STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056394	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Pavilion Healthcare	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record reviews, the facility failed to provide an environment free from accident hazards for Resident 1, one of three sampled residents, when Resident 1 eloped from facility, twice, in the middle of the night, in her nightgown, exposing resident to risk of accidents, injury, or harm. The facility failed to supervise, protect, and monitor residents in their care. Findings: Resident 1 was admitted to facility on 3/31/2025 following hospitalization for Traumatic Brain Injury after assault. Resident's MDS (Minimum Data Set) an assessment tool, indicated resident did not speak or understand English, had unclear speech, was confused, had memory problems, and impaired cognition (thinking ability). Resident had lower leg impairment. During an interview on 5/5/2025 at 1:15 PM, LVN 1 (Licensed Vocational Nurse) stated when asked about checking functionality (working order) of Wanderguard alarm, I've never done that before. No body has shown me. I wasn't oriented. That night was the first time I took care of (resident) . Review of Inservice Compliance Training Record dated April 22, 2025 showed a printed signature of LVN 1's name in attendance at inservice given via phone. On April 22, 2025, the resident had already been discharged to home the day before the inservice. During a telephone interview on 6/19/2025 at 2:30 PM, a family member stated (resident) did not understand any English and spoke Cantonese only. Family member stated since (Resident 1's) brain injury, on 2/25/2025, she has been confused and not always understandable in Cantonese. He stated (Resident 1) eloped, the first time on 4/10/2025, on the night shift, wearing only the facility nightgown, and no sweater or jacket. The second time (Resident 1) eloped was on 4/21/2025, on the night shift, wearing only a facility nightgown, again no sweater or jacket. Police were notified. She was found on the shopping mall underpass, and was confused. She was taken to Chinese Hospital, family came and resident was discharged to home. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 6/24/2025 at 10:25 AM, the Assistant Director of Nurses (ADON) stated residents first elopement was 4/10/2025. A Certified Nurse Assistant (CNA) reported Resident 1 missing at 4 AM, wearing a blue nightgown. Police were called. Police found resident at 5:50 AM in an apartment building across the street from the facility. Patient was confused. Wanderguard alarm order was obtained from physician and alarm applied to residents wrist. Resident was non-compliant and attempted to remove alarm from wrist. On second elopement, 4/21/2025, with resident wearing only a nightgown and Wanderguard alarm on ankle, resident was found at 4:30 AM, on the street, near shopping mall underpass. Staff had not checked for alarm functionality. Resident was taken to Chinese Hospital for further evaluation. Resident was discharged to home with family. ADON could not explain how resident walked by receptionist and out the front door without being seen or hearing door alarm. The ADON stated the receptionist goes home at 8 PM and Supervisor sits at the receptionist desk, when she has time, during night shift. Review of facility policy on Elopement/Wandering, updated on May, 2024, policy statement indicated, The center evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process. Procedure: 1. At admission, the licensed nurse (LN) completes the Nursing admission Evaluation to determine the resident's risk for wandering/elopement. 2. If the data indicate further evaluation, the licensed nurse completes the Elopement /Exit-seeking Evaluation. 3. The LN gathers as much information as possible at the time of admission from the family, significant other or responsible party regarding previous elopement attempts or desire to leave the premises. 4. Based on the results of the Elopement/Exit-seeking Evaluation, care plan interventions to manage wandering and/or exit-seeking behaviors are initiated/implemented. The care plan addresses the resident's wandering behavior, potential to exit Center and/or actual episodes of elopement and the measures taken to manage those behaviors. 5. Resident's deemed at risk to elope, . or have cognitive deficit indicating poor safety awareness: .If staff are unable to keep the resident in line of sight, the resident is accompanied by a staff member assuring resident safety. 6 The care plan is reviewed and updated as appropriate. 7. The Elopement Risk Book is utilized to make staff aware of residents who are at risk of elopement. 8. A color picture is taken of resident on admission and photos are reviewed and updated at least quarterly. Place the picture on the Elopement Risk Identification Form in the Elopement Risk Book. An Elopement Risk Book is kept at each nursing station .If monitoring systems are used: .c. The LN also obtains an order to complete an evaluation for placement and function every shift . 2. The maintenance department or designee tests the monitoring system (at alarmed exits) on a daily basis using the manufacturer supplied device (as applicable) and documents the test. 3. In the event the monitoring system fails, the Center has the system evaluated for repair as soon as possible .