

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 06/05/2025
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of 3 sampled residents (Resident 1) when a scheduled fentanyl patch (a medicated adhesive patch that delivers fentanyl, a strong opioid painkiller, through the skin) was not applied to Resident 1 on 5/30/25 at 9 AM on time.</p> <p>This failure was likely to result in putting Resident 1 at risk for not meeting her pain control need.</p> <p>Findings:</p> <p>Review of Resident 1's clinical record indicated, Resident 1 was admitted to the facility with diagnoses including complex regional pain syndrome (CRPS, a chronic pain condition that causes intense pain, usually in the limbs, often following an injury, surgery, or stroke), functional quadriplegia (a state of complete immobility due to severe physical disability or frailty, without any underlying injury or damage to the brain or spinal cord), and generalized muscle weakness.</p> <p>Review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/30/24 indicated, Resident 1 was cognitively intact. Then her MDS dated [DATE] indicated, Resident 1 was cognitively moderately impaired.</p> <p>During a concurrent observation and interview on 6/5/25 at 10:57 AM, Resident 1 had a fentanyl patch which was dated as 6/5/25 on her left upper chest. Resident 1 stated, she was on pain medications because she had constant pain throughout her body due to CRPS. Resident 1 stated, her nurse forgot to apply her fentanyl patch for several hours on 5/30/25. Resident 1 stated, she did not have the fentanyl patch on time at 9 AM on 5/30/25, but received it in the afternoon on the same day. Resident 1 stated, she was concerned that if she did not take her medications on time, her pain might not be managed well.</p> <p>Review of Resident 1's Order Summary dated 4/12/25 indicated, fentaNYL Transdermal (through the skin) Patch 72 Hour (HR) 75 MCG (a unit of measurement used in medicine to express very small quantities of substances. It is one millionth of a gram)/HR (Fentanyl) . Apply 1 patch . every 72 hours for pain .</p> <p>(continued on next page)</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Concurrent interview and record review on 6/5/25 at 1:05 PM with Licensed Vocational Nurse (LVN) 1, Resident 1's medication administration detail, titled, fentaNYL Transdermal Patch 72 Hour 75 MCG/HR (Fentanyl) undated was reviewed. Resident 1's medication administration detail indicated, . Administration History Scheduled For 0900 (9 AM) Effective Date 5/30/2025 . Code 9 ., entered by Registered Nurse (RN) 1. It further indicated, . Chart Codes: . 9-Other / See Progress Notes . LVN 1 stated, Code 9 meant the scheduled 9 AM dose of fentanyl transdermal patch was not given on time to Resident 1.</p> <p>Review of Resident 1's MEDICATION ADMINISTRATION RECORD (MAR) dated from 5/1/25 to 5/31/25 indicated, Resident 1 did not receive the fentanyl patch at 9 AM on 5/30/25. The MAR indicated, Resident 1 received her fentanyl patch at 6:18 PM on 5/30/25.</p> <p>Review of Resident 1's Nursing Progress Note dated 5/30/25 at 10:45 AM indicated, No C/O (complaint of) bladder pain .</p> <p>Review of Resident 1's MEDICATION ADMINISTRATION RECORD (MAR) dated from 5/1/25 to 5/31/25 indicated, Resident 1's pain scale was 0 (from 0 to 10 scale) in the day, evening, and night shifts on 5/30/25.</p> <p>Review of Resident 1's Nursing Progress Note dated 5/30/25 at 6:20 PM indicated, Patient did not receive her scheduled fentanyl patch this morning due to delayed delivery. MD (Doctor of Medicine) was notified and an order for one time fentanyl patch was obtained to maintain pain management. patch applied .</p> <p>During a concurrent interview and record review on 6/5/25 at 2:18 PM with Registered Nurse (RN) 1, Resident 1's medication administration detail titled, fentaNYL Transdermal Patch 72 Hour 75 MCG/HR (Fentanyl) undated was reviewed. RN 1 acknowledged, she did not apply the scheduled 9 AM dose of fentanyl patch on time on 5/30/25 to Resident 1. RN 1 stated, On May 29th at 7 AM Night nurse endorsed to me that despite ordering the patches 5 days earlier, they had still not arrived. She (Night shift nurse) informed me that she would call the pharmacy and check on the patches. On May 30th at 7 AM, the patch still had not arrived from pharmacy. Supervisor was immediately notified . I worked 7 AM to 3:30 PM and the patch did not arrive. RN 1 further stated, Resident 1 received the fentanyl patch on the same day after she left. RN 1 stated, There is a pharmacy refill sheet. You place the stickers from the prescription onto the sheet and fax the sheet to the pharmacy. You do this 5-7 days before the medication runs out, when asked about the facility's medication refill policy and procedure.</p> <p>During a concurrent interview and record review on 6/5/25 at 2:39 PM with Assistant Director of Nursing (ADON), the facility's document titled, REFILL REQUEST ONLY undated was reviewed. The document indicated, . Best Practice: . Fax refill request 3-5 days prior to supply depletion . ADON stated, this document is for the standard practice in the facility when they refill medications, and they fax the request 3-5 days before the medications run out. ADON stated, the facility did not have a policy and procedure regarding medication refill except REFILL REQUEST ONLY.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/5/25 at 3:45 PM with ADON, Resident 1's document titled, LTCF (Long Term Care Facility) Patient dated 5/30/25 was reviewed. The document indicated, the fentanyl transdermal patch prescription was signed on 5/30/25. ADON stated, the facility's pharmacy was waiting for the doctor's signature for the form before delivering the fentanyl patch in the afternoon on 5/30/25. ADON stated, there was no evidence except this form that they requested the refill of the fentanyl patch for the scheduled dose of 9 AM on 5/30/25. ADON stated, there was no nursing documentation that they ordered refill or tried to receive the doctor's signature for the scheduled 9 AM dose of fentanyl patch before 5/30/25 when asked about evidence of requesting refill to the pharmacy. ADON acknowledged, the resident did not receive the patch on time at 9 AM on 5/30/25.</p> <p>During a concurrent interview and record review on 6/5/25 at 4:30 PM with ADON, the facility's policy and procedure (P&P) titled, PREPARATION AND GENERAL GUIDELINES dated October 2017 was reviewed. The P&P indicated, . MEDICATION ADMINISTRATION-GENERAL GUIDELINES . B. Administration . 2) Medications are administered in accordance with written orders of the attending physician . ADON acknowledged, they did not apply the scheduled 9 AM dose of fentanyl transdermal patch on time on 5/30/25 per the doctor's order. ADON stated, It can lead the patient to have a pain, when asked about the risk of not having the fentanyl patch on time.</p> <p>Review of the facility's P&P titled, Pain Management dated January 2025 indicated, . It is the policy of this center that residents receive care to attain and maintain the highest quality of care and life .</p>		