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	06/09/2026

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 - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe environment free from potentially serious accident hazards for all residents when its policies and procedures were not implemented for the following practices: 1. The facility failed to implement their smoking policy and procedures (P&P) when it allowed one (1) of 11 residents (Resident 88) who smoked in the facility to keep in possession of their own lighters and cigarettes inside the resident care area. 2a. The facility failed to provide adequate supervision to prevent accidents when Resident 225 was left unsupervised while smoking, and was later found at a nearby facility. This deficient practice placed the resident at risk for injury and unsafe wandering/elopement.2b. The facility failed to provide adequate supervision to Resident 225 when he eloped from the facility and was not located for 19 hours. These failures had potential for Residents 88 and 225 to experience significant harm and/or death. 1. During a review of Resident 88's admission Record, dated 6/3/26, the admission Record indicated admitted on [DATE] with diagnoses including, Fracture of left Femur(a break in the thigh bone), Chronic Obstructive Pulmonary Disease(COPD) (a long term lung condition that makes it hard to breathe due to lack of oxygen exchange in the lungs). During an observation on 6/1/26 at 10 AM, resident 88's room, there were two cigarette lighters and a small red bottle with fluid and other mini collectibles cars, a mug and umbrella on the windowsill. Resident 88 was not in the room. During an interview on 6/2/26 at 11 AM with Registered Nurse Supervisor (RNS2), RNS 2 stated, Resident 88 is an independent smoker, he is ambulatory and goes out to the smoking area. Showed RNS 2 the lighters and bottle on the windowsill, RNS2 stated, resident is not supposed to have his smoking materials with him. During an observation and interview on 6/2/26 at 11:30 AM in Resident 88's room. Resident 88 sitting in bed, greeted and introduced myself. Asked him where his collections are, since it is not on the windowsill anymore. Resident opened his bedside drawer and showed me all of his lighters and small cars. Confirmed the red bottle is a vape. Resident stated, he vapes, and he has collections of these vapes, you want to see it?. During a review of Smoking Safety Evaluation, dated 4/29/26, indicated IDT Decision : Resident BIMS is 14. Can smoke independently. Resident educated on always keeping items in safe and locked location. During a review of Resident 88s Care Plan Report, dated 6/2/26, the Care Plan Report indicated, Resident Independent with smoking. Resident was vaping in his room on 6/2/26. Interventions: The (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident can smoke unsupervised. The resident's smoking supplies are stored in the Smoking supply cabinet. During a review of facility's Resident Smoking Safety Independent and Unsupervised Policy, dated 11/2005, the Policy indicated, 1. a. Resident who are safe to smoke independently must store their materials in a locked box in their room or a lockable mailbox container outside. 2a. Review of Resident 225's admission record indicated, was admitted to the facility on [DATE] with diagnoses including multiple fractures of left ribs; contusion of lung (a bruise to the lung tissue caused by blunt or penetrating trauma, which causes blood and fluid to leak into the lungs); stroke; cognitive communication deficit (difficulty with communication skills due to an underlying disruption in thinking processes, such as memory, attention, or executive function); abnormalities in gait and mobility (irregular, unsteady, or inefficient walking patterns and difficulties moving around freely); other psychoactive substance dependence (a clinical diagnosis for a moderate or severe substance use disorder). Review of Resident 225's MDS assessment dated [DATE], indicated Resident 225 has severe cognitive impairment. Section GG of the MDS indicated, Resident 225 has impairment on one side of the upper extremity (shoulder, elbow, wrist, hand); required set up or clean up assistance with eating; partial/moderate assistance with oral hygiene, personal hygiene, and mobility; substantial/maximal assistance with toileting, bathing, and dressing; and dependent on propelling a manual wheelchair. During a concurrent interview and record review on 6/9/26 at 12:15 PM with Registered Nurse Supervisor (RNS) 2, Resident 225's change in condition (CIC) progress note was reviewed. The CIC indicated that on 1/30/26, staff from [Name of facility] called to inform the facility that Resident 225 was in their building and appeared confused. RNS 2 stated that Resident 225 had gone outside to smoke and became lost attempting to return to the facility. Review of Resident 225's Elopement Risk Evaluation dated 1/23/26 indicated the resident was documented as having no cognitive impairment, being able to walk independently with an assistive device, able to self^propel, and not an elopement risk. Review of Resident 225's admission Nursing Evaluation dated 1/23/26 indicated Resident 225 was not a smoker. Review of the Smoking Safety Evaluation dated 1/26/26 indicated the resident was safe to smoke with supervision. During a concurrent interview and record review on 6/9/26 at 12:20 PM with RNS 2, Resident 225's smoking care plan was reviewed. The care plan, initiated 1/31/26, indicated The resident is a supervised smoker. RNS 2 stated that Resident 225 required supervision when smoking as indicated in the Smoking Safety Evaluation completed on 1/26/26. RNS 2 further stated that the smoking care plan should have been initiated immediately after the Smoking Safety Evaluation was completed. Review of the facility's policy and procedures titled, Resident Smoking Safety Independent and Unsupervised, updated January 2025, indicated, .Residents who wish to smoke are evaluated for their ability to smoke safely. An established set of criteria is used to evaluate safety risks. Residents who (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	do not meet the established criteria to smoke independently are aided/supervised during smoking activities . Review of the facility's policy and procedures titled, Elopement/Wandering, updated February 2025, indicated, .1. A resident is found in the parking lot of the Center by a staff or visitor without staff knowledge or presence. This is elopement . Procedure: .2. Residents with a diagnosed substance use disorder (SUD) or that have a history of substance use are counseled on the risks of leaving the premises without adequate supervision or assistance and the risks of drug use without medical supervision and counseled on the center leave process. 2b. During a record review of Discharge Summary, dated 1/23/26, the discharge summary indicated, Resident 225's chronic problems included .Polysubstance Use Disorder/ Methadone- Utox (urine toxicology test; a laboratory test that detects the presence of specific legal drugs, illicit substances in a person's urine) positive for cocaine, fentanyl, methadone. During a review of Resident 225's admission Record (document containing a resident's essential demographic, medical, and personal information), (undated), the admission Record indicated, Resident 225 was initially admitted to the facility on [DATE] and re-admitted with multiple diagnosis with an onset of 3/18/6 including, but not limited to: Adjustment Disorder with Depressed mood, Cognitive Communication Deficit, Other Psychoactive Substance Dependence, uncomplicated. A review of Resident 225's Minimum Data Set (MDS: a standardized resident assessment tool), dated 1/26/26, the Minimum Data Set indicated, a Brief Interview of Mental Status assessment (BIMS, a brief memory test to help determine memory, thinking, learning, and decision making ability: a score of 15-13 = intact memory/reasoning; a score of 12-8 = moderate impairment in memory/reasoning; a score of 7-0= severe impairment in memory/reasoning) was completed. Resident 225 scored 3 out of 15, this indicated Resident 225 had severe impairment in memory/reasoning. During an interview on 6/8/26 at 1:29 PM with Director of Social Services (DSS), when asked what was the facility protocol for residents admitted with a history of Substance Use Disorder (SUD; recurrent use of alcohol or drugs, causing clinically significant impairment), the DSS stated the resident is placed on behavior monitoring and the facility develops and implements a personalized comprehensive care plan regarding the substance use history are triggers. If a resident is demonstrating behaviors that may be related and/or caused by SUD the Social Services department will add a care plan (such as Impaired Psychosocial Wellbeing). The DSS stated there are no current care plans identifying risks or potential behaviors for residents with a history of SUD. The DSS later added, she was not currently aware of any referrals to mental health services/evaluations in place for residents within the facility with hx of SUD. During a review of Elopement Risk Evaluation- V 2 dated 1/30/26, the elopement evaluation indicated, Resident 225 had a history of wandering which placed him in significant risk of getting to an unsafe situation, had a substance use disorder, had wandered in the past month, and was an elopement risk. During a concurrent interview and record review on 6/8/26 at 1:35 PM with the Assistant Director of Nursing (ADON 2), Resident 225's Progress Notes dated 3/14/26 was reviewed. The progress note indicated, Resident 225 was .last seen around 1300 (1pm).Resident was not seen in the tv room and supervisor was notified resident has (not) been seen since 1300. ADON 2 stated resident 225 was last seen in the facility on 3/14/26 at 1pm and was not located until 3/15/26 at 8:37 AM. ADON 2 added, the resident was wearing a wander [NAME] (monitoring device), although no documentation was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted of device alarming staff when Resident 225 exited the facility. During a concurrent interview and record on 6/8/26 at 1:42 PM with ADON 2, Resident 225's Progress Notes dated 3/15/26, was reviewed. The progress note indicated, Resident 225 was in a local hospital emergency room for evaluation and was brought to the emergency room on 3/14/26 at 11:54 PM. ADON 2 stated, prior to the incident Resident 225 was monitored with frequent visual checks. When asked how frequent the visual checks were completed for Resident 225, ADON 2 stated It's just when we do our rounds referring to the certified nursing assistant and Licensed Nurse staff. ADON 2 was unable to provide documentation for referenced visual checks. During a concurrent interview and record on 6/8/26 at 1:51 PM with ADON 2, Resident 225's ED Provider Notes dated 3/16/26, was reviewed. The provider notes indicated, Resident 225 was assessed in the emergency room for Clinical Impressions that included Pneumonia and Rib fracture. ADON 2 stated, no documentation was found in Resident 225's medical record regarding Nurse to Nurse Report or condition of resident upon his arrival to the emergency room following his elopement. During a review of the facility's policy and procedure titled Elopement/Wandering, last revised on 2/2025, the P&P indicated, .Examples of Elopement.5. A resident with a substance use disorder, leaves the premises without signing out or doesn't let staff know they are leaving. This is a (SUD) elopement.