD consultant stated the Key and Comments column was blank. The DSD consultant stated CNAs 4 and 5's Master Competency Worksheet forms upon hire were incomplete, as all skills were signed off without documentation of the method of skills validation. The DSD consultant stated it is important to evaluate certified nursing assistants' skills competency before releasing them from orientation to determine whether additional training is needed and to ensure residents' safety. During a review of the Facility Assessment, updated 4/13/2026, the Facility Assessment indicated that all staff complete an orientation program and ongoing in-service training. Training plans are guided by the DSD with input from the Director of Nursing, Infection Preventionist, and Administrator. The Facility Assessment also indicated that CNAs are required to have competency checklist after orientation and annually. During a review of the facility's P&P titled, Competency Evaluation, reviewed on 1/1/2026, the P&P indicated skills checklist will be completed for each nursing staff to ensure that related services provided in the facility is maintained.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for one (1) of eight (8) sampled residents (Resident 56) reviewed and observed for medication administration (med pass) in accordance with the facility's policy and procedure (P&P) by failing to:Correctly check Resident 56's enteral tubing (G-tube a soft, flexible plastic tube used to deliver liquid nutrition, fluids, or medications directly into the stomach) placement when Licensed Vocational Nurse 4 (LVN) instilled approximately 50 ml of water instead of air before administering Resident 56's medications.Mix Resident 56's crushed medications with 10 milliliter (ml- unit of measurement for liquid) of water before administering Resident 56's medications.Flush Resident 56's G-tube with 5 to 15 ml of water in between two medications.Flush Resident 56's G-tube with 20 to 30 ml of water before and after administering Resident 56's medications. These deficient practices had the potential to result in inconsistent effectiveness of medications and G-tube blockage for Resident 56.Findings: During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included encephalopathy (damage or disease that affects the brain), gastroparesis (a condition where the stomach empties food too slowly, despite there being no physical blockage), and gastrostomy (G-Tube- a flexible tube surgically inserted through the wall of the abdomen directly into the stomach for feeding, fluid, and medication administration) malfunction. During a review of Resident 56's Care Plan, revised on 2/26/2026, the Care Plan indicated Resident 56 had a gastrostomy tube secondary to dysphagia (difficulty or discomfort in swallowing). Resident 56's Care Plan intervention indicated to use 10 ml of water to mix with crushed meds and to flush tube with 20-30ml of water before and after administration of medication pass. During a review of Resident 56's Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 56 was assessed having severely impaired (never/rarely made decisions) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 56 is dependent (helper does all of the effort, resident does none) with oral/toileting/personal hygiene, upper/lower body dressing, and shower/bathe self. The MDS indicated Resident 56 had a G-Tube. During a review of Resident 56's Order Summary Report, dated 7/10/2026, the Order Summary report indicated the following physician orders:Bethanechol (medication used to treat urinary retention) 25 milligrams (mg- unit of measurement for weight), give 1 tablet via G-tube three times a day for bladder emptying, with a start date of 12/5/2025.Multivitamin (a supplement), give 1 tablet, via G-tube one time a day for supplement, with a start date of 3/23/2026.Flush enteral tubing with at least 5 to 15 ml of water in between each medication, with a start date of 7/5/2026.Flush tube with 20-30 ml of water before and after administration of medication pass, with a start date of 6/30/2026. During an observation of the medication preparation, on 7/9/2026, at 4:42 PM, LVN 4 crushed the following medications and placed them in medication cups:Bethanechol 25 mg 1 tabletMultivitamin 1 tabletLVN 4 transferred Resident 56's bethanechol and multivitamin medications from the medicine cups to large clear plastic cups (5 oz or approximately 148ml). LVN 4 added approximately 50 ml of water in each clear plastic cup and swirled each cup to mix the medication with the water. LVN 4 grabbed another clear plastic cup and poured approximately 120 ml (3/4 full) of water into the clear plastic cup. LVN 4 entered Resident (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	56's room to administer the medications. During a concurrent observation and interview, on 7/9/2026, at 4:48 PM, with LVN 4 of medication administration, LVN 4 turned off Resident 56's G-tube feeding and checked Resident 56's G-tube for residual with a 60 ml syringe. LVN 4 walked to the bedside table and drew up approximately 50 ml of water from the clear plastic cup. LVN 4 placed her stethoscope (a medical device used to listen to internal sound in a human body) on Resident 56's stomach and attached the syringe to Resident 56's G-tube. LVN 4 pushed all of the water in the syringe and stated she was checking Resident 56's G-tube for placement and then administered the following medications: Bethanechol 25 mg, with approximately 60 ml of water. Multivitamin 1 tablet, with approximately 60 ml of water. LVN 4 drew up the remaining contents of water (approximately 50 ml) from the clear plastic cup and flushed Resident 56's G-tube. LVN 4 reconnected Resident 56's G-tube feeding and exited the room. LVN 4 stated she did not measure the amount of water she added to Resident 56's bethanechol and multivitamin medication. LVN 4 also stated she did not flush Resident 56's G-tube with 5 to 15 ml of water in between administering each medication (Bethanechol and multivitamins). LVN 4 added she did not flush Resident 56's G-tube with 20-30 ml of water after administering Resident 56's medications in accordance with the physician's order. During an interview on 7/9/2026, at 5:14 PM, with LVN 4, LVN 4 stated she checked Resident 56's G-tube placement by flushing water into the resident's G-tube. LVN 4 stated the correct way to check for G-tube placement was to push air in and not water and listen for the gurgling sound. LVN 4 stated water can mask the gurgling sound, which can be mistaken for correct G-tube placement. LVN 4 stated if the G-tube was in the wrong place, the water could go outside of the stomach. LVN 4 also stated that she flushed Resident 56's G-tube with the remaining water in the clear plastic cup after administering Resident 56's medications which were more than 30 ml of water. LVN 4 further stated she did not know that she had to flush Resident 56's G-tube with 10 ml of water in between medications in accordance with the physician's order. During an interview on 7/10/2026, at 10:40 AM, with LVN 1, LVN 1 stated it was standard practice in the facility for the licensed nurses to flush the resident's G-tube with 10 ml of water in between medications. LVN 1 stated it was important to flush the G-tube in between medications to clear and prevent the G-tube tubing from getting clogged. LVN 1 stated that licensed nurses should use the medication cup when adding water to dilute the medication because it had measurements, which help ensure the correct amount of water is added to the medications. LVN 1 stated the clear plastic cups should not be used when mixing the medications with water because it could hold around 150 ml of water and the medication can end up getting mixed with too much water. LVN 1 stated crushed medications should be mixed with approximately 10 ml of water before administering the medication in the G-tube. LVN 1 stated licensed nurses should follow the residents' physicians order and care plan on flushing the G-tube during medication administration. During an interview on 7/10/2026, at 1:04 PM, with the Director of Nursing (DON), the DON stated the correct way to check for G-tube placement was to push approximately 10 ml of water in the stomach using a 60 ml syringe. The DON stated that if the G-tube was not in the right place, pushing water can cause water to enter the peritoneal space (the membrane that lines the inside of the belly and covers the organs) and not the stomach. The DON stated crushed medications should be mixed with approximately 10 ml of water before administering the medication through the G-tube and not more than 10 ml of water. The DON stated licensed nurses should flush the G-tube with 20 to 30 ml of water before and after medication administration and not more than 30 ml of water. The DON stated licensed nurses should measure the amount of water that is flushed and mixed with the medications and the physician's order should be followed. The DON stated giving the Resident too much water through the G-tube can cause stomach discomfort. The DON stated licensed nurses should follow the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physicians order and the care plan for the safety of the resident. During a review of the facility's policy and procedure (P&P), titled, Medication-Administration, revised 6/1/2017, the P&P indicated:Medication will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner.The resident's MAR (Medication Administration Record) will be reviewed for allergies and/or special considerations for administration including accepted professional standards and principles. During a review of the facility's P&P, titled, Feeding Tube-Administration of Medication, revised 6/1/2017, the P&P indicated:Medications are administered appropriately and safely when the resident has a feeding tube in place and medication are delivered through the feeding tube.Dilute medication according to resident's administration orders making sure that medications are dissolved completely prior to administration.Check for tube placement by gently inserting 15 cubic centimeter (cc is also same as ml) of air into the tube via the piston syringe (a type of syringe used to safely administer medications directly into a feeding tube) and auscultating (listening) the resident's abdomen about 3 inches (unit of measurement) below the sternum with the stethoscope.Medication must be given separately, flush with 5 cc of warm water in between each medication.Flush with 30 cc of water after the final medication is administered.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records in accordance with the facility's policy by failing to accurately document the administration of oxygen to one (1) of 1 sampled resident (Resident 56) reviewed for oxygen use, in the Medication Administration Record (MAR - a document used to record the administration of prescribed medications). This deficient practice resulted in incomplete and incorrect clinical information, which had the potential for delayed interventions, or failure to identify changes in Resident 56's condition and put the resident at risk for compromised respiratory status and other adverse health outcomes. Findings: During a review of Resident 56's admission Record, the admission Record indicated Resident 56 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and shortness of breath. During a review of Resident 56's Order Summary Report, dated 12/5/2025, the Order Summary Report indicated oxygen at two (2) liters (L- a unit of measurement in volume) a minute (min) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed due to increased respiratory secretions (fluids produced in the airways, including mucus and saliva) every 24 hours. During a review of Resident 56's annual Minimum Data Set (MDS- a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 56 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 56 required dependent (helper does all the effort) assistance with oral, personal and toileting hygiene, dressing, and shower/bathing self. During an observation on 7/7/2026 at 9:53 AM at Resident 56's bedside, Resident 56 was observed receiving oxygen therapy at 2 L/min via nasal cannula. During a concurrent interview and record review on 7/9/2026 at 9:05 AM with Respiratory Therapist 1 (RT1, a healthcare professional who helps people with breathing problems by assessing their lungs and providing treatments to improve their breathing), Resident 56's Respiratory MAR, dated 7/1/2026 through 7/31/2026, was reviewed. The Respiratory MAR failed to indicate oxygen administration on 7/7/2026 and 7/9/2026. The RT stated there was no documented oxygen administration on the MAR for 7/2026, but Resident 56 had received oxygen therapy on 7/7/2026 and 7/9/2026. During a concurrent observation and interview on 7/9/2026 at 9:31 AM with RT 1 at Resident 56's bedside, Resident 56 was observed receiving oxygen therapy at 2L/min via nasal cannula. The RT stated Resident 56 received oxygen continuously and daily along with other respiratory care because of respiratory secretions. During a concurrent interview and record review on 7/10/2026 at 11:40 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 56's MAR, dated 7/1/2026 through 7/31/2026 was reviewed. The MAR failed to indicate oxygen administration given to Resident 56 on 7/7/2026 and 7/9/2026. LVN 2 stated Resident 56 had shortness of breath and was given oxygen 2L for increased secretions. LVN 2 stated Resident 56 had received oxygen therapy and should have been documented on the MAR. During an interview on 7/10/2026 at 2:11 PM with the Director of Nursing (DON), the DON stated any oxygen therapy provided to Resident 56 should have been documented on the MAR to ensure the resident was receiving oxygen as ordered, to determine whether the therapy was necessary, and to allow staff to accurately know what treatments the resident was receiving and how often. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, dated 1/1/2026, the P&P indicated for oxygen administration, the following should be documented in the resident's (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MAR:Date and time oxygen is being used;Oxygen flow rate and device being used;Findings of physical assessment;Residents must be assessed each shift or as needed to determine the need for oxygen/nebulizer.Oxygen saturation levels (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) as indicated; andResident's response to oxygen therapy.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055862	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
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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** Based on observation, interview, and record review, the facility failed to ensure that the call light (a device used by a resident to signal his or her need for assistance) was within reach of one (1) or four (4) sampled residents (Resident 17) reviewed for environment. This deficient practice had the potential to negatively impact on the psychosocial well-being (the individual's mental and emotional health and their social interactions and environment) of Residents 17 due to the delay of provision of care and services. Findings: During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included quadriplegia (the partial or total loss of motor function and sensation in all four limbs and the torso), abnormal posture, and muscle wasting and atrophy (the shrinking and weakening of muscle tissue due to injury, disease, or prolonged inactivity). During a review of Resident 17's Care Plan, revised on 5/29/2026, the Care Plan indicated Resident 17 was at risk for falls related to right side weakness, confusion and left above the knee amputation (AKA). The Care Plan indicated an intervention to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed and Resident 17 needs prompt response to all requests for assistance. The Care Plan also indicated Resident 17 needs a safe environment with a working and reachable call light. During a review of Resident 17's Minimum Data Set (MDS- a resident assessment tool), dated 6/1/2026, the MDS indicated Resident 17 was assessed having moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 17 required substantial/maximal assistance (helper does more than half the effort) with eating, oral/personal hygiene, and upper body dressing. The MDS also indicated Resident 17 was dependent (helper does all of the effort) with toileting hygiene, shower/bathe self, lower body dressing, and lying to sitting on side of bed. The MDS further indicated Resident 17 had impaired functional limitation in range of motion (ROM- the full movement potential of a joint) of both sides of his upper extremities (shoulder, elbow, wrist, and hand). During a concurrent observation and interview on 7/7/2026, at 10:10 AM, in Resident 17's room, Resident 17 was lying in bed with both arms under the blanket. Resident 17 had a call light pad (a specialized call device which can be triggered by only slight pressure for a hand, foot, chin or elbow, designed for residents with limited mobility, dexterity or strength) placed on top of the resident's stomach. Resident 17 stated he could not reach his call light pad because he was not able to move his arms and hands. Resident 17 stated he had discussed with different staff members that his call light pad should be placed where he could reach it, but they continue to put it on top of his stomach. Resident 17 stated he usually starts hollering for staff when he cannot reach his call light pad. Resident 17 stated on some occasions his roommates call the staff for him (Resident 17) when the roommates hear Resident 17 yell for help. During an observation on 7/9/2026, at 11:33 AM, in Resident's 17's room, Resident 17 was observed sleeping in bed. Resident 17's call light pad was placed on top of his stomach. During an interview on 7/9/2026, at 11:33 AM, with Resident 81 (Resident 17's roommate), Resident 81 stated he has called facility staff for Resident 17 when Resident 17 was not able to reach his call light pad. During an interview on 7/9/2026, at 11:41 AM, with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 17's call light pad was different from the usual call lights used by residents in the facility because the resident's call light pad was round and flat and sensitive to touch. CNA 6 stated the call light pad was used for residents who were paralyzed or had upper extremity weakness. CNA 6 stated Resident 17's call light pad should be placed on the side of the resident's (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Golden Rose Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1899 N Raymond Ave Pasadena, CA 91103	
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	head so Resident 17 can trigger it when he turns his head and call for staff when needed. During a concurrent observation and interview, on 7/9/2026 at 11:55 AM, with Occupational Therapy Assistant 1 (OTA 1), in Resident 17's room, Resident 17 was observed lying in bed with both arms on the resident's side under the blanket. Resident 17's call light pad was placed on top of Resident 17's chest. Resident 17 informed OTA 1 that he could not move his arms from under the blanket and reach his call light pad. OTA 1 pulled Resident 17's blanket down to the resident's stomach and attempted to move Resident 17's left hand towards his chest but Resident 17 refused and stated moving his arm to cause him to feel pain. OTA 1 stated Resident 17's call light pad should have been placed within the resident's reach, which was close to the resident's hands. OTA 1 stated facility staff should not have placed Resident 17's call light pad on the resident's chest because it was too high for Resident 17. OTA 1 stated it was important for Resident 17 to reach the call light pad so the resident can express his needs with repositioning and comfort and get assistance from staff. During an interview on 7/10/2026, at 12:44 PM, with the Director of Nursing (DON), the DON stated the facility had two different types of call lights in the facility. The DON stated Resident 17 had the call light pad, which was flat, round and sensitive to touch. The DON stated facility staff should know which side or extremity was stronger for Resident 17 to know where to correctly place the call light. The DON stated Resident 17's call light pad can also be placed on the side of the resident's head if he was not able to move his upper extremities. The DON stated it was not appropriate for staff to place Resident 17's call pad (call light pad) alarm on the resident's chest because the resident cannot reach it to ask for assistance. The DON stated residents can have an accident, end up hospitalized and get harmed if they cannot reach the staff for help. During a review of the facility's policy and procedure (P&P), titled, Accommodation of Needs, revised 1/1/2025, the P&P indicated: The facility will provide an environment and services that meet residents' individual needs. The facility's environment is designed to assist the resident in achieving independent functioning and maintaining the resident's dignity and well-being. In order to accommodate residents' individual needs and preferences, facility staff will assist residents in maintaining independence, dignity and well-being to the extent possible according to residents' wishes. During a review of the facility's P&P, titled, Communication-Call System, revised 5/1/2026, the P&P indicated call cords (call light) will be placed within the resident's reach in the resident's room.		