

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/22/2024
NAME OF PROVIDER OR SUPPLIER Golden Pavilion Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 99 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)
<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26875</p> <p>Based on interview and record review, the facility failed to retain personal possessions of Resident 1, one of two sampled residents, when after return from hospitalization Resident 1's two head phones, one Blue Tooth speaker/microphone and two full Lysol disinfectant spray cans were missing from his closet.</p> <p>This failure resulted in depression, disappointment, and mental anguish to the resident.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE], initial admission on 12/24/2022, with diagnoses including osteomyelitis of vertebra, sacral region (bone infection of spine), pressure ulcer of sacral region (wound on lower back area), diabetes mellitus, heart failure, chronic pain syndrome, functional quadriplegia (complete immobility of limbs), and history of pulmonary embolism (blocked artery in lungs). Review of resident's MDS (Minimum Data Set) an assessment tool, indicated Resident 1 had good cognition (thinking ability), had clear speech and good hearing, required assistance to roll side to side, unable to sit, stand, or walk. Required staff sponge bath twice a week for hygiene.</p> <p>During an interview on 8/22/2024, at 4:20 PM, Resident 1 stated his personal property, two pairs of head phones, a Blue Tooth speaker/microphone and two spray cans of Lysol disinfectant went missing from his closet while he was at hospital. He appeared depressed and disappointed over the loss of his property.</p> <p>During an interview on 8/22/2024, at 4:50 PM, Social Services staff member, with Assistant Director of Nurses present (ADON), stated he would look for the missing personal property of Resident 1 and made note of the missing personal possessions.</p> <p>During a telephone interview on 8/26/2024 at 10:45 AM, Ombudsman stated she was aware of the missing personal possessions belonging to Resident 1 and would be following up on the outcome.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26875</p> <p>Based on interview and record review, the facility failed to protect the resident's right to be free from neglect when Resident 1, one of two sampled residents, was deprived of care and did not receive a sponge bath for one month.</p> <p>This failure resulted in discomfort, humiliation, and embarrassment to the resident.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE], initial admission on 12/24/2022, with diagnoses including osteomyelitis of vertebra, sacral region (bone infection of spine), stage 4 pressure ulcer of sacral region (wound on lower back area), diabetes mellitus, heart failure, chronic pain syndrome, functional quadriplegia (complete immobility of limbs), and history of pulmonary embolism (blocked artery in lungs). Review of resident's MDS (Minimum Data Set) an assessment tool, indicated Resident 1 had good cognition function (thinking ability), had clear speech and good hearing, required staff assistance to roll side to side, was unable to sit, stand, or walk. Required staff assistance for sponge bath twice a week for good hygiene.</p> <p>During an interview on 8/22/2024. 2:45 PM, Assistant Director of Nurses (ADON) was asked for policy on bathing residents and was informed that Resident had not been bathed for a month.</p> <p>During an interview on 8/22/2024, at 4:20 PM, Resident 1 stated on July 23, 2024, he had been asking for a sponge bath for a month and reported it to California Department of Public Health. Staff would reply to the resident they ran out of time or the next shift would do it. The next shift would say the previous shift (day shift) would do it. Resident asked staff many times to give him a sponge bath. He stated he felt dirty, grimy, slimy and embarrassed. He stated he did not get a sponge bath until he was hospitalized after the 7th of August.</p> <p>The facility deprived Resident 1 of physical care when they would not bathe him. His pressure ulcer had worsened upon admission to hospital and he became septic.</p> <p>Review of the facility policy on Bed Bath, revised March, 2021, indicated, Purpose: The purpose of this procedure are to promote cleanliness, provide comfort and to observe the condition of the residents skin.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26875</p> <p>Based on interview and record review, the facility failed to provide prn medication (as needed) on time to Resident 1, one of two sampled residents, when the resident waited for pain relief caused by pressure ulcer (wound infection in lower back) and bone infection.</p> <p>This failure caused the resident unnecessary pain, discomfort, and anxiety.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility on [DATE], initial admission on 12/24/2022, with diagnoses including osteomyelitis of vertebra, sacral region (bone infection of spine), pressure ulcer of sacral region (wound on lower back area), diabetes mellitus, heart failure, chronic pain syndrome, functional quadriplegia (complete immobility of limbs), and history of pulmonary embolism (blocked artery in lungs). Review of resident's MDS (Minimum Data Set) an assessment tool, indicated Resident 1 had good cognition function (thinking ability), had clear speech and good hearing, required assistance to roll side to side, unable to sit, stand, or walk. Required staff assistance for sponge bath twice a week for good hygiene.</p> <p>During an interview on 8/22/2024 at 4:20 PM, Resident 1 stated on 7/15/2024 at 5:44 PM, he waited 1-2 hours for his PRN pain medication. He stated he put his call light on and no one came. Later someone disconnected his call light and his call light was no longer usable. He tried to report it to a nurse manager and was told she was in a meeting. He reported it to the Ombudsman and the California Department of Public Health. He stated he was in great pain and discomfort and needed his pain medication.</p> <p>During an interview on 8/26/2024 at 2:45 PM, Assistant Director of Nurses (ADON) stated staff are told they are not to disconnect residents call light and are expected to provide care to the resident when they request it.</p>		