STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055968	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Heights Healthcare	35 Escuela Drive Daly City, CA 94015

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 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** 44477 Based on interview and record review, the facility failed to ensure one of 3 sampled residents (Resident 1) received care in accordance with professional standards of practice when there was no evidence of nursing notes and vital signs by night shift nurse on 6/14/24 for Resident 1. This failure had the potential to delay identifying symptoms of atrial fibrillation (Afib, an irregular and often rapid heart rate that commonly causes poor blood flow and can increase the risk of stroke) for Resident 1. Findings: Review of Resident 1's clinical record indicated, Resident 1 was admitted on [DATE] with diagnoses including atrial fibrillation, hypertension (high blood pressure), benign prostatic hyperplasia (BPH, an enlarged prostate), and diabetes (high blood sugar). Resident 1 had a history of transient ischemic attack (TIA, known as a mini stroke which is a temporary disruption in the blood supply to part of the brain). Review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 6/13/24, indicated, his memory was intact. During an interview on 8/7/24 at 1:51 PM with Complainant via phone, Complainant stated, Resident 1 had been diagnosed with the new onset of Afib in XXXXX (the name of the hospital), so he was prescribed two new medications which are Amiodarone (a medicine to treat life-threatening heart rhythm problems) and Apixaban (known as Eliquis, a kind of blood thinner that is used to prevent and treat blood clots in blood vessels and the heart), then was sent to the facility on [DATE] for Rehabilitation (a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment). Complainant stated, Resident 1 was transferred from the facility to a hospital on 6/15/24 because the facility staff found him unconscious, and vomiting, then he passed away on 6/20/24. Review of Resident 1's death certificate, dated 7/5/24 indicated, his date of death was on 6/20/24 with the causes of death with (A) non-traumatic intracerebral hemorrhage (spontaneous bleeding into the brain tissue, a common cause of stroke) and (B) hypertension. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's Medication Administration Record (MAR) from 6/1/24 to 6/30/24 indicated, Resident 1 took Amiodarone oral tablet 400 MG (milligram) 1 tablet by mouth two times a day and Apixaban oral tablet 5 MG 1 tablet by mouth two times a day for A-fib from 6/11/24 to 6/14/24 because he was discharged to the hospital on the morning of 6/15/24. Review of Resident 1's Weights and Vitals Summary dated from 6/14/24 to 6/15/24 indicated, . 06/14/2024 22:57 (10:57 PM) 115/79 mmHg (millimeters of mercury, a measurement of blood pressure) . Review of Resident 1's Nursing Note dated 6/15/24 at 7:50 AM indicated, . Noted resident verbally non-responsive (unconscious) but responsive to tactile stimuli (touch) . Mouth was clear. No respiratory distress noted however coffee-ground emesis (the act of vomiting) noted with elevated blood pressure, 210/108 (normal blood pressure for most adults is defined as less than 120/80). Promptly called 911 while immediate interventions are ongoing . no facial grimace (a facial expression usually of disgust, disapproval, or pain) noted. Afebrile . Paramedics arrived and assisted . Left facility at 8:15pm (typo of AM). Dr. (doctor) Agreeable with the transfer, noted. Called wife . Left a voice mail message on the second attempt . During an interview on 8/8/24 at 2:30 PM with Director of Nursing (DON), DON stated, Resident 1 did not fall on the floor on 6/15/24. DON stated, Resident 1 was found nonresponsive in his bed in the room. During a concurrent interview and record Review on 8/8/24 at 2:52 PM with DON, Resident 1's N Adv (Nursing Advantage) Skilled Evaluation, dated 6/14/24, and Nursing note, dated 6/15/24 were reviewed. N Adv Skilled Evaluation indicated, it was documented at 10:55 PM on 6/14/24 by Licensed Vocational Nurse (LVN) 1, and Nursing note was documented at 7:50 AM on 6/15/24 by Registered Nurse (RN) 1. DON stated, nurses should document resident assessments in the nursing note for each shift when asked about nursing documentation. During a concurrent interview and record review on 8/8/24 at 4:03 PM with DON, Resident 1's nursing note, and the facility's daily assignment sheets dated 6/14/24 and 6/15/24 were reviewed. DON stated, she could not find the night shift's charting on 6/14/24 when asked. DON stated, The missing one is Noc (Night shift), when asked about the nursing documentation. DAILY ASSIGNMENTS: GOLDEN HEIGHTS HEALTHCARE dated 6/14/24 indicated, LVN 1 was the PM shift, and RN 2 was the night shift. DAILY ASSIGNMENTS: GOLDEN HEIGHTS HEALTHCARE dated 6/15/24 indicated, RN 1 was the AM shift. DON stated, RN 2 who was the night shift nurse of 6/14/24 missed writing documents during her shift. DON stated, the facility has 3 shifts which are AM, PM, and Night shift, and every shift works for 8 hours. During an interview on 8/13/24 at 3:31 PM with DON via phone, DON stated, it was documented by the PM shift nurse on 6/14/24 when asked who documented Resident 1's blood pressure at 10:57 PM on 6/14/24. DON verified, RN 2 did not document Resident 1's vital signs and nursing note during her night shift. DON stated, the facility's policy and procedure on checking vital signs did not specify when to take vital signs, but with the facility's practice, nurses of the facility take vital signs at the beginning of the shift, prior to hypertensive/hypotensive medication administration, post incident evaluation, change of condition, and transferring a resident in/out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and procedure (P&P) titled, Routine Resident Checks revised July 2013 indicated, . 1. To ensure the safety and well-being of our residents, nursing staff shall make a routine resident check on each until at least once per each 8-hour shift. 2. Routine resident checks involve entering the resident's room and/or identifying the resident elsewhere on the unit to determine if the resident's needs are being met, identify any change in the resident's condition, identify whether the resident has any concerns, and see if the resident is sleeping, needs toileting assistance, etc.