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	03/26/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 52224 Based on observation, record review, and interview, the facility failed to ensure staff conducted finger-stick blood sugar (FSBS) checks in accordance with physician's orders for 1 (Resident #33) of 3 residents observed for blood sugar monitoring. Specifically, staff failed to perform Resident #33's FSBS before meals as specified by the physician. Findings included: An Admission Record indicated the facility admitted Resident #33 on 06/07/2024 and most recently admitted the resident on 08/21/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of type two diabetes mellitus with diabetic chronic kidney disease. Resident #33's Care Plan Report included a focus area, initiated on 08/01/2024, that indicated the resident was at risk for hyperglycemia (high blood sugar levels) or hypoglycemia (low blood sugar levels). An intervention dated 08/01/2024 directed staff to complete FSBS checks as ordered and as needed. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 02/20/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #33's Order Summary Report contained an active order, dated 12/02/2024, to monitor the resident's blood sugar daily before meals and at bedtime. Resident #33's 03/2025 Medication Administration Record (MAR) revealed the resident's FSBS checks were scheduled for before meals and at bedtime at 6:30 AM, 11:30 AM, 4:30 PM, and 9:00 PM each day. (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	A concurrent observation and interview on 03/24/2025 at 12:41 PM revealed Resident #33 was in their room eating their lunch meal. Resident #33's lunch meal tray was approximately 75% complete when Licensed Practical Nurse (LPN) #2 entered the resident's room with medications and a glucometer. LPN #2 informed Resident #33 that he would provide medications and complete FSBS monitoring. LPN #2 administered the medications, completed a FSBS check, and informed the resident their FSBS result was 190 milligrams per deciliter (mg/dL). After LPN #2 administered the resident's medications and performed the FSBS check, LPN #2 exited the room and reviewed the resident's MAR with the surveyor. LPN #2 stated the resident's FSBS order specified to complete the FSBS checks before meals; however, LPN #2 stated, I just got back from taking my lunch, so I checked the blood sugar when I got back. I was very hungry, and I had to take a lunch break. LPN #2 stated he was trained to check blood sugars before meals, and that was what he should have done but thought he had an hour window to complete the FSBS check. During an interview on 03/25/2025 at 3:36 PM, the Director of Nursing (DON) stated that if a physician's order for FSBS checks specified before meals, the lunchtime FSBS should be conducted between 11:00 AM and 11:30 AM, before lunch. The DON further stated that if a nurse checked a resident's blood sugar during a meal, the results could provide inaccurate information, which defeated the purpose of the physician specifying to check the blood sugar before meals. The DON reviewed Resident #33's MAR and confirmed the resident's FSBS check order specified before meals and at bedtime. The DON stated that the nurse should have completed Resident #33's FSBS monitoring before the resident's lunch meal and before the nurse took his lunch break, because FSBS monitoring only took one to two minutes to complete. During an interview on 03/26/2025 at 9:44 AM, the Administrator stated he expected nurses to complete FSBS checks before meals, per Resident #33's physician's order, because FSBS results would be different before a meal than they would be after a meal or after the resident already started eating.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 52219 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that medications were stored in a safe and secure manner for 2 (Resident #2 and Resident #27) of 2 residents observed with medications at their bedside. Findings included: A facility policy titled, Storage of Medications, revised 04/2007, revealed, The facility shall store all drugs and biologicals in a safe secure and orderly manner. The policy revealed the section titled Policy Interpretation and Implementation included 2. The nursing staff shall be responsible for maintaining medication storage AND preparation areas in a clean, safe, and sanitary manner. A facility policy titled, Self-Administration of Medications, revised 11/2022, revealed, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The policy revealed the section titled Policy Interpretation and Implementation included 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. Further review revealed, 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. A facility policy titled, Administering Medications, revised 12/2012, revealed, Medications shall be administered in a safe and timely manner, and as prescribed. The policy revealed the section titled Policy Interpretation and Implementation included 21. Topical medications used in treatments must be recorded on the resident's treatment record (TAR). Further review revealed, 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR [medication administration record] space provided for that drug and dose. The policy revealed, 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. 1. An Admission Record revealed the facility admitted Resident #2 on 05/14/2018. According to the Admission Record, the resident had a medical history that included diagnoses of senile degeneration of the brain and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/03/2025, revealed Resident #2 had a Brief Interview for Mental Status score (BIMS) of 10, which indicated the resident had moderate cognitive impairment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/24/2025 at 9:12 AM, Resident #2 was dipping their finger into a blue jar of ointment and then putting their finger with the ointment just inside both nostrils. During a concurrent interview, Resident #2 stated they used Vicks VapoRub (a medicated ointment) so they would not get a cold. The blue jar of the medicated ointment had the resident's name on the jar. Resident #2 then placed the jar of medicated ointment into the drawer of their nightstand that was next to the bed. Resident #2 had slight redness under each nostril. During this observation, a staff member was in the room tending to Resident #2's roommate's bed. Resident #2's Orders Summary Report, with active orders as of 03/25/2025, contained an order dated 12/28/2024, informing staff that the resident was incapable of understanding rights, responsibilities, and informed consent. The Order Summary Report revealed no order for the medicated ointment. Resident #2's Care Plan Report revealed no focus area or interventions related to the self- administration of medication for the medicated ointment. During an observation on 03/25/2025 at 9:35 AM, Resident #2 was in their room in a wheelchair and the jar of medicated ointment was on top of the bedside table. During a concurrent interview Resident #2 stated the jar was Vicks VapoRub. Resident #2 stated they used it daily. Resident #2 would not state who gave them the jar of medicated ointment. During an observation on 03/25/2025 at 11:48 AM, Resident #2 was in their room lying down in bed doing a word search, and the jar of medicated ointment was on the resident's nightstand and visible from the hallway. During an observation on 03/25/2025 at 11:57 AM, Registered Nurse (RN) #7 observed the medicated ointment on Resident #2's bedside table while the resident was lying down in bed doing a word search. RN #7 confirmed that the jar was Vicks VapoRub. RN #7 reviewed the resident's physician orders and during a concurrent interview, confirmed there was an active order that informed staff that the resident could not understand rights, responsibilities, and informed consent. RN #7 stated she was not aware of a self-administration for medications assessment for Resident #2. RN #7 stated the certified nursing assistants (CNAs) should check the residents' side tables every shift and notify the nurse if there were medications. RN #7 stated she was not aware of the medicated ointment until that day at the time of the observation. During an interview on 03/25/2025 at 12:03 PM, RN #8 stated there should be a physician order for any topical lotions. RN #8 stated the resident was supposed to have a self-administration medication assessment if they could self-administer medications. RN #8 stated if they got the okay for a resident to self-administer medications, then the doctor would say to keep it at the bedside or not. RN #8 stated if it was okay for the resident to keep the medication at bedside then staff needed to ask the resident where they put the medication on their body, when they used it, and if they had any side effects. RN #8 said the nurses would document this under the Progress Notes and report it to the next nurse to watch for side effects. RN #8 stated that the CNAs on every shift were to check the bed side table and let the nurse know if they found anything, like medications or treatments. RN #8 confirmed there was no physician order for Resident #2 to self-administer the medicated ointment and no self-administration of medication assessment. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/25/2025 at 5:16 PM, the Director of Nursing (DON) stated her expectation would be that medications should not be at the resident's bedside. She stated they had assigned staff members that checked cabinets, drawers, and closets to ensure there were no medications at bedside. The DON stated this was done by two staff members every day on every shift. She stated the two staff members should have found the medicated ointment. During an interview on 03/26/2025 at 8:35 AM, the Staff Development Director (SDD) stated two CNAs were on modified duty. The SDD stated they had special duties that included checking the resident's room. She stated CNA #10 and CNA #11 were the CNAs on modified duty. She confirmed that on 03/24/2025, no staff that was on modified duty was assigned to Resident #2. The SDD stated the CNA assigned to Resident #2 on 03/24/2025 was CNA #9 who worked from 7:00 AM to 3:00 PM. She stated the CNA assigned to Resident #2 on 03/25/2025 from 7:00 AM to 3:00 PM was CNA #12 and further indicated that CNA #10 and CNA #11 were also working and primarily responsible for looking for medications in the residents' rooms. During an interview on 03/26/2025 at 10:01 AM, CNA #10 stated she worked with Resident #2 on 03/25/2025. She stated that for Resident #2 she was able to open their drawer and only saw personal belongings. She stated she did not see the medicated ointment. During a phone interview on 03/26/2025 at 11:06 AM, CNA #9 confirmed she worked on 03/24/2025 from 7:00 AM to 3:00 PM and worked with Resident #2. She stated Resident #2 had medicated ointment, and after she took the resident to the shower around 8:00 AM she saw it. She stated the resident was in their room and was putting something on their nose. CNA #9 stated she saw the medicated ointment on the resident's nightstand, and it had the resident's name on it. She stated the resident wrote their name on all their items. CNA #9 stated she told the SDD after lunch on Monday (03/24/2025) that Resident #2 had medicated ointment on their table. CNA #9 stated the SDD informed her to take it from the resident if she could. CNA #9 stated the resident refused and told her that it was their belongings. CNA #9 stated that at that point she did not feel comfortable taking it. CNA #9 stated she did not let the SDD know at end of her shift, but she let RN #7 know. During an interview on 03/26/2025 at 11:53 AM, CNA #12 confirmed she regularly worked with Resident #2 and that she worked 03/25/2025 from 7:00 AM to 3:00 PM. She stated she did not see medications at Resident #2's bedside. She stated that Resident #2 usually refused to allow staff to touch their drawers. During an interview on 03/26/2025 at 8:57 AM, MDS RN #13 confirmed Resident #2 did not have a self-administration for medication evaluation (assessment). During an interview on 03/26/2025 at 10:06 AM, the Administrator stated his expectation was that if a staff member saw something like medications at the resident's bedside, they were to remove it. The Administrator stated they would let the doctor know, and the doctor would determine if the resident could have the medication at bedside. The Administrator stated there would be an order if a resident could have the medication at bedside. 52224 2. An Admission Record indicated the facility admitted Resident #27 on 02/24/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic pain. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Minimum Data Set (MDS), with an Assessment Reference Date of 03/02/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #27's Order Summary Report, with active orders as of 03/25/2025, contained an active order dated 02/24/2025, for docusate sodium 250 milligrams (mg), with instructions to give one capsule by mouth daily for bowel regularity. The Order Summary Report contained an order dated 02/24/2025 for senna 8.6 mg, with instructions to give two tablets by mouth two times daily for constipation. Further review revealed there were no physician orders to leave medication at the bedside for self-administration. Resident #27's March 2025 Medication Administration Record [MAR] included a transcription of an order for docusate sodium 250 mg, with instructions to give one capsule by mouth daily for bowel regularity and senna 8.6 mg, with instructions to give two tablets by mouth two times daily for constipation. The MAR revealed that Licensed Practical Nurse (LPN) #2 documented that on 03/24/2025 at 9:00 AM, they administer the resident's docusate sodium and Senna. During an interview and observation on 03/24/2025 at 12:26 PM, Resident #27 expressed concerns with constipation but stated that the stool softeners received from LPN #2 that morning (03/24/2025) were not taken when offered by LPN #2. Resident #27 stated that they had agreed to take the stool softeners later. A medicine cup that contained three pills (one red and two brown pills) was observed on Resident #27's over bed table. Resident #27 stated the pills in the medicine cup were the stool softeners that they told LPN #2 would be taken later, but then they decided not to take the medication. Resident #27 stated that when they agreed to take the medication later, LPN #2 left the medicine cup with the three pills for them to self-administer later. During an interview and observation on 03/24/2025 at 12:47 PM, LPN #2 entered the room of Resident #27. The surveyor asked LPN #2 if he left the medication in the medicine cup on Resident #27's over bed table for the resident. LPN #2 stated that he left docusate sodium and senna in the medicine cup that morning (03/24/2025) at about 9:30 AM because Resident #27 declined to take the medication when he offered it. He further stated that the resident agreed to self-administer the medication after breakfast, so he left the medication for the resident to self-administer because Resident #27 was alert and oriented, and he trusted the resident to do so. LPN #2 stated he was trained to keep the medication if the resident did not take the medication when offered and to offer the medication again when the resident was ready to take it. LPN #2 further stated that Resident #27 promised to take the medication after breakfast. He stated that he believed the resident, so he left the medication for the resident to take. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 03/25/2025 at 2:58 PM. The DON stated that Resident #27 had told the nurse in the past which medication they wanted to take at the time of medication administration. The DON stated if a resident requested to take medication later, she expected the nurse to come back and offer it later. The DON stated that the nurse should not leave medication for the resident to take later, but that the medication that was declined should be taken back by the nurse, offered later in the same shift, and endorsed to the next nurse to administer if the medication was not taken by the resident during the shift. The DON stated that the nurse should be present for administration of medications if the resident did not have an assessment that allowed the resident to self-administer medications but should not be left at bedside unless there was a physician's order to do so. The DON reviewed Resident #27's medical record during the interview and confirmed there was no physician's order for the resident to keep medication at the bedside. The Administrator was interviewed on 03/26/2025 at 9:30 AM. The Administrator stated that the nurse should not give the resident medication if the resident refused but should go back again and offer the medication again. He further stated that if the resident still did not take the medication, the nurse should find a nurse who had a better rapport with the resident to see if the resident would take the medication from that nurse. He stated that if the resident still refused the medication, the nurse should record that the resident refused the medication. The Administrator stated the medication should not be left at the bedside for them to take themselves. The Administrator stated that should only occur for the resident who was assessed for self-administration. The Administrator stated that for Resident #27, the nurse should not have left the medication for the resident, who was not assessed for self-administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 52224 Based on observation, interview, facility document review, and facility policy review, the facility failed to accurately record the discard date on the label for a potentially hazardous food (thawed chicken breast) stored in 1 of 3 refrigerators and failed to conduct temperature monitoring prior to placing a potentially hazardous cold food (chocolate mousse) on residents' meal trays that was identified prior to the tray line service with a temperature of 47.3 degrees Fahrenheit. This failure had the potential to affect 88 of 88 residents who received meals from the facility's kitchen. Findings included: An undated facility policy titled, Food Preparation and Service, indicated, Food and nutrition services employees prepare, distribute and serve food in a manner that complies with safe food handling practices. The policy revealed the section titled, Policy Interpretation and Implementation included 2. 'Potentially Hazardous Food' (PHF) or 'Time/Temperature Control for Safety (TCS) Food' means food that requires time/temperature control for safety to limit the growth of pathogens (i.e. [id est, that is], bacterial or viral organisms capable of causing a disease or toxin formation). Examples of PHF/TCS foods include ground beef, poultry, chicken, seafood (fish or shellfish), cut melon, unpasteurized eggs, milk, yogurt and cottage cheese. The policy revealed the section titled, Food Distribution and Service included 1. Proper hot and cold temperatures are maintained during food distribution and service. An undated facility policy titled, Food Receiving and Storage, indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. The policy revealed the section titled Policy Interpretation and Implementation included 1. 'Critical Control Point [CCP]' means a specific point, procedure, or step in food preparation and serving process at which control can be exercised to reduce, eliminate, or prevent the possibility of a food safety hazard. Some operational steps that are critical to control in facilities to prevent or eliminate food safety hazards are thawing, cooking, cooling, holding, reheating of foods, and employee hygienic practices. The policy revealed the section titled Refrigerated, Frozen Storage included 1. All foods stored in the refrigerator or freezer are covered, labeled and dated ('use by' date). 2. PHF/TCS foods are stored at or below 41 F [degrees Fahrenheit], unless otherwise specified by law. Further review revealed 7. Refrigerated foods are labeled, dated and monitored so they are used by their 'use by' date, frozen or discarded. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. During an observation on 03/24/2025 at 8:56 AM, the walk-in refrigerator revealed two plastic bus tubs were stored on the bottom shelf of the walk-in refrigerator. The plastic bus tubs contained multiple bags of thawed chicken breasts. Each of the two plastic bus tubs contained a printed label that recorded frozen chicken, opened 03/20/2025 at 1:55 PM, and discard Saturday, 04/19/2025 at 1:55 PM. During a concurrent interview, the Director of Food Service (DFS) stated that the facility used an automatic labeling system. The DFS stated that the printed labels were incorrect and should have a label that recorded the chicken thawing and not frozen chicken. The DFS stated the opened date of 03/20/2025 was correct, but the employee should have chosen the words chicken thawing from the menu on the label machine when he printed the label and not the words frozen chicken, so that the label had the correct use-by date. The DFS stated that the thawing chicken should have a use-by date of four days after opening and not 30 days as indicated on the label. She stated that when using the label system, staff should select the correct item they are putting in cold storage, and the label system automatically recorded the opened date and discard date for the item selected. She stated that the day of the week recorded on the label was the day of the week the food item should be discarded. During an interview on 03/25/2025 at 11:32 AM, [NAME] #5 stated that he removed the frozen chicken breasts from the freezer (on 03/20/2025), but that he chose the wrong item in the label machine. [NAME] #5 stated that he chose frozen chicken instead of chicken thawing, which printed a discard date 30 days out, which was the wrong discard date. During an interview on 03/25/2025 at 12:04 PM with the DFS, Dietary Supervisor (DS) #3, and DS #6, the DFS stated the supervisors should have gone behind the cooks during their rounds to ensure the labels were correct. DS #3 and DS #6 both stated that they missed seeing the incorrect label for a couple of days that was placed on the two plastic bus tubs that contained thawed chicken breasts. DS #3 and DS #6 both stated that this incorrect label should have been checked, and the error should have been caught during their kitchen rounds. During an interview on 03/25/2025 at 4:11 PM, the Director of Nursing (DON) stated it was her expectation that dietary staff followed policies for labeling and dating foods. The DON stated that due to the potential risk of salmonella, chicken should not be left in refrigeration for four days with the wrong label and discard date on the label. The DON stated that she expected the label on chicken to have an accurate date to discard and that she expected the supervisor there in the kitchen to monitor labels for accurate discard dates and catch these errors. During an interview on 03/26/2025 at 9:11 AM, the Administrator stated he expected the food provided to the residents to be provided according to the guidelines per the state. He stated that anything staff opened and put in the refrigerator should be labeled and dated, with daily monitoring, and if the date recorded was more than the threshold date, the food item should be removed from the refrigerator and tossed and should not be used. The Administrator stated that the dietary staff used a labeling sticker to record the open and discard dates. He stated that when dietary staff put chicken in the freezer, staff should use the frozen label for the freezer, and when the chicken was removed from the freezer to thaw, staff should change the label to a label for thawing chicken. The Administrator stated that he expected the DFS and supervisors to monitor and provide supervision. 2. A facility recipe titled, Chocolate Mousse, with a print date of 05/14/2024, revealed the ingredients for the recipe included chocolate mousse mix and 2% milk. The recipe revealed the section titled Directions included CCP: Chill and hold under refrigeration (41 F), until ready to serve. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation of temperature monitoring for the lunch meal tray line completed by Dietary Supervisor (DS) #3 on 03/25/2025 at 11:00 AM, the observation revealed a cart that contained four plastic bus tubs with multiple bowls of chocolate mousse covered with ice. DS #3 completed temperature monitoring of the chocolate mousse, which revealed a temperature of 47.3 F. DS #3 was observed instructing staff to put the bowls of chocolate mousse in the freezer, and the four plastic bus tubs of chocolate mousse were placed in the freezer by staff. During an interview on 03/25/2025 at 11:09 AM, Dietary Aide (DA) #4 stated he prepared the chocolate mousse around 8:00 AM to 8:30 AM on 03/24/2025 and put the chocolate mousse in the refrigerator. He stated that on 03/25/2025 around 9:00 AM to 9:30 AM, he put the chocolate mousse in bowls for the lunch meal service and placed the bowls of chocolate mousse in the refrigerator. An observation of the lunch meal service tray line on 03/25/2025 at 11:15 AM revealed a cart that contained two plastic bus tubs with multiple bowls of chocolate mousse covered with ice. DA #4 placed bowls of chocolate mousse on resident meal trays for the lunch meal service. During an observation on 03/25/2025 at 11:16 AM, the surveyor requested temperatures of the bowls of chocolate mousse that DA #4 had placed on resident meal trays for the lunch meal service. Temperature monitoring completed by the DFS of bowls of chocolate mousse placed on resident meal trays for the lunch meal service revealed temperatures of 49.1 F, 43 F, and 48 F. During a concurrent interview, the DFS stated that the temperature of the chocolate mousse was still too high and that the chocolate mousse needed to cool down. During an interview on 03/25/2025 at 11:24 AM, DA #4 stated he was trained to serve cold foods at 41 F or below. DA #4 stated that he should have waited for the chocolate mousse to cool down, but that he thought the chocolate mousse was in the freezer long enough to cool down. DA #4 stated that he did not ask a supervisor to obtain a temperature of the chocolate mousse before he placed the bowls of chocolate mousse on resident meal trays for service. During an interview on 03/25/2025 at 11:25 AM, DS #3 stated that the chocolate mousse should be served at a temperature of 41 F or below. DS #3 stated that when she completed temperature monitoring of the chocolate mousse before the lunch meal service, the temperature was too high, so she instructed staff to put more ice on the bowls of chocolate mousse and return the plastic bus tubs of chocolate mousse to the freezer. She stated that staff should have waited for her to recheck the temperature of the chocolate mousse before it was served. DS #3 stated that the temperature of the chocolate mousse placed on resident meals trays by DA #4 was still too hot to serve to residents. During an interview on 03/25/2025 at 12:08 PM, the DFS stated staff were trained to leave four plastic bus tubs of chocolate mousse on the tray line at one time but going forward she would instruct staff to have less chocolate mousse on the tray line at one time. She stated that staff were trained to keep cold foods at 40 F or below to be stricter than the regulations required. (continued on next page)

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	03/26/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/25/2025 at 4:11 PM, the Director of Nursing (DON) stated that it was her expectation that dietary staff followed policies for serving foods at the correct temperatures. The DON stated that staff should have checked the temperature of the chocolate mousse before it was served, since staff identified that the temperature of the chocolate mousse taken before the lunch meal service was too high. She stated that staff should ensure the chocolate mousse was served at the correct temperature. The DON stated that because milk was one of the ingredients in the chocolate mousse, there was a potential risk to the resident for a stomachache from a possible food borne illness. During an interview on 03/26/2025 at 9:11 AM, The Administrator stated he expected the food provided to the residents to be provided according to the guidelines per the state. He stated when the staff provided food to residents, staff should take the temperature of the food and make sure the temperature met the threshold. The Administrator stated that if staff found that food was not at the correct temperature, staff should fix it and correct the issue to get it right. He stated that staff should not serve food to residents that was not at the correct temperature. He stated he expected the staff to correct the problem and not serve potentially hazardous cold foods that were not cold enough. The Administrator stated that he expected the DFS and supervisors to monitor and provide supervision.

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	03/26/2025

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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 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. 52224 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff did not document the administration of medications after the resident refused to take them for 1 (Resident #27) of 1 resident reviewed for refusal of medications. Findings included: A facility policy titled, Administering Medications, revised 12/2012, indicated, 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. An Admission Record indicated the facility admitted Resident #27 on 02/24/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of dependence on renal dialysis. An admission Minimum Data Set (MDS), with an Assessment Reference Date of 03/02/2025, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #27's Order Summary Report contained an active order, dated 02/24/2025, for docusate sodium (a stool softener) 250 milligrams (mg) by mouth daily for bowel regularity with instructions to hold for loose stools. The Order Summary Report also contained an active order, dated 02/24/2025, for Senna oral tablet (a laxative) 8.6 mg, 2 tablets by mouth two times daily for constipation with instructions to hold for loose stools. During a concurrent observation and interview on 03/24/2025 at 12:26 PM, a medication cup containing one red pill and two brown pills was observed on Resident #27's over-the-bed table. Resident #27 stated Licensed Practical Nurse (LPN) #2 brought them their stool softener (and laxative) after the resident returned from dialysis, but the resident did not want to take them at that time. The resident stated they sometimes did not take those medications, and the nurse would either leave the medications with them to take later or take the medications back out of the resident's room. Resident #27's 03/2025 Medication Administration Record (MAR) revealed the resident's docusate sodium and Senna were scheduled to be administered at 9:00 AM each day, and LPN #2 documented the medications were administered on 03/24/2025, as opposed to refused. During a concurrent observation and interview with LPN #2 on 03/24/2025 at 12:47 PM, LPN #2 observed the medication cup on Resident #27's over-the-bed table and confirmed he left the medications with the resident around 9:30 AM that morning and had not administered them at that time per the resident's request. LPN #2 stated he signed off on the resident's MAR to indicate he administered the medications because he trusted the resident would take them at a later time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/25/2025 at 2:58 PM, the Director of Nursing (DON) stated that if Resident #27 requested to take medications at a later time, she expected the nurse to go back and offer the medications at a later time. The DON stated that the resident's MAR should reflect the resident refused the medications when the nurse offered to administer them. The DON stated that a MAR should not reflect the administration of medications if the medications were not administered. During an interview on 03/26/2025 at 9:30 AM, the Administrator stated that if a resident refused medication, the nurse should document the medication was refused. The Administrator stated that for Resident #27, since the resident did not take the medications, the nurse should not have documented the medications were administered.