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	04/12/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 39714 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure confidential medical information was kept private for 1 (Resident #185) of 4 sampled residents reviewed for dignity. Specifically, the facility failed to remove visible wristbands that identified medical information about the resident after Resident #185 was readmitted from the hospital. Findings included: A review of a facility policy titled, Resident Rights, revised in February 2021, revealed, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: privacy and confidentiality. The policy further specified, The unauthorized release, access, or disclosure of resident information is prohibited. A review of an Admission Record revealed the facility admitted Resident #185 on 06/19/2023 and most recently readmitted the resident on 04/01/2024 with diagnoses that included abnormalities of gait and mobility and abnormal posture. The Admission Record also reflected the resident had an allergy to latex. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/19/2024, revealed Resident #185 had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderately impaired cognition. According to the MDS, the resident had not sustained any falls since their prior MDS assessment. A review of Resident #185's comprehensive care plan for their admission on 04/01/2024 revealed there was no Focus area addressing fall risk. On 04/08/2024 at 11:25 AM, Resident #185 was observed wearing a yellow wristband with black letters that identified the resident as a fall risk and a green wristband that identified the resident had a latex allergy. During an observation and interview on 04/10/2024 at 2:53 PM, Resident #185 was observed wearing wristbands that identified they were at risk for falls and had a latex allergy. Resident #185 said the wristbands were applied while they were in the hospital. (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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/10/2024 at 3:37 PM, Licensed Vocational Nurse (LVN) #5 said that residents were sometimes admitted to the facility with wristbands in place. LVN #5 stated they were unaware that Resident #185 still had wristbands on and said they should have been removed. During an interview on 04/10/2024 at 3:51 PM, Registered Nurse (RN) #4 stated that sometimes residents were admitted to the facility with wristbands in place, and facility staff had to take them off. RN #4 said the facility only utilized name bands, and fall risk bands came from the hospital. RN #4 said the facility used a blue paper on the wall to identify residents that were at risk for falls. During an interview on 04/12/2024 at 11:08 AM, the Administrator stated the facility made sure resident information was maintained in a confidential manner. The Administrator said she expected the nurse who performed the initial assessment on a resident to remove any wristbands from the resident, if any were present.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 28196 Based on record review, interviews, and facility document and policy review, the facility failed to report an allegation of physical abuse involving 1 (Resident #197) of 4 sampled residents reviewed for abuse to the California Department of Public Health (CDPH) within two hours. Findings included: A review of a facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised in September 2022, revealed, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The policy indicated, 1. If resident abuse, neglect, exploitation, misappropriate of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The policy further indicated, 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury. A review of an Admission Record revealed the facility admitted Resident #197 on 09/20/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and severe dementia with other behavioral disturbance. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/25/2024, revealed Resident #197 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. A review of Resident #197's Care Plan, revealed a Focus area, initiated on 03/21/2024, that indicated the resident hit another resident on the chest. An intervention dated 03/21/2024 indicated the facility initiated a Report of Suspected Dependent Adult/Elder Abuse (form SOC 341). A review of a Report of Suspected Dependent Adult/Elder Abuse (form SOC 341), dated 03/21/2024, revealed that on 03/21/2024 at 8:30 AM, a resident alleged they were suddenly hit on the chest by Resident #197. The report indicated CDPH was notified of the allegation on 03/21/2024 via facsimile. A review of a Transmission Verification Report revealed the facility faxed a copy of the Report of Suspected Dependent Adult/Elder Abuse to CDPH on 03/21/2024 at 1:01 PM, approximately four and a half hours after the allegation was made. During an interview on 04/12/2024 at 11:48 AM, the Administrator stated that her expectation was to report allegations of abuse to CDPH immediately but within two hours. She confirmed the facility had not reported the allegation of physical abuse involving Resident #197 within the required two-hour timeframe. The Administrator stated the allegation should have been reported to CDPH no later than 10:30 AM. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/2024 at 1:53 PM, the Assistant Director of Nursing (ADON) stated the allegation of abuse involving Resident #197 should have been reported to CDPH on 03/21/2024 by 10:30 AM.

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F 0641

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident receives an accurate assessment.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 28196

Based on record review, interviews, and facility policy review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the use of an antipsychotic medication and physical behaviors directed towards others for 1 (Resident #197) of 2 sampled residents reviewed for behaviors and accurately reflected the discharge location for 1 (Resident #237) of 3 sampled residents reviewed for discharges.

Findings included:

A review of a facility policy titled, Certifying Accuracy of the Resident Assessment, revised in November 2019, revealed, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. The policy further indicated, 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. Different items on the MDS may have different observation periods.

1. A review of an Admission Record revealed the facility admitted Resident #197 on 09/20/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and severe dementia with other behavioral disturbance.

A review of Resident #197's Order Summary Report, listing active orders as of 04/11/2024, revealed an order dated 09/20/2023 to monitor every shift for episodes of psychotic behavior and an order dated 11/18/2023 to monitor every shift for behaviors of biting, hitting, and entering other residents' rooms. The Order Summary Report also reflected an order dated 01/26/2024 for quetiapine fumarate (an antipsychotic medication) oral tablet 200 milligrams (mg), give one tablet by mouth in the evening for behavior manifestation of dementia illness manifested by physical aggression.

A review of Resident #197's March 2024 Medication Administration Record (MAR) revealed documentation that indicated the resident received quetiapine fumarate daily as ordered. The MAR also reflected documentation that indicated the resident experienced one episode of psychotic behavior and exhibited a behavior of biting on 03/19/2024, exhibited a behavior of hitting on 03/23/2024, and exhibited behaviors of biting and hitting on 03/24/2024.

A review of an IDT [interdisciplinary team] Note, dated 03/28/2024, revealed that on the morning of 03/21/2024, Resident #197 hit another resident on the chest.

A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/25/2024, revealed Resident #197 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. The MDS did not reflect the physical behaviors directed towards others displayed by the resident or the use of an antipsychotic medication during the seven-day look-back period.

(continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/11/2024 at 3:11 PM, MDS Nurse #9 stated she was not aware Resident #197 had behaviors during the seven-day look-back period of their MDS. She stated she had been an MDS nurse for five months and was not used to the facility's electronic health record (EHR) system, so she did not know the various places she could look to identify if a resident exhibited behaviors. MDS Nurse #9 also stated she looked at the physician's orders to complete the medication section of the MDS, but she must have missed that Resident #197 was receiving an antipsychotic medication. During an interview on 04/12/2024 at 11:52 AM, the Administrator stated she expected the MDS team to use their best nursing judgement and to complete MDS assessments accurately. The Administrator confirmed that Resident #197's quarterly MDS should have been coded to reflect behaviors and antipsychotic medication use. 19186 2. A review of an Admission Record revealed the facility admitted Resident #237 on 01/10/2024 with diagnoses that included encounter for surgical aftercare following surgery on the digestive system, malignant neoplasm of colon, type two diabetes mellitus, hypokalemia (low potassium levels in the blood), colostomy status, hypertension, abnormal posture, abnormalities of gait and mobility, cognitive communication deficit, and oropharyngeal phase dysphagia. According to the Admission Record, the facility discharged Resident #237 from the facility on 01/29/2024. A review of Resident #237's discharge Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/29/2024, revealed the resident's discharge date was 01/29/2024. According to the MDS, the facility discharged the resident to a Short-Term General Hospital, and their return to the facility was not anticipated. However, a review of Resident #237's Progress Notes revealed a Nursing Note, dated 01/29/2024, that indicated the resident was discharged from the facility at 12:30 PM, with all medications and personal belongings provided. According to the note, a family member picked the resident up. During an interview on 04/11/2024 at 3:16 PM, Minimum Data Set (MDS) Nurse #3 stated Resident #237 was discharged home. After reviewing the resident's discharge MDS dated [DATE], MDS Nurse #3 said the MDS was inaccurately coded to reflect the resident went to the hospital instead of home. MDS #3 said the inaccurate coding was an oversight. During an interview on 04/12/2024 at 1:54 PM, the Assistant Director of Nursing (ADON) stated she expected MDS assessments to be accurate. The ADON said Resident #237's discharge MDS should have been coded to reflect that the resident was discharged home. During an interview on 04/12/2024 at 11:52 AM, the Administrator stated said she expected the MDS team to use their best nursing judgement and to complete MDS assessments accurately.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 47914 Based on interview, record review, and facility document and policy review, the facility failed to complete a new Level I Preadmission Screening and Resident Review (PASARR) after residents were diagnosed with a new mental illness for 2 (Resident #41 and Resident #164) of 4 sampled residents reviewed for PASARR requirements. Findings included: A review of a facility policy titled, Admission Criteria, revised in March 2019, revealed, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. A review of a facility policy titled, Change in a Resident's Condition or Status, revised in February 2021, revealed, 7. In addition to notifying the resident and/or representative, the state mental health agency or state intellectual disability agency will be notified within 24 hours of a significant change in the mental or physical condition of a resident with a mental disorder or intellectual disability. A review of Resident #41's Admission Record revealed the facility admitted the resident on 09/23/2022 with a primary diagnosis of unspecified psychosis not due to a substance or known physiological condition. Per the Admission Record, Resident #41 received a new diagnosis of schizoaffective disorder on 09/29/2022. A review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/30/2022, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 5, indicating the resident had severe cognitive impairment. Per the MDS, the resident had active diagnoses that included psychotic disorder and schizophrenia and received an antipsychotic medication on four of seven days of the assessment look-back period. The MDS also indicted the resident had a serious mental illness A review of Resident #41's Care Plan revealed a Focus area, initiated on 09/23/2022, that indicated the resident was at risk for behavioral impairment and was receiving medication for schizoaffective disorder. A review of Resident #41's Level I PASARR Screening, dated 09/23/2022, revealed the screening reflected that the resident had a neurocognitive disorder with behavioral disturbance and microvascular cerebral ischemia psychosis and was prescribed psychotropic medications for mental illness. The Level I Screening did not reflect a diagnosis of schizoaffective disorder but was positive for Suspected MI [mental illness], and a Level II evaluation was required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a letter from the State of California, Health and Human Services Agency, Department of Health Care Services to the facility, dated 09/27/2022, revealed a Level II Mental Health Evaluation was not scheduled due to Resident #41 not having a serious mental illness. The letter indicated, The case is now closed. To reopen, please submit a new Level I Screening. 46659 A review of Resident #164's Admission Record revealed the facility admitted the resident on 12/30/2022. According to the Admission Record, the resident was diagnosed with paranoid schizophrenia on 01/25/2024. A review of an annual MDS, with an ARD of 01/02/2024, revealed Resident #164 had a BIMS score of 13, indicating the resident was cognitively intact. According to the MDS, the resident had active diagnoses that included schizophrenia. A review of Resident #164's Care Plan revealed a Focus area, initiated on 03/11/2024, that indicated the resident was at risk for behavioral impairment and received psychotropic medication for a diagnosis of schizophrenia manifested by responding to hallucinations. On 04/09/2024 at 8:40 AM, a review of Resident #164's medical record revealed one Level I PASARR Screening that was completed in January 2023. There were no additional PASARRs contained within the resident's record, after the resident received a new diagnosis of schizophrenia. A review of Resident #164's Level I PASARR Screening, dated 01/01/2023, revealed the screening was Negative, the resident had No Serious Mental Illness, and a Level II evaluation was not required. During an interview on 04/12/2024 at 10:04 AM, the Assistant Director of Nursing (ADON) said PASARRs were completed at the hospital prior to admission and then reviewed to ensure they were accurate. The ADON said if a resident experienced a change in condition, staff should review to ensure their PASARR matched their current condition. The ADON said if a physician diagnosed a resident with a new diagnosis, their Level I PASARR Screening should be reviewed, and if needed, a MDS nurse completed a new PASARR. During an interview on 04/12/2024 at 12:39 PM, the Director of Nursing (DON) said PASARRs were completed prior to admission, and after admission, if a resident had a change in condition or new diagnosis, a MDS nurse completed another PASARR. During an interview on 04/12/2024 at 1:01 PM, the Administrator said she deferred to the nursing department on whether a new Level I Screening should be submitted when a resident was diagnosed with a new mental illness. The Administrator further stated she expected PASARRs to be accurate and for any inaccuracies to be corrected as soon as possible.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 46659 Based on interviews, record review, facility policy review, and review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, the facility failed to ensure a Level I Preadmission Screening and Resident Review (PASARR) was accurately completed for 1 (Resident #139) of 4 sampled residents reviewed for PASARR requirements. Specifically, the facility failed to ensure Resident #139's Level I PASARR Screening reflected the presence of a serious diagnosed mental disorder. Findings included: A review of a facility policy titled, Admission Criteria, revised in March 2019, revealed, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. A review of the California Department of Health Care Services Preadmission Screening and Resident Review (PASRR) Level I Assessment Guide, dated 01/12/2023, revealed, Section III-Serious Mental Illness Questions 10-12 This section helps determine if the individual may have a serious mental illness and benefit from specialized services. Question 10. diagnosed Mental Illness *Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? *If yes, there will be a text box question [to] provide the type of mental illness. A review of Resident #139's Admission Record revealed the facility admitted the resident on 09/19/2023 with diagnoses that included severe major depressive disorder with psychotic symptoms and schizoid personality disorder. A review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/25/2023, revealed Resident #139 had a Brief Interview for Mental Status (BIMS) score of 10, indicating the resident had moderately impaired cognition. Per the MDS, at the time of the assessment, Resident #139 had active diagnoses that included depression and schizoid personality disorder. A review of Resident #139's Level I PASARR Screening, dated 11/02/2023, revealed Section III- Serious Mental Illness Screen, question #10 was answered No, and did not reflect the resident's diagnoses of major depressive disorder or schizoid personality disorder. This resulted in a Negative Level I Screening, and a Level II evaluation was not required. During an interview on 04/12/2024 at 10:03 AM, the Assistant Director of Nursing (ADON) said that when a resident was admitted from the hospital a Level I PASARR was completed before admission and then reviewed for accuracy. She said if a resident was admitted without having a Level I PASARR completed, a MDS nurse was responsible for completing one. The ADON said Resident #139's PASARR dated 11/02/2023 was inaccurate, and Question #10 should have been answered with a yes, which would have triggered the need for a Level II evaluation. The ADON said the Admissions Director or MDS nurses were responsible for PASARRS, and she expected them to make sure they were accurate. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/12/2024 at 12:26 PM, the Admissions Director said when a resident was admitted from the hospital, she asked the hospital to send a copy of their Level I PASARR Screening. She said she reviewed the PASARR, and if it was negative, she accepted the resident as a resident of the facility, and if it was positive, she notified the Director of Nursing (DON). During an interview on 04/12/2024 at 1:00 PM, the Administrator said she expected PASARRs to be accurate.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 46659 Based on record review, interviews, and facility policy review, the facility failed to ensure staff administered medication as ordered by the physician for 1 (Resident #180) of 1 sampled resident reviewed for medication concerns. Findings included: A review of a facility policy titled, Administering Medications, revised in April 2019, revealed, Medications are administered in a safe and timely manner, and as prescribed. The policy specified, 4. Medication are administered in accordance with prescriber orders, including any required time frame. A review of Resident #180's Admission Record revealed the facility admitted the resident on 05/18/2023 with diagnoses that included unspecified atrial fibrillation (an irregular, often rapid heart rate). A review of Resident #180's Care Plan revealed a Focus area, initiated on 05/18/2023, that indicated the resident had impaired cardiac and/or circulatory function with risk for complications related to a history of cerebrovascular accident (CVA, stroke), hypertension (high blood pressure), and atrial fibrillation. An intervention dated 05/19/2023 directed staff to administer medications as ordered by the physician. A review of Resident #180's Order Summary Report, listing active orders as of 04/11/2024, revealed an order dated 05/18/2023 for Pradaxa oral capsule 150 milligrams (mg), one capsule by mouth two times a day for atrial fibrillation. During an interview on 04/08/2024 at 1:54 PM, Registered Nurse (RN) #17 said Resident #180 had not received their Pradaxa since 04/05/2024. During an interview on 04/12/2024 at 1:00 PM, the Administrator said she expected staff to administer residents' medications within the timeframe ordered by the physician.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 49044 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure they posted the total number of and the actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift, which included registered nurses (RN), licensed practical nurses (LPN) or licensed vocational nurses (LVN), and certified nurse aides (CNA) and failed to post this information at the beginning of each shift in a prominent place readily accessible to residents and visitors. This had the potential to affect all 229 residents residing in the facility. Findings included: A review of a facility policy titled Posting Direct Care Daily Staffing Numbers, revised July 2016, revealed, Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for direct care of residents. The policy revealed, Policy Interpretation and Implementation 1. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs, LPNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. 2. Directly responsible for resident care means that individuals are responsible for residents' care or some aspect of the residents' care including, but not limited to, assisting with activities of daily living (ADLs), performing gastrointestinal feeds, giving medications, supervising care given by CNAs, and performing nursing assessments to admit residents or notifying physicians of changes of condition. 3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The information recorded on the form shall include the following: a. The name of the facility. b. The date for which the information is posted. c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility. e. The shift for which the information is posted. f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. The actual time worked during that shift for each category and type of nursing staff. H. Total number of licensed and non-licensed nursing staff working for the posted shift. Further review revealed, 5. Within two (2) hours of the beginning of each shift, the shift supervisor shall compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The shift supervisor shall date the form, record the census and post the staffing information in the location(s) designated by the administrator. A review of a facility document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 04/08/2024 revealed the estimated scheduled total direct care service hours equaled 741.50 for all staff and scheduled total CNA direct care service hours equaled 517.50, with a census of 229 and did not include the total number of staff working per shift and the number of hours of each discipline per shift. Staff indicated the patient date start time as 12AM. A review of a facility document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 04/09/2024 revealed the estimated scheduled total direct care service hours equaled 833.50 for all staff and scheduled total CNA direct care service hours equaled 577.50, with a census of 229 and did not include the total number of staff working per shift and the number of hours of each discipline per shift. Staff indicated the patient date start time as 12AM. (continued on next page)

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 04/12/2024
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)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of a facility document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 04/10/2024 revealed the estimated scheduled total direct care service hours equaled 846.00 for all staff and scheduled total CNA direct care service hours equaled 606.00, with a census of 228 and did not include the total number of staff working per shift and the number of hours of each discipline per shift. Staff indicated the patient date start time as 12AM. A review of a facility document titled Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 04/11/2024 revealed the estimated scheduled total direct care service hours equaled 846.00 for all staff and scheduled total CNA direct care service hours equaled 606.00, with a census of 228 and did not include the total number of staff working per shift and the number of hours of each discipline per shift. Staff indicated the patient date start time as 12 AM. A review of a facility document titled [Facility Name] Daily Staffing Sheet, dated 04/12/2024, revealed the form listed all the staff scheduled for this day and their assignments. The form listed the facility's staff schedules of 7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM. This form was maintained at each nurses' station in a binder not accessible to residents or visitors. This form did not include the number of staff broken out by discipline by shift or the facility's census. An observation on 04/09/2024 at 4:36 PM revealed the facility's staffing posting hung on the wall outside the conference room, not in a conspicuous area. The conference room was located across the large lobby and down a short hall towards the dining/activity room on the first floor of the facility. The posting was not visible when walking into the facility and going directly upstairs by accessing the elevator directly across the large lobby. When walking into the building and turning immediately to the right to head down 1 East Hall, the posting was not visible as it was located across the large lobby from the hallway. The posting was not visible when walking to access the 2nd floor via the stairwell. When entering the building and immediately turning to the left, the posting was not readily visible as it was located past the third door along the short hallway. An observation of the facility's staffing posting showed a census of 229 and did not include the breakdown of staff working in the facility by discipline or the total number of staff. An observation on 04/10/2024 at 8:55 AM revealed the staff posting had not yet been changed to reflect the 04/10/2024 date. During an interview on 04/11/2024 at 2:05 PM, the Assistant Administrator stated she thought the only staffing posting they had was the one right outside the door of the conference room. She stated someone told her they thought it was posted downstairs (the basement), but she did not know as she had not looked. An observation of the entire basement area on 04/11/2024 at 4:11 PM revealed no staff posting and no staff schedules posted. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Pavilion Healthcare	99 Escuela Drive Daly City, CA 94015

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 04/12/2024 at 9:30 AM, the Staffing Coordinator stated she only did the scheduling for nursing staff, including the CNAs and nurses, and then the nursing supervisors made the assignments. She stated she was responsible for posting the DHPPD form. She stated she posted the projected hours of the day and only posted the total number of hours for the nurses combined and the total number of hours for the CNAs for the day. She stated she would have to go through the schedule sheets to know how many RNs/LVNs they had individually. The Staffing Coordinator stated no one had ever told her she needed to post the total number of each discipline working; all she had ever been told was to post the form that was compliant with the State. She stated she updated the form on an hourly basis and gave the updated form to the Administrator for any changes to the census or because of staff callouts. The Staffing Coordinator stated all she had been instructed to do was post the projected hours; it was her responsibility, and she reported the hours to the Administrator. During an interview on 04/12/2024 at 12:25 PM, the Assistant Director of Nursing (ADON) stated her role was to go around to make sure staff were there, to make sure they had their projected PPD (Per Patient Day); if they did not, she would go back to the scheduler to see how they could shuffle staff around until they could call agency staff to get someone in to cover. The ADON stated they had their projected hours and had it broken down at each nurses' station. The ADON stated as far as she knew, it was the DHPPD that was posted for staff and visitors, and then the breakdown by discipline was located at each nurses' station. She stated she knew it was kept in a binder at each station but was not sure if it was posted so visitors and residents could see the breakdown. During an interview on 04/12/2024 at 1:47 PM, the Administrator stated she expected the daily staffing to include the census. The staff that were in the facility and the hours should be broken down by shift and with any changes in the census.

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NAME OF PROVIDER OR SUPPLIER Golden Pavilion Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 99 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 46659 Based on interviews and facility policy review, the facility failed to implement their Legionella (a pathogenic gram-negative bacteria) water management program. This had the potential to affect all 229 residents residing in the facility. Findings included: A review of a facility policy titled, Legionella Water Management Program, revised in September 2022, revealed, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team consists of at least the following personnel: a. The infection preventionist; b. The administrator; c. The Medical Director (or designee); d. The director of maintenance; and e. The director of environmental services. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaires' disease [a type of pneumonia caused by Legionella bacteria]. The policy specified, 5. The water management program includes the following elements: a. An interdisciplinary water management team (see above); b. A detailed description and diagram of the water system in the facility, including the following: (1) Receiving); (2) Cold water distribution; (3) Heating; (4) Hot water distribution; and (5) Waste. c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: (1) Storage tanks; (2) Water heaters; (3) Filters; (4) Aerators; (5) Showerheads and hoses; (6) Misters, atomizers, air washers and humidifiers; (7) Fountains; and (8) Medical devices such as CPAP [continuous positive airway pressure] machines, hydrotherapy equipment, etc. [et cetera, other similar things]. The policy further indicated the water management program also included the following elements: e. Specific measures used to control the introduction and/or spread of Legionella (e.g. [exempli gratia, such as] temperature, disinfectants); f. The control limits or parameters that are acceptable and to be monitored; g. A diagram of where control measures are applied; h. A system to monitor control limits and the effectiveness of control measures; i. A plan for when control limits are not met and/or control measures are not effective; and j. Documentation of the program. During an interview on 04/11/2024 at 1:12 PM, Maintenance Assistant (MA) #1 stated he facility did not have a process for monitoring the facility for Legionella. During an interview on 04/11/2024 at 1:18 PM, MA #2 stated that he did not know anything about monitoring for Legionella. MA #2 said they had a floor plan, but he did not think that it included a diagram of the facility's water lines. MA #2 stated the facility was currently utilizing a Regional Maintenance staff member until a new Maintenance Director started work at the facility the following week. During an interview on 04/11/2024 at 1:22 PM, Regional Maintenance staff said he had been filling the Maintenance Director position since December 2023; however, he was not sure if the facility had a program or plan addressing Legionella. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 04/11/2024 at 1:39 PM, Regional Maintenance staff confirmed the facility had no documentation related to monitoring for Legionella. During an interview on 04/11/2024 at 2:53 PM, the [NAME] President of Clinical Operations (VPCO) said she was unable to locate any documentation related to water management or Legionella. During an interview on 04/12/2024 at 10:03 AM, the Assistant Director of Nursing (ADON) stated she expected maintenance staff to monitor for free-standing water and for the presence of Legionella. During an interview on 04/12/2024 at 1:00 PM, the Administrator said that she expected staff to monitor for Legionella and to maintain records of the monitoring.