

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Golden Haven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 409 W. Glenoaks Blvd. Glendale, CA 91202	
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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor three of three sample residents (Resident 7, 67, and 82) reviewed for pharmacy services for the adverse side effects (unwanted, uncomfortable, or dangerous reactions caused by medication or medical treatments) in their drug regimen to prevent unnecessary drug use by failing to: 1. Monitor Resident 7 for the adverse side effect of Tramadol HCL (powerful pain-relieving medication for moderate to severe pain) oral tablet 50 milligrams (mg, unit of mass) that the resident received for pain. 2. Monitor Resident 67 and 82's for the adverse side effect of Hydrocodone-Acetaminophen (Norco, powerful pain-relieving medication for moderate to severe pain) that the residents received for pain. 3. Implement interventions for Resident 7's Tramadol use and Resident 67 and 82's Hydrocodone-Acetaminophen use to indicate the adverse side effects to monitor while receiving the pain medications such as respiratory depression, nausea, and increased drowsiness, lethargy (decreased alertness) and sedation (sleepiness). These failures had the potential to result in Resident 7, Resident 67, and Resident 82 not to receive immediate care or not receive any care when the resident develops an adverse side effects such may include excessive sedation and lead to coma and death related to Tramadol and Hydrocodone-Acetaminophen. Findings: 1. During a review of Resident 7's admission Record (AR), the facility admitted Resident 7 on 4/17/2025 and readmitted Resident 7 on 12/20/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and polyneuropathy (multiple damaged peripheral nerves that causes weakness, numbness, tingling, and pain). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive skills were intact. The MDS indicated Resident 7 was dependent (helper does all the effort) for ADLs such as toileting and showering and was dependent on staff when repositioning herself in bed. The MDS indicated Resident 7 was on a scheduled pain medication regimen and received as needed pain medication, and the MDS indicated Resident 7 did experience frequent pain. The MDS indicated that Resident 7 was taking an opioid (powerful pain-relieving medication). During a review of Resident 7's Order Summary Report, the order, start date 12/20/2025, indicated Resident 7 was ordered to receive Tramadol HCL with instructions to give 1 tablet by mouth every 12 hours as needed for moderate to severe pain, which included a pain severity of 4 to 10 out of 10 pain severity on the numerical pain scale (tool used to measure severity of form 0 to 10/10; 0 = no pain, 10 = worst pain imaginable). 2. During a review of Resident 67's AR, the facility admitted Resident 67 on 8/21/2025 and readmitted Resident 67 on 9/15/2025 with diagnoses that included COPD, osteoporosis (weak and brittle bones due to lack of calcium and vitamin D), and polyneuropathy (a disease or damage affecting multiple peripheral nerves throughout the body simultaneously, often resulting in symmetrical numbness, tingling, and weakness, typically starting in the feet and hands. During a review of Resident 67's MDS, dated [DATE], the MDS indicated Resident 67's cognitive skills were moderately impaired. The MDS indicated Resident 67 had a pain medication regimen, and the MDS indicated Resident 67 denied pain at that time. The MDS indicated that Resident 7 did not use an opioid. During a review of Resident 67's Order Summary Report, the order, start date (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056317	Facility ID: 056317
		If continuation sheet Page 1 of 20

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/16/2025, indicated Resident 67 had Hydrocodone-Acetaminophen tablet 5-325mg with instructions to give 1 tablet by mouth every 6 hours as needed for severe pain such as 7 to 10 out of 10 pain severity on the numerical pain scale. 3. During a review of Resident 82's AR, the facility admitted Resident 82 on 1/23/2025 and readmitted Resident 82 on 2/15/2025 with diagnoses that included acute and chronic respiratory failure (RF, a condition where there is not enough oxygen or too much carbon dioxide [a colorless and odorless gas that is a waste product when mammals breathe out] in the body) with hypoxia (low levels of oxygen in blood), age- related osteoporosis, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left elbow and hand. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 87's cognitive skills were moderately impaired. The MDS indicated Resident 82 was on a scheduled pain medication regimen and received as needed pain medication, and the MDS indicated Resident 82 did experience frequent pain. The MDS indicated that Resident 82 was taking an opioid. During a review of Resident 82's Order Summary Report, an order, dated 3/3/2025, indicated Resident 82 had Hydrocodone-Acetaminophen tablet 5-325mg with instructions to give 1 tablet by mouth every 6 hours as needed for severe pain such as 8 to 10 out of 10 pain severity on the numerical pain scale. During a concurrent interview and record review on 1/16/2026 at 10:47 AM with Licensed Vocational Nurse (LVN) 3, Resident 7's Order Summary Report was reviewed. LVN 3 stated Resident 7's Tramadol order was considered an opioid. LVN 3 stated that there was no physician's order to monitor the adverse effects of Tramadol. During the same concurrent interview and record review on 1/16/2026 at 10:50 AM with LVN 3, Resident 7's care plans were reviewed. LVN 3 stated Resident 7's Tramadol care plan and did not indicate to monitor the resident for the specific adverse side effects of Tramadol use. During the same concurrent interview and record review on 1/16/2026 at 10:55 AM with LVN 3, Resident 67's Order Summary Report and care plans were reviewed. LVN 3 stated Resident 67's order for Hydrocodone-Acetaminophen was considered an opioid. LVN 3 stated, there was no physician order to monitor for the adverse effects of Hydrocodone-Acetaminophen use. LVN 3 stated, Resident 67's care plan for Hydrocodone-Acetaminophen did not indicate to monitor the resident for adverse effects of Hydrocodone-Acetaminophen use. During the same concurrent interview and record review on 1/16/2026 at 11 AM with LVN 3, Resident 82's Order Summary Report and care plans were reviewed. LVN 3 stated, Resident 82's order for Hydrocodone-Acetaminophen physician order to monitor the side effects of Tramadol use. LVN 3 stated, Resident 67's care plan for Hydrocodone-Acetaminophen did not indicate to monitor the specific adverse side effects of Hydrocodone-Acetaminophen use. During the same interview on 1/16/2026 at 11:05 AM with LVN 3, LVN 3 stated that it was important to monitor the side effects of opioids because the adverse side effects of excessive opioid use may cause decrease respirations and decrease oxygen levels which may lead to excessive sedation and eventually coma or death. During an interview on 1/16/2026 at 1:40 PM with the Director of Nursing (DON), the DON stated, it was important to monitor the side effects of opioid medications such as the respiratory effort, respirations, oxygen levels, and lethargy (feeling sluggish and unusually tired or sleepy) because these adverse side effects may lead to excessive sedation that could result in a coma or death. During the same concurrent interview and record review on 1/16/2026 at 1:45 PM with the DON, Resident 7's, 67's, and 82's Order Summary Report were reviewed. The DON stated that Resident 67 and Resident 82 did not have a current active order to monitor for adverse side effects of Hydrocodone-Acetaminophen. During the same concurrent interview and record review on 1/16/2026 at 1:55 PM with the DON, Resident 7's, 67's, and 82's care plans were reviewed. The DON stated that Resident 7 had a care plan for Tramadol, but the care plan did not indicate monitoring the specific adverse side effects of Tramadol that may affect Resident 7. The DON stated that Residents 67 and 82 had a care plan for Hydrocodone-Acetaminophen, but the care plan did not indicate to monitor for the specific adverse side effects Hydrocodone-Acetaminophen that may affect Resident 67 or 82. During the same interview on 1/16/2026 at 2:05 PM with the DON, the DON stated it was important to indicate what adverse side (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effects the opioid medication may have on a resident to ensure the licensed nurses became aware of what adverse side effects to monitor and to report to the physician. During a review of the facility's policies and procedures titled Medication Administration - General Guidelines, dated December 2019, the P&P indicated that the staff should be monitoring side effects or other medication-related problems continually. During a review of the facility's P&P titled, Administration Procedures for All Medications, dated December 2019, the P&P indicated to monitor for side effects or adverse drug reactions immediately after administration and throughout each shift.		

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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 and interview the facility failed to ensure foods were properly stored and sealed in accordance with the Policy and Procedure titled, Food storage, preparation, distribution and serving food. This deficient practice had the potential to result in food contamination, growth of microorganisms (disease causing organism) that could cause foodborne illness (food poisoning or food illness due to pathogens (harmful organisms that cause illness such as bacteria, viruses, or parasites) and toxins. Findings: During a concurrent initial kitchen observation and interview with the Dietary Supervisor (DS) on 1/13/2026 at 9:20 AM, the dry food storage was observed. A plastic food container which contained dehydrated bread pudding was open, with the lid not on. The DS stated the container that contained the dehydrated banana pudding was not properly closed and was exposed to air which would contaminate the food contents.DS stated that if the pudding was contaminated and served to the residents, it could result in foodborne illness. During a review of the facility's policy and procedures (P&P) titled, Food Storage revised 1/1/2026, indicated that food items will be stored, thawed, and prepared in accordance with good sanitary practice. The P&P indicated any opened products should be place in storage containers with tight fitting lids.		

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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 and interview the facility failed to ensure one of five sampled residents' (Resident 30) call light were within reach and easily accessible for use. This deficient practice had the potential for Resident 30 not to be able to call for assistance when needed especially during emergency and not to receive care or receive delayed care. Findings: During a review of Resident 30's admission Record (AR), the AR indicated that Resident 30 was admitted to the facility on [DATE] with diagnoses including hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (known as CVA/stroke- loss of blood flow to a part of the brain) affecting left dominant side, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified visual loss. During a review of Resident 30's Minimum Data Set (MDS, a resident assessment tool) dated 12/25/2025, the MDS indicated Resident 30 had moderately impaired cognitive skills for daily decision making. The MDS also indicated that Resident 30 required substantial/maximal assistance (helper does more than half the effort) on oral hygiene, personal hygiene, and upper body dressing. During a concurrent observation and an interview on 1/13/2026 at 9:39 AM with Resident 30, Resident 30 was observed lying in bed. Resident 30 stated that she needed assistance to be placed in a comfortable position and to reposition her left arm. Resident 30 stated she could not see well and could not locate her call light. During a concurrent observation and an interview on 1/13/2026 at 9:50 AM with certified nurse assistant (CNA) 1, CNA 1 stated Resident 30's call light was not within reach. CNA 1 stated that Resident 30 could not move her left arm on her own so it was important to keep Resident 30's call light within reach at all times. During an interview on 1/13/2026 at 9:59 AM with the licensed vocational nurse (LVN) 1, LVN 1 stated Resident 30 required maximum assistance for most of her activities of daily living (ADL's, basic self-care tasks essential for independent living) and it was important to ensure residents' call lights were within reach so when a resident needed assistance, the resident could call for help by pressing the call light. LVN 1 further stated the call light cord should not be wrapped around multiple times onto a residents' bed since the cord would be shortened and tight and could prevent the resident from reaching the call light. supposed not to be wrapped multiple times because the cord would be too tight and short to be accessible for Resident 30. During an interview on 1/15/2026 at 12:00 PM with the Director of Staff Development (DSD), DSD stated that a call light is a system that enables resident to call nursing staff from their bed or restroom, and a call light should always be accessible for residents. During a review of the facility's policy and procedures (P&P) titled Communication- Call System revised on 10/24/2022, the P&P indicated that the call cord will be placed within the resident's reach in the resident's room.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 11) was provided a written notice of Bed-hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) policy upon transfer to the General Acute Care Hospital (GACH) on 1/4/2026. This deficient practice resulted in Resident 11 and/or their representatives not being informed of their rights regarding bed reservation during hospitalization, which could lead to confusion and disruption in continuity of care. Findings: During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted the resident to the facility on 9/7/2024, with diagnoses including dementia (a general term for a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life) with behavioral disturbance (loss of memory and thinking ability with agitation and physical aggression) and hypertension (HTN - high blood pressure). During a review of Resident 11's History and Physical (H&P) dated 10/18/2025, the H&P indicated Resident 11 did not have the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 12/8/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 11's Physician Discharge summary dated [DATE], the summary indicated that Resident 11 was transferred to the general acute care hospital (GACH) on 1/4/2026 for abnormal vital signs with a documented heart rate of 110 beats per minute (bpm). During a review of Resident 11's medical records Hard Chart on 01/15/2026 at 8:26 AM, Resident 11's records were reviewed for bed hold documentation. The hard chart did not indicate any documentation for a bed hold. During a concurrent interview and record review on 1/15/2026 at 8:38 AM with the Director of Nursing (DON), Resident 11's medical record Hard Chart under the admission records tab documents were reviewed. The DON stated that there was no bed hold document signed or present in Residents 11's medical record hard chart and it was unknown if the responsible party (RP) or conservator was notified regarding the bed hold. The DON stated that the absence of the bed hold document indicated the facility was noncompliant with state & federal regulations, and that if not appropriately documented Resident 11's RP would get billed incorrectly. During a review of the facility's policy and procedure (P&P) titled Bed Hold revised on 9/1/2023, the P&P indicated that the facility advises residents or the resident's representative in writing that the Facility has a bed hold policy and will hold the resident's bed for up to seven (7) days if the resident is transferred to a general acute care hospital.		

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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 comprehensive care plan to indicate interventions in the management of dementia (a general term for a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life) for one of three sampled residents (Resident 3). This deficient practice had the potential for Resident 3's not to received or receive delayed care that is individualized care to the resident's needs. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted the resident to the facility on [DATE], with diagnoses including dementia (a general term for a decline in thinking, memory, and reasoning skills severe enough to interfere with daily life) and unspecified psychosis (loses of touch with reality) experiencing symptoms like hallucinations (seeing/hearing things not there). During a review of Resident 3's History and Physical (H&P) dated 5/24/2025, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 12/10/2025, the MDS indicated that Resident 3 had a severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 3's Care Plan titled Resident 3 has impaired cognitive functions/impaired thought processes related to dementia initiated on 3/13/2025, the care plan indicated interventions that included statements such as keep the resident's routine consistent, monitor and report as needed (PRN) changes, and reminisce with photos, without identifying resident-specific behaviors, triggers, communication needs, safety risks, or individualized approaches required to meet the resident's dementia-related needs. During an interview on 1/15/2026 at 1:10 PM with Certified Nursing Assistant (CNA), CNA 4 stated that Resident 3 could not verbally communicate her needs but used eye gestures and hand movements. CNA 4 stated that Resident 3 gets frustrated and agitated 2 to 3 times a week and that Resident 3 would wave her hands around and grunt when Resident needed something. CNA 4 stated once Resident 3's needs were met; Resident 3 would calm down. During a concurrent interview and record review on 1/15/2026 at 1:45 PM, with Licensed Vocational Nurse (LVN) 2, Resident 3's Care Plan on Dementia care was reviewed. LVN 2 stated that Resident 3's dementia care plan lacked specific, individualized treatments and interventions to address the resident's dementia-related behaviors and care needs. LVN 2 stated that the care plan did not address when Resident 3 was frustrated and agitated and how to respond to treat the behavior. During a concurrent interview and record review on 1/15/2026 at 2:11 PM, with Director of Staff Development (DSD) Resident 3's Care Plan on Dementia care was reviewed. DSD stated Resident 3's dementia care plan was not resident-specific and lacked individualized interventions based on the resident's assessed needs, behaviors, and preferences. DSD stated that Resident 3's care plan contained generic interventions and did not clearly guide staff on how to respond to Resident 3's specific behaviors or triggers when Resident 3 was frustrated or agitated. During a concurrent interview and record review on 1/15/2026 at 2:30 PM, with the Director of Nursing (DON), Resident 3's Care Plan on Dementia care was reviewed. DON stated that Resident 3's care plan contained generic interventions and did not clearly guide staff on how to respond to the resident's specific behaviors or triggers. DON stated that this practice had the potential to result in inconsistent or ineffective care for residents with dementia. During a review of the facility Policy and Procedure (P&P) titled Care Planning revised on 6/12/2025, the P&P indicated that each resident's Comprehensive Care Plan will describe the following: Interventions and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.		

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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. Based on observation, interview and record review, the facility failed to provide the necessary care and services to one of three sampled residents (Resident 30), who was unable to carry out activities of daily living (ADLs) by failing to: 1. Ensure that Resident 30 received services to maintain good oral hygiene as indicated in the care plan by Certified Nurse Assistant (CNA) 3 after Resident 30 finished with her meal. 2. Ensure that Resident 30 was assisted to be properly positioned for her meal. Specifically, on 1/14/2026 Resident 30 was observed in high Fowler's position leaning to her right side when CNA 2 set up tray and cued the resident to start eating. These deficient practices had the potential to place Resident 30 at risk for diseases of the mouth, gums, and teeth, and aspiration (something other than air gets into the airways) of the food pieces in the mouth could further lead to pneumonia (an infection/inflammation in the lungs). Findings: During a review of Resident 30's admission Record (AR), the AR indicated that the facility admitted Resident 30 on 3/15/2022 with diagnoses including hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (known as CVA/stroke- loss of blood flow to a part of the brain) affecting left dominant side, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified visual loss. During a review of Resident 30's Care Plan dated 6/21/2024, the Care Plan indicated that Resident 30 had self-care deficits due to decreased strength and endurance, and Impaired physical mobility related to limitation of joint mobility. The Care Plans also indicated that Resident 30 required assistance with ADLs functions. The Care Plan interventions indicated to provide oral care to keep teeth and mouth free of odor and debris. The Care Plans did not indicate interventions including proper positioning of Resident 30. During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/25/2025, the MDS indicated Resident 30 had moderately impaired cognitive skills for daily decision making. The MDS also indicated that Resident 30 required substantial/maximal assistance (helper does more than half the effort) on oral hygiene, personal hygiene, and rolling left and right. During a review of Resident 30's Physician Orders dated 12/30/2025, the Orders indicated to provide Regular diet, Soft & Bite Sized-SB6 texture (Foods are soft and fork-tender; they are moist, but there is no separate thin liquid present), Thin-0 consistency (Thin liquids are also called level 0, they are unchanged). During a review of Resident 30's Flowchart for Activities of Daily Living (ADLs Flowchart) dated from 1/1/2026 to 1/15/2026, the ADLs Flowchart indicated that Resident 30 required partial/moderate assistance (helper does less than half the effort) on eating. During a concurrent observation and interview on 1/14/2026 at 12:38 PM in the resident room, CNA 2 was observed assisting Resident 30 to high Fowler's position (semi-sitting posture where the head of the bed is elevated 60 to 90 degrees). CNA 2 was then observed setting up meal tray and about to leave the resident room while Resident 30 was sitting in the center of the bed with upper body leaning to right upper bed rail. CNA 2 stated Resident 30 was only able to feed herself with the right arm. CNA 2 also stated she was supposed to help and make sure the resident was in the correct position for meal. During a concurrent observation and interview on 1/15/2026 at 9:30 AM, Resident 30 was observed sleeping in bed in a semi-Fowler position (a position in which the individual lies on their back on a bed with the head of the bed elevated at 30-45 degrees), mouth open with visible traces of food on Resident 30's gums. CNA 3 stated Resident 30 was not provided with oral care after breakfast that morning, 1/15/2026. CNA 3 stated she was supposed to provide oral care to Resident 30 after the resident had her breakfast and it was one of her responsibilities to maintain residents in good hygiene. During a concurrent record review and an interview on 1/15/2026 at 9:59 AM with the Licensed Vocational Nurse (LVN) 1, Resident 30's MDS was reviewed. LVN 1 stated Resident 30 required maximal assistance on majority of ADLs including oral hygiene. LVN 1 stated Resident 30's dental health will be at risk if not done. During an interview on 1/15/2026 at 12:05 PM with the Director of Staff Development (DSD), the DSD stated she was responsible for supervising CNAs and (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensuring the CNAs provide proper care and assistance to residents. The DSD stated that any CNA delivering the meal tray to a resident should also provide assistance as needed and ensure that the resident was positioned and supported properly for eating. The DSD stated improper position could cause the resident to have spine problems, or aspirate (something other than air gets into airways). The DSD further stated if the CNA was not familiar with the level of assistance of the resident whom they served meal to; he or she should seek recommendations from their charge nurse. The DSD stated oral hygiene was important and the assigned CNA for Resident 30 should have provided oral care once Resident 30 was done with her meal. The DSD further stated by not having oral hygiene maintained, the resident could be at risk for bad mouth odor or even aspirate on anything remaining from the gum and that can lead to pneumonia. During a review of the facility's Policy and Procedures (P&P) titled Grooming dated 1/1/2026, the P&P indicated that the facility would work with residents to promote hygiene, comfort, and dignity. The P&P also indicated that residents who have teeth should brush them twice daily, and residents who do not have teeth or who have dentures should perform mouth care twice daily. During a review of the facility's policy and procedures (P&P) titled Eating and Swallowing dated 1/1/2026, the P&P indicated the following: 1. Body positioning is a critical component in addressing self-feeding and swallowing skills. Posture affects the resident's ability to use the upper extremities during self-feeding and also plays significant role in safe swallowing. 2. The resident's weight should be evenly distributed on the buttocks and thighs to prevent weight shift and leaning to one side. 3. The resident's trunk, neck and head should be supported in midline.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure one of three sampled residents (Resident 13) received appropriate services ensuring Restorative Nursing Assistant (RNA) demonstrated proper hand placement while providing passive range of motion (PROM). This deficient practice placed Resident 13 at risk for pain, injury, and compromised joint integrity. Findings: During a review of Resident 13's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included spondylosis (spinal osteoarthritis, where the protective cartilage cushioning the ends of your bones gradually break down over time causing bones to rub together, leading to joint pain, stiffness, and reduced mobility), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue often leading to restricted joint mobility) of left and right knee, and difficulty in walking. During a review of Resident 13's History and Physical (H&P) dated 9/8/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 13's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 12/24/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent (helper did all of the effort and the resident did none) from facility staff for all self-care areas and functional abilities. The MDS indicated the resident received restorative nursing programs. During a review of Resident 13's Order Summary Report dated 9/8/2025, the Order Summary Report indicated RNA for active-assistive range of motion (AAROM, when the resident partially moved a body part themselves but received extra help from a therapist to move further and more safely) to left upper extremity, every day, five times a week, ongoing as tolerated. During a review of Resident 13's Order Summary Report dated 9/8/2025, the Order Summary Report indicated RNA for active-assistive range of motion (AAROM, when the resident partially moved a body part themselves but received extra help from a therapist to move further and more safely) to right upper extremity, every day, five times a week, ongoing as tolerated. During a review of Resident 13's Order Summary Report dated 11/21/2025, the Order Summary Report indicated Restorative Nursing Assistant (RNA, helped resident's get stronger and more independent after illness or injury focusing on regaining daily skills like walking, eating, and bathing) program for PROM exercise to left lower extremities, every day, seven days a week, as tolerated. During a review of Resident 13's Order Summary Report dated 11/21/2025, the Order Summary Report indicated RNA program for PROM exercise to right lower extremities, every day, seven days a week, as tolerated. During an observation in Resident 13's room on 1/15/2026 at 2:55 PM, RNA 1 was observed providing flexion/extension (simple movements that involved bending [flexion] and straightening [extension] the joints) PROM exercises to the resident's left and right lower extremity. RNA 1 placed her left hand under the resident's lower right thigh and placed her right hand over the resident's right toes holding the resident's toes in her hand. Upon completion, RNA 1 moved to the resident's left leg and placed her right hand under Resident 13's lower left thigh and placed her left hand under the ball of the foot (the padded, fleshy area on the sole of your foot located between the arch and the toes) of the resident's left foot. During an interview on 1/15/2026 at 3:14 PM, RNA 1 stated when providing flexion and extension exercise, the hands should have been under the resident's thigh and under the ankle. RNA 1 stated if the proper technique was not used the resident could be uncomfortable, be in pain, or might get hurt. During an interview on 1/15/2026 at 3:30 PM, Physical Therapist (PT) 1 stated proper hand placement when providing PROM exercises during flexion and extension of the leg would be to have one hand under the ankle and the other one at the resident's lower thigh to support the entire leg. PT 1 stated if facility staff were not using proper hand placement, the resident could be uncomfortable, could cause skin breakdown or even a fracture if a resident had brittle bones. During a (continued on next page)		

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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: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the facility's P&P titled, Restorative Nursing Program Guidelines dated 1/1/2026, the P&P indicated The Restorative Nursing Program provides nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The P&P indicated, The basic restorative nursing categories include active range of motion (AROM) and passive range of motion (PROM). During a review of the facility's policy and procedure (P&P) titled Performing Range of Motion Exercises dated 1/1/2026, the P&P indicated When assisting the resident, hold the part of the body being exercised securely, but gently above and below the joint, not on the joint. Begin ROM exercises at the larger joints and work outward toward the smaller, finer joints. The P&P indicated ROM exercises are performed with caution to prevent injury or pain. During a review of the facility's undated P&P titled, Range of Motion Exercises, the P&P indicated for flexion/extension for the hip and knees Support the leg at the knee and ankle joints and keep the knee straight. Raise and lower the leg. Bend the knee and move toward the chest; slowly straighten the knee.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide respiratory care in accordance with professional standards of practice and the facility's policy and procedures for one of three sampled residents (Resident 7) by failing to ensure: 1. Resident 7 was evaluated for the refusal to use Bilevel Positive Airway Pressure (BiPAP, a noninvasive mask-based device used to help residents breathe easier by pushing air into the lungs) machine and implement interventions to ensure the resident received adequate oxygenation. 2. Resident 7 had a physician order was received before the administration of oxygen delivered via nasal cannula (a tubing that connects to the oxygen concentrator machine used to deliver oxygen into the nares) when the resident refused to use the BiPAP. 3. Implement interventions for Resident 7's who uses oxygen delivered via NC and indicate what are the negative outcomes to monitor related to the use or refusal to use BiPAP machine as specified in the care plan to prevent shortness of breath and respiratory failure (failure of the lungs to meet the oxygen demand of the body). These failures had the potential for Resident 7 to receive inadequate oxygen and result in recurrent hospitalization due to respiratory failure and a potential to result in shortness of breath, discomfort from difficulty breathing and death. Findings: During a review of Resident 7's admission Record (AR), the facility admitted Resident 7 on 4/17/2025 and readmitted Resident 7 on 12/20/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), respiratory failure and asthma (a chronic condition where the airways narrow and swell making it difficult to breathe). During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive skills were intact. The MDS indicated Resident 7 was dependent (helper does all the effort) for ADLs such as toileting and showering and was dependent on staff when repositioning herself in bed. The MDS indicated Resident 7 used continuous oxygen therapy and used a BiPAP machine as her non-invasive mechanical ventilator. During a review of Resident 7's Nursing Progress Notes (PN), dated 12/13/2025 timed at 11 AM, the PN indicated that Resident 7 had a change in mental status and appear to look tired. The PN indicated PCP 1 was notified and recommended Resident 7 to be transferred to GACH 1. During a review of Resident 7's Weight and Vitals Summary, the following were reviewed: 12/13/2025 at 2:03 AM - 18 breaths per minute, 82 beats per minute, 93% oxygen levels via nasal cannula, 2. 12/13/2025 at 9:49 AM - 19 breaths per minute, 98 beats per minute, 93% oxygen level via nasal cannula During a review of Resident 7's GACH 1 Records, Physician 3's (GACH Family Medicine Physician) History and Physical (HP), dated 12/13/2025, the PN indicated that Resident 7 had been hypoxemic (low levels of oxygen in blood) oxygen saturation in the upper 80's while on oxygen therapy. The PN indicated that Resident 7 had chronic hypercapnic (too much carbon dioxide in the blood) and hypoxemic respiratory failure. During a review of Resident 7's Order Sheet, dated 12/15/2025 ordered by Physician 2 (a pulmonologist or a physician that treats lung disorders and diseases), the order indicated to continue BiPAP on and off during the daytime and continuous at night and to titrate (adjust) Resident 7's oxygen therapy level to keep her oxygen saturation (amount of oxygen in the blood, normal levels are 94 - 100%) levels around 92%. During a review of Resident 7's GACH Records, Physician 2's PN, dated 12/19/2025, the PN indicated to continue Resident 7's oxygen therapy to keep her oxygen saturations above 92% and to alternate the oxygen therapy between the nasal cannula (NC, a lightweight flexible tube with two prongs that sit just inside the nares used to deliver supplement oxygen therapy) and the BiPAP machine. Physician 2 indicated that Resident 7 will wear the BiPAP machine on and off during the daytime and continuously during the nighttime. During a review of Resident 7's Order Summary Report, an order, dated 12/22/2025, indicated Resident 7 would wear the BiPAP machine at bedtime continuously and as needed during the daytime. During a review of Resident 7's care plan, initiated on 1/6/2025 and revised on 1/13/2026, the care plan indicated Resident 7 was noncompliant and refused to use the BiPAP machine as ordered. The care plan's interventions included to monitor (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and report any negative outcomes from noncompliance to physician and to educate consequences of non-compliance. During an observation and interview on 1/13/2025 at 10:52 AM with Resident 7 in Resident 7's room, Resident 7 was observed lying in bed receiving oxygen via NC connected to the oxygen concentrator (a medical device that used the air in the atmosphere to filter and provide oxygen) on the left side of the head of her bed. The oxygen concentrator gauge was set at 4 liters per minute (LPM) of oxygen. The BiPAP machine was on the right bedside table. Resident 7 stated, she has always used oxygen therapy through the nasal cannula and it was hard for her to breathe without it. Resident 7 stated, she did not like using the BiPAP machine at night because it felt like it was suffocating her. During an observation on 1/14/2026 at 8:30 AM in Resident 7's room, Resident 7 was observed sleeping in bed receiving oxygen via NC connected to an oxygen concentrator gauge was at 4 LPM of oxygen. During an observation on 1/15/2026 at 9:25 AM in Resident 7's room, Resident 7 was observed sleeping in bed receiving oxygen via NC Connected to an oxygen concentrator gauge was at 4 LPM of oxygen. During an interview on 1/15/2026 at 2:20 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 7 continuously used oxygen therapy via her NC because she feels more comfortable using the NC than the BiPAP machine. LVN 2 stated, Resident 7 rarely used the BiPAP at night because she does not get enough oxygen with the BiPAP machine. During a concurrent observation and interview on 1/15/2026 at 2:28 PM in Resident 7's room with LVN 2, Resident 7 was observed lying in bed with oxygen delivered via NC the oxygen concentrator was set at 2 LPM of oxygen. LVN 2 stated, Resident 7's oxygen concentrator was at 2 LPM and he turned it down because he saw [the surveyor] in Resident 7's room looking at the oxygen concentrator. LVN 2 stated, this morning (1/15/2026), Resident 7's oxygen concentrator was between 3 to 4 LPM and yesterday (1/14/2026), Resident 7's oxygen concentrator was at 4 LPM. During a concurrent interview and record review on 1/15/2026 at 2:45 PM with LVN 2, Resident 7's Order Summary Report was reviewed. LVN 2 stated that there was no physician's order active order for Resident 7 to received oxygen therapy via NC. During the same concurrent interview and record review on 1/15/2026 at 2:50 PM with LVN 2, Resident 7's care plans were reviewed. LVN 2 stated that there was no documented evidence of a care plan was developed for Resident 7 who uses oxygen delivered via NC. LVN 2 stated it was important to indicate the type of care and interventions needed by the resident while receiving oxygen therapy the included specific respiratory status, oxygen saturations level to monitor etc. During the same concurrent interview and record review on 1/15/2026 at 2:55 PM with LVN 2, Resident 7's care plans were reviewed. LVN 2 stated, Resident 7's care plan for noncompliance with the use of BiPAP noncompliance was not resident specific. The care plan did not indicate what specific behavior to monitor and what are the negative outcomes to monitor. During a concurrent interview and record review on 1/15/2026 at 3:06 PM with the Director of Nursing (DON), Resident 7's Order Summary Report was reviewed. The DON stated Resident 7 was a well-known oxygen therapy user. The DON stated that Resident 7 had an order for BiPAP use but did not have an order to receive oxygen therapy via NC. The DON stated, without the right amount of oxygen therapy order for oxygen delivered via NC, Resident 7 could be getting unnecessary oxygen which is considered a medication. During the same concurrent interview and record review on 1/15/2026 at 3:10 PM with the DON, Resident 7's care plans were reviewed. The DON stated, there was no documented evidence of a care plan for Resident 7 to received oxygen therapy via NC. The DON stated there was no resident-specific care plan and interventions to help monitor the staff monitor and management Resident 7's COPD and oxygen therapy to monitor the effectiveness of the therapy. During the same concurrent interview and record review on 1/15/2026 at 3:15 PM with the DON, Resident 7's care plans were reviewed. The DON stated that Resident 7's BiPAP compliance care plan was not resident specific and did not have resident-specific interventions to monitor for negative outcomes. During a review of the facility's policies and procedures (P&P) titled Oxygen Administration, dated 5/7/2025, the P&P indicated all resident's receiving oxygen must have oxygen orders. During a review of the facility's P&P titled, Care Planning, dated 6/12/2025, the P&P indicated (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident's comprehensive care plan should describe the interventions and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial [NAME].		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper use of bed rails (are adjustable metal or rigid plastic bars that attach to the bed) for two of five sampled residents (Resident 4 and 6) by failing to: 1. Attempt to use nonrestrictive measures and other appropriate alternatives prior to installing bed rails. 2. Complete the resident assessment for Resident 6's risk for entrapment (an event in which a resident is caught, trapped, or entangled in the space in or above the bed rail). 3. Implement intervention to monitor the residents for the use of bed rails. These deficient practices had the potential to result in Resident 4 and 6 to be at risk for accident and entrapment that could lead to injuries. Findings: a. During a review of Resident 4's admission Record (AR), the AR indicated that Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), morbid obesity (a severe form of obesity characterized by a body mass index [BMI] of 40 or higher), and acquired absence of left leg below knee (loss of the left leg below the knee, typically due to medical intervention such as surgery following severe injury or disease). During a review of Resident 4's Care Conference IDT (IDT- An interdisciplinary team is defined as a group of professionals who collaborate interdependently to achieve goals) Meeting dated 10/30/2025, there was no documented evidence indicating any review of bed rails use. During a review of Resident 4's Order Summary Report (OSR) dated 12/16/2025, the OSR indicated to put a bilateral full side rails up as enabler (support) to enhance bed mobility/ repositioning/ transferring/ ADL (activities of daily living) care and safety. During a review of Resident 4's Nursing admission Assessment (NAA) dated 12/16/2025, the NAA indicated that Resident 4 needed a siderail (known as bed rail), and frequent monitoring was selected as initiated among 19 alternative measure options. The NAA also indicated that Resident 4 was alert, confused, cannot follow commands or remember the use and purpose of bed rails. During a review of Resident 4's Nursing Progress Notes (NPN) dated from 12/16/2025-1/12/2026, there was no documented evidence indicating alternative measures were attempted prior to the use of bed rails. There was also no documented evidence of monitoring proper placement and function of bilateral full side rails. During an observation and a concurrent interview on 1/13/2026 at 10:15 AM, Resident 4 was sleeping in bed, and both full side rails were up. Licensed Vocational Nurse (LVN 1) stated that Resident 4's had full bed rails up because the resident requested it. During a concurrent record review and an interview on 1/15/2026 at 4 PM with LVN 1, Resident 4's clinical records were reviewed. LVN 1 stated Resident 4's bed rails were ordered to grant the Resident 4's request. LVN 1 stated there was no documentation of discussion with Resident 4 or his responsible party (RP) regarding feasible alternative methods. LVN 1 also stated there was no documentation about attempted alternative measures or monitoring for the safe use of bed rails for Resident 6 in the nursing progress notes. During a concurrent record review and an interview on 1/16/2026 at 3:15 PM with MDSN, Resident 4's clinical records were reviewed. MDSN stated the date of physician's order for bed rails and the date Resident 4's readmission was the same day, 12/16/2025. MDSN stated there was supposed to have more alternatives initiated or attempted prior to the use of bed rails. MDSN further stated the documentation on MAR was only to ensure side rails were up but should have required the nurses to monitor and ensure resident's safety during use of bed rails due to potential risks. MDSN also stated Resident 4's Care plans were supposed to include IDT for initial and quarterly review. b. During a review of Resident 6's AR, the AR indicated that Resident 6 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including asthma (is a condition in which the airways narrow and swell and may produce extra mucus), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consciousness), and dementia (a progressive state of decline in mental abilities). During a review of Resident 6's Order Summary Report (OSR) dated 10/27/2025, the OSR indicated to have bilateral padded full side rails up as enabler to enhance bed mobility and provide safety from potential seizure. During a review of Resident 6's CCIDT Meeting dated 10/30/2025, there was no documented evidence indicating any review prior to the use of bed rails. During a review of Resident 6's Nursing Quarterly Assessment (NQA) dated 10/30/2025, the NQA indicated that Resident 6 needed a siderail (known as bed rail), frequent monitoring and reminder to use call light were selected among 19 initiated alternative measure options. The NQA indicated that Resident 6 was alert, confused, cannot follow commands or remember the use and purpose of bedside rails, and could not use call alarms. The Resident Measurement for head, neck, and chest breath in the NQA as part of entrapment risk assessment was left blank. During a review of Resident 6's Nursing Progress Notes (NPN) dated from 10/27/2025-1/12/2026, there was no documented evidence indicating alternatives were attempted prior to the use of bed rails. There was also no documented evidence of monitoring the resident for proper placement and function of bilateral padded full side rails. During an observation and a concurrent interview on 1/13/2026 at 3:11 PM in the resident's room, Resident 6 was lying in bed and both side rails were up. Certified Nursing Assistant (CNA) 5 stated that Resident 6's bed rails needed to be up when in bed for fall precaution. During a concurrent record review and an interview on 1/15/2026 at 3:39 PM with LVN 1, Resident 6's clinical records were reviewed. LVN 1 stated Resident 6's bed rails were ordered to prevent injury and for seizure precautions. LVN 1 stated there was no documentation of attempted alternative measures or monitoring safe use of bed rails for Resident 6 in the nursing progress notes. During a concurrent record review and an interview on 1/15/2026 at 1:10 PM with MDSN, Resident 6's clinical records were reviewed. MDSN stated the Device/ Restraint Assessment in NQA dated 10/30/2025 should have been completed and evaluated by IDT team. MDSN also stated there was no documentation in Resident 6's medical record indicating all appropriate alternatives initiated or attempted prior to the use of bed rails. MDSN further stated the current documentation on MAR dated from 11/1/2025 to 1/12/2025 was only to ensure side rails were up but should have required the nurses to monitor and ensure resident's safety during use of bed rails due to potential risks. During a review of the facility's Policy and Procedures (P&P) Bed Rails dated 1/1/2026, the P&P indicated the following: Decisions to use or to discontinue the use of a bed rail will be made in the context of an individualized resident assessment using an Interdisciplinary Team (IDT) with input from the resident or resident representative and will take into account the resident's medical needs. The Assessment of whether to use bed rails should include an evaluation of the alternatives to the use of bed rail that were attempted and how these alternatives failed to meet the resident's assessed needs. For bed with rails that are incorporated or pre-installed, the facility must determine whether or not disabling the bed rail poses a risk to the resident. The plan of care should also include documentation of the type of specific direct monitoring and supervision provided during the use of the bed rails and the identification of how needs will be met during the use of bed rails (e.g., repositioning, hydration, etc.) assessed needs.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the licensed nursing staff and physician failed to act upon the pharmacist's recommendations documented in the Medication Regimen Review (MRR, a comprehensive evaluation of a resident's medication regimen intended to promote positive outcomes and minimize adverse effects) to assess the resident's pain condition and add respiratory monitoring to the Physician's Order for the use Morphine Sulfate (Morphine, a potent opioid analgesic, used to treat severe pain) for one of two sampled residents (Resident 5). This deficient practice had the potential for delayed identification of clinical changes, ineffective medication administration, and adverse effects that could lead to acute medical events requiring emergency care or hospitalization. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), depression (constant feeling of sadness and loss of interest, which stops you doing your normal activities), and anxiety disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress). During a review of Resident 5's History and Physical (H&P) dated 9/11/2025, indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 11/8/2025, indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident's active diagnoses included anxiety, depression, and bipolar disorder. The MDS indicated the resident was receiving antipsychotic (psychiatric medications that manage psychosis [hallucinations (sensory experiences that seem real but were caused by brain changes), delusions (fixed, false beliefs strongly held despite evidence to the contrary), disordered thinking] in conditions like bipolar disorder and severe depression), antianxiety (reduce symptoms like excessive worry and panic), and antidepressant (prescription drug used to primarily for depression and anxiety) medication. During a review of Resident 5's Pharmacist's Medication Regimen Review (MRR) dated 11/29/2025 and 11/30/2025, the MRR indicated the resident was on a schedule pain management regimen that could increase the risk of respiratory depression. The MRR indicated recommendations to assess the resident's pain condition and consider adding respiratory monitoring (watching and measuring how often and how well someone was breathing) to the order. During a review of Resident 5's Physician's Order dated 12/17/2025 at 6:15 PM, the Physician's Order indicated to administer morphine sulfate extended release (ER) oral tablet extended release 30 milligrams (mg, unit of measurement) one tablet by mouth every 12 hours for severe pain (7-10, from a 0 out of 10 pain scale where 0 was no pain and 10 signified the worse pain imaginable). During a concurrent interview and record review of Resident 5's MRR on 1/16/2026 at 2:17 PM, the Director of Nursing (DON) stated the facility staff was not following the Pharmacist's recommendations of assessing the resident's pain condition and adding respiratory monitoring to the Physician's Order. The DON stated Resident 5 could have been at risk for adverse effects. During a review of the facility's policy and procedure (P&P) titled Drug Regimen Review dated 1/1/2026, the P&P indicated The intent is that the facility maintains the resident's highest practicable level of physical, mental, and psychosocial well-being and prevents or minimizes adverse consequences related to medication therapy to the extent possible, by providing oversight by a licensed pharmacist, attending physician, medical director, and the director of nursing (DON). The P&P indicated, The pharmacist will report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. The P&P indicated The Medical Director and DON will also review the pharmacist's report if any irregularities are identified. The DON is responsible for following up with the Attending Physician, as indicated. The (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: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2026
NAME OF PROVIDER OR SUPPLIER Golden Haven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 409 W. Glenoaks Blvd. Glendale, CA 91202	
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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated a definition for Irregularity, refers to use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy.		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on interview and record review, the facility failed to obtain laboratory test as ordered by the physician for one of three sampled residents (Resident 67) who was ordered by Physician (Attending Physician) 1 to obtain urinalysis (urine test to determine presence of infection or other kidney disorder) urine culture (a urine test to identify if bacteria was growing in the urine) after Resident 67 complained of dysuria (painful, burning, or discomfort when urinating) on 1/7/2026. The urinalysis and urine culture test were obtained eight (8) days since the physician ordered the laboratory test after the facility was informed that there was no laboratory test obtained for Resident 67. As a result of this deficient practice Resident 67 did not receive the antibiotic (medication used to treat infection) resulting in continued to experience of burning sensation and a potential to have worsened UTI, permanent kidney damage, hospitalization, and death. Findings: During a review of Resident 67's admission Record (AR), the facility admitted Resident 67 8/21/2025 and readmitted on 9/15/2025 with diagnoses that included UTI, chronic obstructive pulmonary disease (COPD, chronic lung disease causing difficulty in breathing), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 67's Minimal Data Set (MDS, a resident's assessment), dated 11/29/2025, the MDS indicated Resident 67's cognitive (a resident's thought process) skills were moderately impaired. During a review of Resident 67's care plan (CP), dated 12/19/2025, Resident 67 had a UTI. The CP's goal indicated Resident 67's UTI will resolve without complications by 12/15/2025. The CP's interventions included for the staff to check Resident 67 every 2 hours for incontinence, monitor and report signs and symptoms of UTI such as dysuria, flank (lateral sides of the body between the ribs and hip) pain, and altered mental status, to obtain and monitor lab or diagnostic work as ordered, and to report results to MD and follow up as indicated. During a review of Resident 67's SBAR Communication Form (situation, background assessment recommendation, communication tool used by healthcare workers when there is a change of condition among the residents) dated 1/7/2026, the SBAR form indicated Resident 67 verbalized having burning sensation upon urination. Physician 1 recommended collecting Resident 67's urine for a urinalysis and urine culture. The SBAR indicated Physician 1 ordered to start Resident 67 on Macrobid (antibiotic medication used to treat UTI) 100 milligrams (mg, unit of weight) twice a day for five (5) days after the urine was collected. During a review of Resident 67's Order Summary Report, the physician order, dated 1/7/2026, indicated the urinalysis and urine culture were uncollected 1/7/2026 for one time only related to UTI infections. During an observation and interview on 1/14/2026 at 9:18 AM with Resident 67 room, was observed lying in bed watching television. Resident 67 stated, she recently told the nurses It burns when she urinates that started sometime last week, and she was supposed to start medication for the burning sensation which she had not received yet. Resident 67 stated she was still experiencing a burning sensation when urinating even this morning (1/14/2026). During a concurrent interview and record review on 1/15/2026 at 2:55PM with Licensed Vocational Nurse (LVN) 2, Resident 67's Change of Condition (CoC) record, dated 1/7/2026, was reviewed. LVN 2 stated the CoC indicated Resident 67 complained of a burning sensation when urinating and Physician 1 recommended to start Resident 67 on a Macrobid, an antibiotic, for five (5) days after urinalysis and urine culture was collected. During a concurrent interview and record review on 1/15/2026 at 3 PM with LVN 2, Resident 67's laboratory test results from 12/2025 to 1/2026 were reviewed. LVN 2 stated there was no documented evidence Resident 67's urine for urinalysis and urine culture were collected or Macrobid antibiotics was administered. During a concurrent interview and record review on 1/15/2026 at 3:30 PM with the DON, Resident 67's Nursing Progress Notes, dated 1/7/2026 to 1/9/2026, were reviewed. The DON stated there was no documented evidence that Resident 67's urine tests were collected on (continued on next page)		

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/7/2026.~~The~DON~stated, there was no~documented~evidence Resident 67 was started~on an antibiotic on or after 1/7/2026.~~The~DON~stated, there was no~documented~evidence Resident 67 was started~on an antibiotic on or after 1/7/2026~to~this~day~(1/15/2026), which was a total of eight (8)^days.~~ During the same interview on 1/15/2026 at 3:38 PM with the DON, the DON stated, it was important to implement the physician order for a urinalysis and urine culture to determine what was causing Resident 67's discomfort and dysuria because there may be some infection happening in her body that the facility was unaware of. During an interview on 1/16/2026 at 4:25 PM with the Infectious Preventionist (IP), the IP stated, Resident 67's CoC record on 1/7/2026 was not followed up. The IP stated, if the physician order was missed on one shift, then the following shift should follow up on physician order. During a review of Resident 67's Lab Results Report Urine Culture record, collected on 1/16/2026 and reported on 1/18/2026, the report indicated Resident 67's urine grew greater than 100,000 colony forming units per milliliter (cfu/mL) of Klebsiella Pneumoniae (bacterial infection of urinary tract that often causes burning or painful urine). During a review of the facility's policies and procedures (P&P) titled Laboratory, Diagnostic and Radiology Services, dated 6/1/2027, the P&P indicated laboratory, diagnostic, and radiology services will be coordinated pursuant to an order by the physician. The P&P indicated the facility is responsible for the quality and timeliness of services provided by the laboratory, diagnostic, or radiology provider.		