ATTACHMENT H

Notice of Temporary Suspension from CDPH, dated June 10, 2020

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

June 10, 2020

Golden Cross Health Care
1450 N. Fair Oaks Ave.
Pasadena, CA 91103

Joseph R. LaMagna
jlamagna@health-law.com
Hooper, Lundy & Bookman, P.C.
101 W. Broadway
Suite 1200
San Diego, CA 92101-3890

RE: Notice of Temporary Suspension Order

Dear Administrator:

This letter serves as notice that effective June ~~XX~~ 10 (15), 2020, the California Department of Public Health (Department) shall issue a Temporary Suspension Order (TSO) of the license (License No: 970000082) at your facility in response to ongoing risk to the health and safety of the public. Specifically, the Department has determined over the course of multiple surveys of the skilled nursing facility between May 15 and June 1 that multiple deficiencies existed, including failure to properly administer wound care, failure to maintain clean linens and proper hygiene of residents, failure to maintain confidentiality of medical records, insufficient nutrition and hydration of residents, failure to properly care for diabetic residents, as well as others. As a result, the Director finds the temporary suspension of the license necessary to protect the public welfare.

If you have any questions regarding this notice or require assistance, please contact Scott Vivona, Assistant Deputy Director, Center for Health Care Quality at (916) 440-7377.

Sincerely,

Heidi Steinecker
Deputy Director

BEFORE THE
STATE DEPARTMENT OF PUBLIC HEALTH

In the Matter of the Accusation Against: GOLDEN CROSS HEALTH CARE 1450 N. Fair Oaks Avenue Pasadena, CA 91103 License Number: 970000082 Facility ID: 970000171 Respondent	CPH Case No. 20-AL-LNC-39848 **TEMPORARY SUSPENSION ORDER PURSUANT TO HEALTH AND SAFETY CODE SECTION 1296 AND STATEMENT TO RESPONDENT**

RESPONDENT IS HEREBY NOTIFIED that the Director of the California Department of Public Health (Department) has made a determination, in accordance with Health and Safety Code section 1296, to temporarily and immediately suspend your license to operate Golden Cross Health Care. This temporary suspension shall remain in effect until the conclusion of the administrative proceedings herein. Upon receipt of notice of defense, the Director shall, within 15 days, set the matter for hearing, which shall be held as soon as possible but not less than 30 days after receipt of the notice. If the Director fails to make a final determination on the merits within 60 (sixty) days after the hearing has been completed, the temporary suspension shall be deemed vacated. The Department maintains that there is an exception to the automatic stay which allows the Department, a governmental regulatory agency, from enforcing or utilizing its regulatory power.

EFFECTIVE JUNE 11, 2020,

1. Your license to operate the skilled nursing facility Golden Cross Health Care is temporarily suspended; and
2. You must immediately cease operation of the skilled nursing facility and any other services that are part of the license for Golden Cross Health Care. and work with and take direction from the Temporary Manager currently appointed to Golden Cross Health Care to conduct and orderly transfer of residents.

RESPONDENT IS HEREBY ADDITIONALLY NOTIFIED that at any hearing regarding the proceedings for the Temporary Suspension, the California Department of Public Health also seeks that Respondent's license to operate Golden Cross Health Care be revoked pursuant to Health and Safety Code section 1294.

The enclosed Accusation in this matter is served on you. All communications pertaining to this matter, including the notices and requests referred to below, should be sent to the attorney who represents the Department.

Unless a written request for a hearing signed by or on behalf of the person named as the Respondent in the accompanying Accusation is delivered or mailed to the agency within 15 days after the Accusation has been personally served on you or mailed to you, the Department may proceed upon the Accusation without a hearing. The request for a hearing may be made by delivering or mailing the enclosed form entitled, "Notice of Defense" or by delivering or mailing a notice of defense as provided by section 11506 of the Government Code to:

Daniel Meyer
Attorney IV
California Department of Public Health
1415 L Street, Suite 500
Sacramento, CA 95814

If you use the enclosed form Notice of Defense as your request for a hearing, it will be deemed a specific denial of all parts of the Accusation not expressly admitted. However, you cannot use this form to present any of the other defenses or objections permitted by Government Code section 11506. Other defenses or objections permitted by Government Code section 11506 must be raised in specific conformance with the language of section 11506.

If you desire the names and addresses of witnesses or an opportunity to inspect and copy the items mentioned in section 11507.6 of the Government Code in the possession, custody or control of the Department, you may contact the Department's attorney identified above.

Copies of Government Code sections 11507.5, 11507.6 and 11507.7, are enclosed.

The procedures which govern this hearing process are contained in Health and Safety Code sections 1296, 1295, 100171, and to the extent it is not inconsistent with this section, the California Administrative Procedure Act (Chapters 4.5 and 5 (commencing with section 11400) of Part 1 of Division 3 of Title 2 of the Government Code). If you would like a copy of these governing procedures, you may contact the Department's attorney identified above.

The hearing may be postponed for good cause. If you have good cause, you are obliged to notify the Department, and if an Administrative Law Judge has been assigned to the hearing, the Office of Administrative Hearings and Appeals, within 10 working days after you discover the good cause. Failure to notify the Department within 10 working days will deprive you of a postponement.

DATED: June 18, 2020

Heidi Steinecker
Deputy Director
Center for Health Care Quality
California Department of Public Health

REBECCA DIETZEN
SBN: 233072
Assistant Chief Counsel
DANIEL MEYER
SBN: 252348
Attorney IV
Department of Public Health
1415 L Street, Suite 500
Sacramento, CA 95814
Telephone: (916) 558-1775

Attorney for the State
Department of Public Health
Licensing and Certification Division

BEFORE THE
STATE DEPARTMENT OF PUBLIC HEALTH

In Matter of: GOLDEN CROSS HEALTH CARE 1450 N. Fair Oaks Avenue Pasadena, CA 91103 License Number: 970000082 Facility ID: 970000171 Respondent	CDPH Case No. 20-AL-LNC-39848 **ACCUSATION**

I

Heidi Steinecker, Complainant herein (Complainant), files this Accusation in her official capacity as the Deputy Director, Center for Health Care Quality, California Department of Public Health, State of California. Complainant makes and files the instant Accusation solely in her official capacity and not otherwise. This Accusation is based on Complainant's information and belief.

II

The Department of Public Health (Department) is the agency of the State of California responsible for the licensure of Skilled Nursing Facilities pursuant to California Health and Safety Code section 1250 et seq. and California Code of Regulations, Title 22, section 720001 et seq.

///

III

Respondent, (Respondent), is licensed by the Department to operate and maintain the skilled nursing facility (SNF) known as Golden Cross Health Care (Facility) located at 1450 N. Fair Oaks Avenue, Pasadena California 91103 (License No. 970000082). (A true and correct copy of the license is attached hereto as Exhibit A) Pursuant to said license, Respondent is required to comply with Health and Safety Code section 1250 et seq. and California Code of Regulations, title 22, section 720001, et seq.

At all times mentioned in this Accusation, Respondent was licensed to operate and maintain said Facility. Wherever it is alleged in this Accusation that Respondent violated one or more statutes or regulations, the allegation shall be deemed in each case to mean that Respondent, through its employees or agents, violated the statute or regulation and that Respondent aided, abetted, or permitted the violation.

IV

DEPARTMENT AUTHORITY

Health and Safety Code section 1294 provides that the Department may revoke a license to operate a skilled nursing facility for violation by the licensee of any of the provisions of chapter 2, division 2, of the Health and Safety Code, or of the rules and regulation promulgated there under; or for conduct inimical to the public health, morals, welfare, or safety of the people of the State of California in the maintenance and operation of a skilled nursing facility.

Health and Safety Code Section1296 provides that the Director may temporarily suspend any license or special permit prior to any hearing, when in his or her opinion the action is necessary to protect the public welfare. This temporary suspension shall remain in effect until the hearing is completed and the Director has made a final determination on the merits.

///

///

///

V

BACKGROUND

The Department conducted multiple inspections of Respondent's facility. An inspection completed on May 27, 2020 resulted in a pattern of widespread deficiencies that resulted in a level L immediate jeopardy citation. The deficiencies are detailed in State Form 2567 dated May 27, 2020. (A true and correct copy of the State Form 2567 is attached hereto as Exhibit B and is incorporated by reference herein.) Another inspection was completed on May 28, 2020. Numerous deficiencies, including six immediate jeopardy deficiencies, were found and are detailed in State Form 2567 dated May 28, 2020. (A true and correct copy of the State Form 2567 is attached hereto as Exhibit C and is incorporated by reference herein.) An additional inspection was completed on May 31, 2020 which resulted in Respondent being cited for a pattern of deficiencies that resulted in a level K immediate jeopardy citation being issued. (A true and correct copy of the State Form 2567 is attached hereto as Exhibit D and is incorporated by reference herein.)

Based on the seriousness of the deficiencies, on June 2, 2020, a Statement of Cause and Concerns was served on Respondent and a temporary manager (TM) was installed in the facility. On June 3 and 10, 2020, amended versions of this Statement of Cause and Concerns were sent to the Respondent to correct clerical errors. (A true and correct copy of all three Statements of Cause and Concerns are attached hereto as Exhibit E and are incorporated by reference herein.) TM observed continued violations of State and Federal statutes and regulations. Based upon the findings in the above-referenced report, and the observations of the TM, the Director has made a determination that, in order to protect the welfare of the facility's residents, Respondent's license to operate the skilled nursing facility should be temporarily suspended effective June 11, 2020.

///

///

Good cause exists for the revocation of Respondent's license, pursuant to Health and Safety Code section 1294, in that Respondents have violated, and permitted the violation of State and Federal regulations governing the operation of the facility, and has engaged in conduct inimical to the public health, welfare, and safety of the people of the State of California.

VI

VIOLATIONS

Respondent violated the following regulations and/or statutes, which are grounds for the temporary suspension of Respondent's license to operate the skilled nursing facility known as Golden Cross Health Care.

1. MAY 27, 2020 VIOLATIONS

Code of Federal Regulations, title 42, §§ 483.80(a), (1), (2), (4), (e) and (f) – Infection Prevention and Control

Respondent failed to provide a safe sanitary environment to help prevent the spread of infections during the Coronavirus (COVID-19) crisis. Respondent failed to ensure that the facility had:

- Certified/licensed staff members in the facility to oversee the infection control practices in the residential care areas;
- Certified/licensed staff members in the facility to review the template for an investigation of outbreaks;
- Designated units to separate infected residents from uninfected residents and from residents awaiting COVID-19 lab test results;
- Assigned dedicated healthcare staff to care for suspected or confirmed COVID-19 residents;
- Kept infected residents in their rooms;
- Instructed staff on how and where to put on and take off personal protective equipment;
- Separate donning and doffing areas from COVID and Non-COVID areas.

These deficient practices had the potential to result in the spread of infections that could lead to death to residents and staff.

2. May 28, 2020 VIOLATIONS

a) Code of Federal Regulations, title 42, § 483.12(a)(1) - Freedom from Abuse, Neglect, and Exploitation.

The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

Respondent failed to ensure that three of three sampled residents who had the Corona virus received the necessary care and services in accordance with the resident's care plans to maintain and improve their wellbeing, as indicated in the facility's policies and procedures. Respondent's failures include, but are not limited to the following:

- Failed to ensure Resident 1 had clean linen, clean fingernails, wound treatments, fresh water available, and assistance to reposition in bed;
- Failed to ensure Resident 2 had showers and clean clothes;
- Failed to ensure Resident 6 received fresh drinking water;
- Failed to ensure the facility had a knowledgeable department head staff and/or staff to oversee the care and treatment practices in the resident care areas sin the COVID-19 unit.

The Respondent's failure to ensure that residents were not neglected increased the risk of the spread of infections (including COVID-19) to residents which could result in health complications likely resulting in hospitalization or death. Failure to maintain adequate personal hygiene may also result in psychosocial harm that could lead to a negative effect on the residents' health, well-being and overall quality of life.

b) Code of Federal Regulations, title 42, § 483.25 - Quality of Care

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. The facility must ensure that residents receive treatment

and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Respondent failed to provide nursing care and services for two sampled residents during the Coronavirus crisis in accordance with the facility's policies and procedures. This was evidenced by;

- Facility Staff did not provide Resident 1 with grooming and personal care to keep the resident clean and comfortable. The facility's nursing staff also failed to assess the resident's skin when he developed wounds on the right hip, and discoloration on bilateral toes;
- Facility nursing staff did not provide nursing care when the Resident 2 had abnormally low and high blood sugar levels. The nursing staff also did not check residents blood sugar nor administer the right amount of insulin.
- The Facility's administrative staff did not oversee the nursing care and treatment for both residents, due to the fact that both residents resided in the COVID-19 area, which the administrative staff refused to enter.

c) Code of Federal Regulations, title 42, *§483.25(b)(1) - Pressure ulcers.*

Based on the comprehensive assessment of a resident, the facility must ensure that:

> (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
> (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

(42 C.F.R. sec. 483.25(b)(1).)

The facility failed to provide wound care treatments for seven of seven sampled residents as ordered by the facility physician and according to the facility's policies and procedures by failing to:

- Assess and notify Resident 1's physician of, implement a treatment, and provide care for Resident 1's black discolorations on his toes;

///

- Assess for the location, stage, length, width and depth, presence of fluid or necrotic tissue of, provide treatment for Resident 1's pressure ulcers/injuries to his buttocks and hip;
- Provide treatment and ensure Resident 4 had heel protectors on to prevent pressure injury as ordered by his physician;
- Provide treatment and ensure Resident 6 received wound treatment on the right hip as ordered by the physician;
- Provide treatment and ensure Resident 7 received skin treatment on her right heel and left leg as ordered by the physician;
- Provide treatment and ensure Resident 8 received treatment for a scrape on his buttocks;
- Provide treatment and ensure that Resident 9 received treatment for toe discoloration;
- Provide treatment and ensure that Resident 10 received treatment for abrasions to his toes.

These deficient practices resulted in the residents experiencing worsening of their wounds, to experience pain, and put them at risk for infection that could lead to hospitalization, health complications and death.

d) Code of Federal Regulations, title 42, §483.25(l) - Dialysis.

The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

The Facility's nursing staff failed to monitor and identify hemodialysis complications for one of one sampled resident after the resident returned from the dialysis center. This was evidenced by Respondent's failure to:

- Ensure that licensed nurses assessed resident's right upper arm arteriovenous fistula and vein, made by the surgeon to remove and return blood during hemodialysis, for bleeding as indicated in the resident's care plan;

- Monitor resident's am AV fistula for bruit and thrill (sounds and sensations that can be monitored by stethoscope and by feel) as indicated in the facility's policies and procedures;
- Ensure the dialysis emergency kit was available at resident's bedside for staff to use during a bleeding emergency that occurred;
- Ensure the facility had a knowledgeable department head/staff to oversee the resident's nursing care while the resident was in the COVID-19 unit.

These deficient practices placed resident at risk for life threatening emergencies due to bleeding from the AV fistula. It took staff over twenty minutes to find the emergency kit to stop the bleeding. During that time period, the resident had to keep pressure on his own wound.

e) Code of Federal Regulations § 483.25(i) - Respiratory/Tracheostomy Care and Suctioning

The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

Respondent failed to provide oxygen treatment, as the physician ordered, for eight of eight sampled residents who had COVID-19, per physician's orders. The facility failed to:

- Ensure staff were monitoring O2 saturation;
- Label a residents' humidifiers;
- Provide oxygen treatment at the correct rate;
- Obtain an order to titrate the oxygen rate;

These deficient practices placed residents at risk for health complications from COVID-19 including respiratory distress and/or infection that could lead to hospitalization or death.

///

///

f) Code of Federal Regulations, title 42, § 483. 483.60(i)(1)(2) Food safety requirements.

The facility must store, prepare, distribute and serve food in accordance with professional safety requirements. Respondent failed to develop and implement a system to identify, report, monitor and control unsafe food sanitation practices in the facility kitchen that provides food services for all 65 residents in the facility. Respondent's failures include:

- A dirty food cart from the COVID-19 unit was rolled back into the kitchen and placed next to the food preparation area;
- The dietary staff wiped the dirty food cart next to the food preparation area during dinner tray line service;
- The evening snacks in a tray cart were not labeled with time, date and resident name as required to prevent pathogenic microorganism growth or toxic formation;
- The two dietary staff present did not practice hygiene or follow proper sanitary food preparation rules. Both staff member were not wearing beard or hair nets, did not wash hands or change gloves when moving from dirty tasks to clean ones.
- Staff stored personal items, including alcohol, in facility refrigerator, leaving open the potential of cross contamination of residents' food that could cause food borne illnesses;
- Facility did not serve the dinner meals of 10 residents in a timely manner;
- Facility staff did not check the food temperature prior to serving the food, did not wear gloves while serving the food, and served the food cold to residents.

These deficient practices had the potential to cross-contaminate food served to the 65 residents in the facility. These practices could cause health complications that could lead to hospitalization or death.

g) Non-Immediate Jeopardy Deficiencies

The facility was also cited for multiple deficiencies that did not rise to the level of an immediate jeopardy. These include, but are not limited to, violations for:

///

- Code of Federal Regulations, title 42, §§ 483.10(h)(1)-(3)(i)(ii) - failing to ensure residents privacy/confidentiality of records.
- Code of Federal Regulations, title 42, §§ 483.25(d)(1)(2) – Failing to keep facility free of accidents/Hazards/Supervision/Devices.
- Code of Federal Regulations, title 42, §§ 483.35(a)(3)(4)(c) – Failure to Employ a Competent Nursing Staff.
- Code of Federal Regulations, title 42, §§ 483.45(a)(b)(1)-(3) – Failure to have adequate Pharmacy Services, Procedures and Records.
- Code of Federal Regulations, title 42, §§ 483.45(g)(h)(1)(2) – Failure to store/Label Drugs and Biologicals Properly.
- Code of Federal Regulations, title 42, §§ 483.20(f)(5) and 483.70(i)(1)-(5) – Failure to Keep Proper Resident Records.
- Code of Federal Regulations, title 42, §§ 483.80(a)(1)(2)(4)(e)(f) – Infection Control

3. MAY 31, 2020 VIOLATIONS

a) Code of Federal Regulations, title 42, §§ 483.45(a)(b)(1)-(3) - Pharmacy Services, Procedures, Pharmacists and Records

Respondent failed to ensure that 10 of 10 sampled residents in the facility received pharmaceutical services to meet the needs of each resident in a consistent manner in accordance with physician orders and the facility's policies and procedures by failing to:

- Administer three doses of Levimar (insulin), two doses of Levimar 15 and four doses of Klonopin (seizure/anxiety medication) for Resident 1;
- Administer five doses of Haldol (mental/mood disorder medication), 10 doses of Depakote (seizure/psychiatric medication), five doses of benztropine mesylate (controls involuntary or uncontrollable movements), and four doses of atorvastatin (cholesterol medication) for Resident two;
- Administer four doses of Depakote to Resident 3;

///

- Administer four doses of Dilantin (seizure medication), five doses of Dilantin, three doses of dorzolamide HCl 2% solution (glaucoma eyedrops) and one dose of Exelon for Resident 4;
- Administer five doses of Namenda (medication to treat severe confusion) for resident;
- Administer two doses of Lipitor (cholesterol medication) for Resident 6;
- Administer two doses of Plavix (blood clot medication) for Resident 7;
- Administer eleven doses of memantine HCL (to treat confusion), nine doses of metformin (controls blood sugar levels), three doses of pantoprazole (used to treat stomach problems), five doses of Thera-M (supplement), four doses of Claritin (allergy medication), six doses of donepezil (treats confusion), two doses of escitalopram oxalate (to treat depression), five doses of fenofibrate sulfate (iron supplement), and two doses of folic acid (supplement) for Resident 8;
- Administer one dose of Neurontin (seizure/nerve pain medication), two doses of Pepcid (ulcer medication), three doses of Prozac (depression medication), two doses of Revia (addiction medication), three doses of thiamine (vitamin), and one dose of Zocor (cholesterol medication) for Resident 9;
- Administer three doses of anastrozole (breast cancer treatment) for Resident 10.

These deficient practices of failing to administer medications for seizures, diabetes, cancer and various psychiatric conditions in accordance with physician orders increased the risk for the Residents to experience health complications likely resulting in serious harm.

b) Code of Federal Regulations, title 42, § 483.45(f)(2) – Medication Errors

Respondent failed to ensure that the facility administered medications in a timely manner that was consistent with the physician's orders and the facility's policies and procedures by failing to:

- Administer three doses of Levimar (insulin), two doses of Levimar 15 and four doses of Klonopin (seizure/anxiety medication) for Resident 1;

- Administer five doses of Haldol (mental/mood disorder medication), 10 doses of Depakote (seizure/psychiatric medication), five doses of benztropine mesylate (controls involuntary or uncontrollable movements), and four doses of atorvastatin (cholesterol medication) for Resident two;
- Administer four doses of Depakote to Resident 3;
- Administer four doses of Dilantin (seizure medication), five doses of Dilantin, three doses of dorzolamide HCl 2% solution (glaucoma eyedrops) and one dose of Exelon for Resident 4;
- Administer five doses of Namenda (medication to treat severe confusion) for resident;
- Administer two doses of Lipitor (cholesterol medication) for Resident 6;
- Administer two doses of Plavix (blood clot medication) for Resident 7;
- Administer eleven doses of memantine HCL (to treat confusion), nine doses of metformin (controls blood sugar levels), three doses of pantoprazole (used to treat stomach problems), five doses of Thera-M (supplement), four doses of Claritin (allergy medication), six doses of donepezil (treats confusion), two doses of escitalopram oxalate (to treat depression), five doses of fenofibrate sulfate (iron supplement), and two doses of folic acid (supplement) for Resident 8;
- Administer one dose of Neurontin (seizure/nerve pain medication), two doses of Pepcid (ulcer medication), three doses of Prozac (depression medication), two doses of Revia (addiction medication), three doses of thiamine (vitamin), and one dose of Zocor (cholesterol medication) for Resident 9;
- Administer three doses of anastrozole (breast cancer treatment) for Resident 10.

These deficient practices of failing to administer medications for seizures, diabetes, cancer and various psychiatric conditions in accordance with physician orders increased the risk for the Residents to experience health complications likely resulting in serious harm.

///

VII

OBSERVATIONS OF THE TEMPORARY MANAGER

Karen Lapcewich was appointed as the temporary manager of Golden Cross Health Care on June 02, 2020. She has submitted a declaration to the Department that attests to the numerous ongoing and serious quality of care issues at Golden Cross. (A true and correct copy of the declaration is attached hereto as Exhibit F.) Violations that she has observed and concerns she has include, but are not limited to:

- An outside nurse consultant identified that at least 13 residents are suffering from dehydration because there is no existing hydration program monitoring. Outside consultants and the TM have had to provide intravenous (IV) hydration. To date, the facility has not initiated the IVs. Nor was water timely provided to patients throughout the day.
- There is no skin management program to prevent residents from getting pressure ulcers. There are no preventative measures for skin break down including proper care planning and pressure relieving devices to address ongoing pressure ulcer problems. Residents are not being turned on a regular basis. Consequently, residents are continuing to develop pressure ulcers and existing ones are worsening.
- Similarly, residents are not changed and often lay in their urine for hours.
- There is no current maintenance manager and no logs or maintenance program could be provided when sought. Of concern is the air filter system, which is not working properly, and dirt and heavy dust were observed on facility air vents.
- Overall infection control is also of grave concern. Not only is there is no basic functioning infection operational control program, but there is also not one specific to COVID-19. Thus, there are infection control issues related to donning and doffing personal protective equipment (PPE), handwashing, cross-contamination, and food transport. Moreover, there is no basic infection surveillance tracking and trending, no COVID-19 surveillance and tracking, and staff are moving in and out

of red and green zones (COVID-19 positive and negative areas) without taking the proper precautions.

- The facility is not addressing or preventing resident abuse by the facility staff. Bruises are not being investigated or reported, so incident reports are not being generated to understand the origin of the injuries. Cases of abuse are not reported timely, investigated, and are difficult to prevent. This includes the recent alleged physical abuse where a staff member allegedly slapped and pushed a resident into his bed. The owner and director of nursing were notified of this event shortly after it occurred. They did not report the event within two hours, and they allowed the staff to continue working through the shift. The staff member was not taken off the schedule and returned the next day. The police were not notified until several days later. The TM provided the information to the police rather than the facility reporting the incident. To date there has been no investigation, no notes in the patient's chart of the events, and no incident report has been generated.
- There is no weight management program. Approximately 90 percent of residents have recently lost weight. The dietary department is not following menus or portion control. Also, it was observed that staff remove meals from the residents prior to the resident completing the meal and are not allowing the residents to eat their entire meal. Residents were not offered evening snacks, so the CalMat team (Medical Assistance Teams (CAL-MATs) are a group of highly trained medical professionals and other specialists organized and coordinated by the State Emergency Medical Services Authority (EMSA) for rapid field medical response in disasters) have been assisting by preparing snacks for residents because the facility failed to address this issue.
- There is inadequate supervision of patients. One resident has been identified as a risk for elopement. The resident’s care plan is clearly not effective to prevent this resident from eloping. The National Guard (brought in after CalMat was demobilized) found the resident just before the resident ran into the street.

- Nurses are failing to identify when a resident has a change of condition and failing to report a change of condition.
- The facility is not conducting interdisciplinary team care plan meetings to meet and address the residents' needs.
- There is no full-time staff developer working during day hours to conduct in-service trainings and monitor staff.
- The Registered Nurse Supervisor's keys are left out and unsupervised. These keys include those that secure the narcotics.
- There is no existing activity program. Though COVID-19 may prevent community activities and room visits, activities can still be easily scheduled for residents. Residents just watched TV all day with nothing to do and remain isolated.
- There is no Quality Assessment and Improvement Program or even basic quality assurance.

These observations are being investigated by the Department and may lead to further deficiencies to be assessed against the facility.

VIII

HEARING

The purpose of the hearing is to permit Respondent an opportunity to present evidence to rebut the Department's determination regarding the penalty assessment against Respondent, the amount of the penalty, the alleged deficiency, or the alleged failure to correct a deficiency.

IX

RESPONDENT HAS DEMONSTRATED A PATTERN OF CONDUCT INIMICAL TO THE HEALTH, MORALS, WELFARE, AND SAFETY OF ITS PATIENTS

The Respondent is hereby notified that the Director has made a determination, in accordance with Health and Safety Code section 1296 to temporarily and immediately suspend Respondent's license to operate the skilled nursing facility. This temporary suspension shall remain in effect until the conclusion of the administrative proceedings

herein. However, if the director fails to make a final determination on the merits within 60 (sixty) days after the hearing has been completed, the temporary suspension shall be deemed vacated.

EFFECTIVE IMMEDIATELY, your license to operate the skilled nursing facility is temporarily suspended; and; you must immediately cease operation

RESPONDENT IS HEREBY ADDITIONALLY NOTIFIED that, after hearing or conclusion of these proceedings, the Complainant also seeks that: Respondents' license to operate Golden Cross Health Care be revoked.

WHEREFORE, Complainant seeks to have the Respondent's license be temporarily suspended.

DATED: June 10, 2020

HEIDI STEINECKER
Deputy Director
Center for Health Care Quality
Department of Public Health

Complainant

Exhibit A

License: 970000082
Effective: 01/13/2020
Expires: 01/12/2021
Licensed Capacity: 96

State of California
Department of Public Health

In accordance with applicable provisions of the Health and Safety Code of California and its rules and regulations, the Department of Public Health hereby issues

this **License** *to*

1450 North Fair Oaks LLC

to operate and maintain the following **Skilled Nursing Facility**

GOLDEN CROSS HEALTH CARE
1450 N Fair Oaks Ave
Pasadena, CA 91103-1801

Bed Classifications/Services
96 Skilled Nursing

This **LICENSE** is not transferable and is granted solely upon the following conditions, limitations and comments:
None

Sonia Y. Angell, MD, MPH
State Public Health Officer & Director

Michelle Dunlap, Staff Service Manager II

Refer Complaints regarding these facilities to: The California Department of Public Health, Licensing and Certification, L.A. Region 1 District Office, 5050 Commerce Drive, Suite 102, Baldwin Park, CA 91706, (626)430-5600

POST IN A PROMINENT PLACE

Exhibit B

COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY HEALTH AGENCY

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

NWAMAKA ORANUSI, RN
Chief, Health Facilities Inspection Division
12440 East Imperial Highway, Suite 522
Norwalk, CA 90650
Tel: (562) 345-6884
Fax: (562)409-5096

www.publichealth.lacounty.gov
Tel: (562) 345-6884
Fax: (562)409-5096

Date: May 27, 2020

To:	From:
NAME: **Administrator**	NAME: **Naiades Paule, Supervisor, HFEN**
ORGANIZATION: **Golden Cross Health Care**	**LA DPH Health Facilities Inspection Division Region 1/East District Office**
PHONE #: (626) 791-1948	PHONE #: (626) 312-1113
Fax #:	FAX #: (626) 288-7241
Email: joe@goldencrosshealthcare.com	PAGES, INCLUDING COVER PAGE - 20

NOTES TO ADDRESSEE:

Please find the attached CMS 2567, Administrator letter, and Signature Requirement Notice for abbreviated survey **for intake CA00688967**completed **on 5/27/2020.**

Please submit the plan of correction for the abbreviated survey with your supporting documents/evidences (see AFL 12-23) on or before **6/6/2020.**

Naiades Paule, Supervisor, HFEN
(626) 312-1187

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility		City
Golden Cross Health Care	CA00688967	Pasadena

Copy of this notice received:

Licensee or designee signature	Date

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
Naiades Paule	5/27/20

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Naiades Paule	(626) 312-1113

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00688967 Representing the Department of Public Health: HFEN # 36904 and HFEN # 42334. The inspection was limited to the specific complaint investigated and does not represent a full inspection of the facility. One deficiency was written for complaint number CA00688967.	F 000		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, sanitary environment to help prevent the spread of infections during the Coronavirus ([COVID-19], an illness caused by a virus that can spread from person to person) crisis for affected 4 of 64 sampled residents (Resident 1, 2, 3, and 4) and placed the 60 of 64 in the census at risk as indicated in the facility's Mitigation Plan by failing to: a. Ensure the facility had certified/licensed staff (Director of Nursing and Infection Preventionist) were physically in the facility to oversee the infection control practices in the resident care areas. b. Ensure the facility had a certified/licensed staff (Director of Nursing and Infection Preventionist) to review the line listing (template for investigations of outbreaks) of residents and staff. c. Ensure to have designated units to separate infected resident from uninfected residents and from residents who were waiting on COVID-19 laboratory results. d. Assign dedicated healthcare staff to care for suspected or confirmed COVID-19 residents. e. Ensure infected residents remained in their	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 rooms. f. Instruct staff on how and where to don (put on) and doff (take off) protective personal equipment (PPE). g. Ensure the facility had separate donning and doffing areas from COVID and Non COVID areas. These deficient practices had the potential to result in the spread of infections that could lead to death to other residents and staff. On 5/15/19 at 7:06p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Interim Administrator (IADM) for the facility's failure to implement measures to prevent infection that threatened the health and safety of the residents and staff. On 5/22/20 at 8:15 p.m., after the facility submitted an acceptable plan of action (POA), the survey team verified and confirmed on-site the implementation of the POA by observation, interviews, and record review confirmed the removal of the immediate jeopardy in the presence of the Administrator. The Administrator provided an acceptable POA as follows: 1. Facility protocol on the Cohorting of residents who are positive for COVID-19. 2. Keeping the door of each room with positive COVID-19 residents closed to the hallway at all times, with Isolation cart outside the room by the doorway.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 3. Use of appropriate color-coded signage for confirmed COVID-19 cases, for resident who are still awaiting for test results and for residents with exposure to COVID-19 that are on empiric isolation 4. Staff designated to care only for COVID-19 residents. 5. Proper donning and doffing of Personal Protective Equipment (PPE) 6. Proper Hand Hygiene and preferred use of ABHR/ ABHS (Alcohol-based Hand Rub/ Alcohol-based Hand Sanitizer). Findings: 1. A review of the facility's census, dated 5/14/20, indicated facility had 62 residents residing in the facility. During an observation on 5/14/20 at 5:45 pm, the isolation barrier (a device used to differentiate a hallway area) between the COVID unit (rooms for COVID positive residents) and the Non-COVID unit (rooms for COVID negative residents) was not sealed. There was a zipper opening that was open. During an interview with the Director of Staff Development (DSD) on 5/14/20 at 5:45 pm, she stated that the zipper had been broken and it was not able to seal. The DSD said the facility is aware and needs to fix it. During an observation on 5/15/20 at 10:45 am, the isolation barrier between the COVID and non-COVID side was unzipped and open. During an interview on 5/15/20 at 10:45 am, the Activity Director (AD) stated that facility was aware the zipper was still broken. When asked when it would be fixed, she said she didn't know and the facility would work on it.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 A review of the facility's document indicated the facility census on 5/17/20 was 64 residents, 39 residents who were tested positive with COVID-19, 18 tested with pending results, and seven residents who were Non-COVID-19. 2. During an observation on 5/14/20 at 6:00 pm, Resident 4 was in a room that was in the Non-COVID resident area. The room did not have a sign for isolation precautions. There was no isolation card observed. During an interview on 5/14/20 at 6:15 pm, the DSD confirmed that Resident 4 tested positive for COVID-19. The DSD stated she did not know that the resident was still in that room, and he was supposed to be moved earlier in the day. It wasn't until opening the door and seeing the resident that the DSD knew the resident had not been moved. 3. During an observation on 5/14/20 at 6:20 pm, when entering the COVID unit, the doors to the residents' room were open. During an interview on 5/14/20 at 6:20 pm, the DSD stated that the doors of the COVID positive resident's rooms should be closed, and the DSD instructed the staff present to close all the doors. 4. During an observation on 5/14/20 at 6:30 pm, there was no administration staff in the residents' unit. During an interview on 5/14/20 at 6:45 pm, the IADM stated that she was unable to go up on the unit because of health concerns. When asked who from administration can go up, the IADM stated that the staffs report to her, and she directs the staff remotely from the administrative areas of the building. During an interview on 5/14/20 at 7:00 pm, the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 DSD stated the administrator and Director of Nursing were both out sick. The Infection Preventionist (IP, a person who is an expert on practical methods of preventing and controlling the spread of infectious diseases) nurse was out and could return next week. There was no IP designee during the interim. The DSD stated the IADM is acting as both Director of Nursing and Administrator. 5. During an interview on 5/15/20 at 10:40 am, the IADM stated the AD is acting as her assistant and would be the person to accompany and answer questions during the tour of the facility as the DSD, DON, ADMIN, and IP were all unavailable. During an observation on 5/15/20 at 11:00 am, there was no registered nurse in the residents' care areas. There were two Licensed Vocational Nurses (LVN). During an interview on 5/15/20 at 11:00 am, the AD stated that there were two registry LVNs and no RNs on the unit. The AD stated there was no designee at the time for the Director of Nursing, who was out ill. When asked who the nursing staff report to, she said that the CNAs report to the LVNs, and the LVNs are the supervisors. When asked about the IP, the AD stated the DON was expected back on Monday. She said there was no designee. When asked about staffing assignments, the AD stated the DSD made the assignments before the shift start. 6. During a review of the Staffing Assignments for the 7 am-3 pm shift, on 5/15/20, indicated one CNA and one LVN were assigned to take care of residents, who were positive and negative for	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 COVID-19 at the same time. The Staffing Assignment also indicated LVN 1, who was assigned to South Station (Non-COVID unit) was requested to "go to North Station (COVID unit) to help out." During an interview on 5/15/20 at 11:20 am, the AD stated she did not know the process of how staff was assigned. The AD confirmed that there were mixed case assignments. During an interview on 5/15/20 at 11:25 am, when asked about nursing supervision, the IADM stated Registered Nurse 1 (RN 1) was in the facility's office and could not be in the residents' unit, because she was too busy getting orders from doctors. During an interview on 5/15/20 at 11:45 am, RN 1 stated she was unable to go upstairs (residents' unit) because she had asthma. When asked who was supervising the licensed nurses, RN 1 stated she was available by phone. 7. During an interview on 5/15/20 at 12:00 pm, the IADM stated the process for grouping or cohorting (grouping residents with common infection) residents was currently a two tier process. The IADM stated the facility puts the confirmed negatives in one area, and all others in the other area. When asked about the residents who were in isolation (separating a person with a contagious or infections disiease) and quarantine (confining individuals who may have been exposed to the disease), she stated that the facility does not differentiate at this time. When asked about the process for residents that have been tested as negative but exposed, she said the negative goes to the negative side. When	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 asked to explain the difference between isolation and quarantine, the IAD did not answer. During an interview on 5/15/20 at 12:15 pm, RN 1 stated the facility does not differentiate between isolation and quarantine. That all residents are in the same area until testing negative and then they are moved to the negative area. When asked about mixed exposed (quarantine) residents with negative residents, RN 1 said that if the resident tests negative, they go to the negative side. She said there is no system of isolation versus quarantine. During an interview on 5/15/20 at 7:02 p.m., the IADM stated she did not know which residents were positive or suspected and stated she did not know which residents were pending results. The IADM stated the residents were not separated. The IADM stated she could not go upstairs to oversee the resident care areas, because she did not want to infect herself with COVID-19. 8. During an observation on 5/15/20 at 7:30 p.m., there was one designated donning and doffing area and no separation between COVID area and Non-COVID area, and no separation between clean and dirty. During an interview on 5/15/20 at 7:40 p.m., Licensed Vocational 2 (LVN 2) stated she did not know which residents were negative of COVID-19 and which residents were suspected of COVID-19. 9. During an observation on 5/15/20 at 7:53 p.m., in the COVID area hallway, the residents' room doors were all opened, and there were no isolation carts or signs to indicate if the rooms were isolation. The Nursing Student (NS) was	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 observed walking in the hallway with a blue torn gown. During the concurrent observation, LVN 3 stated the unit was the COVID area. LVN 3 stated the staff from the COVID area and the non-COVID area donned and doffed PPE in the same area mixed with clean and dirty. During an interview on 5/16/20 at 1:20 p.m., Housekeeping 1 (HK 1) stated she did not know which residents were positive or negative. HK 1 did stated she did not know which rooms to clean first. 10. During an interview on 5/16/20 at 2 p.m., Certified Nursing Assistants (CNA 1, CNA 2, and CNA 3) stated they had to reuse the disposable blue gowns for an entire week. 11. During an interview on 5/17/20 at 11:40 a.m., the AD stated she was assigned to do the line listing and did not have the line listing updated and stated she did not know the count of the residents who were positive, negative, and pending results. 12. During an observation on 5/18/20 at 3:21 p.m., Resident 1 walked down the driveway had a surgical mask on and stated with derogatory words that he wanted to leave the facility and entered the first floor, Non-COVID area. During the concurrent interview the AD stated Resident 1 was confirmed positive with COVID-19 and was not compliant to stay inside his room in the COVID unit. The AD stated the facility did not conduct an interdisciplinary (IDT, a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient) meeting to discuss	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 Resident 1's noncompliance, because most of the department heads had confirmed COVID and were sick. The AD stated the facility had no control over Resident 1. Resident 1 was agitated and preferred not to talk. During a telephone interview on 5/21/20 at 10:57 a.m., the facility's Medical Director (MD 1) stated the facility's IADM would not communicate with him regarding current issues in the facility. A review of Resident 1's Admission Record indicated the facility admitted the resident on 12/27/19 with diagnosis of paranoid (an unrealistic distrust of others) schizophrenia (mental illness with unreasonably suspicious of others). A review of Resident 1's History and Physical dated 12/30/19 indicated the resident had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 5/18/20 indicated the resident was cognitively intact for daily decision making. A review of Resident 1's Laboratory Report dated 5/12/2020 indicated 2019 Novel Corona Virus was detected. 13. During an interview on 5/18/20 at 3:35 p.m., the AD stated the facility implemented one entrance for staff caring for COVID and non COVID residents to don PPE. AD stated assigned staff for the COVID area would walk from the donning room to the non-COVID area to get to the COVID area.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 14. During an observation on 5/18/20 at 3:50 p.m., Resident 2 walked in the hallway, and his nose was exposed. The AD told Resident 2 to place the surgical mask over his nose. Resident 2 stated he did not want to cover his nose, walked outside to the parking area, and met with Resident 3. The AD stated Resident 2 was pending results and Resident 3 was confirmed positive. The AD stated the residents were non-compliant to stay inside their rooms. A review of Resident 2's Admission Record indicated the facility admitted the resident on 1/22/2020 with diagnosis of pain on right ankle and joints. A review of Resident 2's MDS dated 5/18/2020 indicated the resident was cognitively intact for daily decision making. A review of the facility's undated form indicated the facility readmitted Resident 2 on 5/16/2020 and the acute general hospital (GACH) indicated the resident tested negative for COVID-19 (unknown date). A review of Resident 3's Admission Record indicated the facility admitted the resident on 1/16/2020 with diagnoses of lack of coordination and alcohol abuse. A review of Resident 3's History and Physical dated 1/17/2020 indicated the resident had the capacity to understand and make decisions. A review of Resident 3's Laboratory Report dated 5/12/2020 indicated 2019 Novel Corona Virus was detected.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 During an interview on 5/18/2020 at 5:20 p.m., the IADM stated she did not know what to do with the residents who were non-compliant and stated she would have to discharge them from the facility. 15. During an observation on 5/18/20 at 4:15 p.m. CNA 4 did not have a gown, gloves, face shield and had a small N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) his nose was exposed in the COVID resident care area. CNA 4 stated his N95 was too small for his face size and his nose was exposed. CNA 4 stated he did not know the instructions on how and where to don and doff his PPE. CNA 4 stated the facility did not fit test him to ensure which N95 was a good size for him. During the concurrent observation, CNA 4 took off the small N95 in the hallway in the COVID unit and tried to don the new N95 and the IP nurse did not guide CNA 4 on where and how to don. During the concurrent observation, the IP nurse had PPE on and used an entrance door from the COVID area to walk to the non COVID area as a short cut. The IP nurse did not doff PPE nor performed hand hygiene to walk to the non COVID area. A review of the facility's Mitigation Management Plan dated 5/12/20 indicated: 1. All residents with COVID-19 infection confirmed by testing, or those residents who were recovering from COVID-19 infection would be separated from residents who are not infected or have unknown infection status were placed in	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 dedicated COVID-19 positive units. 2. Symptomatic residents with suspected COVID-19 infection may remain in their room (if multi-occupancy room, with 6 feet, or as far as possible, between beds and curtains closed) while testing was pending. 3. All residents who were not suspected to be infected with COVID-19 were placed in rooms or units that did not include confirmed or suspected cases, unless they were already cohorted with a symptomatic or confirmed positive roommate. 4. Dedicated healthcare staff would be assigned to care for suspected or confirmed COVID-19 residents during their shift in the designated COVID-19 rooms/ unit. 5. Healthcare Staff should strictly follow basic infection control practices between residents (e.g., Hand Hygiene, cleaning and disinfecting shared equipment). 6. Residents should wear a facemask to contain secretions during transport. If residents cannot tolerate a facemask or one is not available, they should use tissues to cover their mouth and nose. 7. The Director of Nursing Services and the Staff Developer or Infection Preventionist designate consistent staffing teams who directly interact and provide care to residents that are COVID-19 positive. 8. The facility designated Infection Preventionist implements line listing using the facility's "Presumptive & Positive COVID-19 Resident Tracker."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 9. Designated Infection Preventionist initiates Surveillance Mapping of residents that are symptomatic. 10. Ensure isolation carts with isolation supplies and signs are outside the room. 11. Complete staff competency on Handwashing, and proper donning and doffing of Personal Protective Equipment. (include all therapy personnel, engineering/environmental services and administrative staff, etc.) According to the Centers for Disease Control and Prevention (CDC), the disposable gowns are not typically amenable to being doffed and re-used because the ties and fasteners typically break during doffing. Reference: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html#crisis-capacity	F 880		

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

NWAMAKA ORANUSI, RN, MPH, REHS
Chief, Health Facilities Inspection Division
12440 East Imperial Highway, Suite 522
Norwalk, CA 90650
Tel: (562) 345-8884
Fax: (562)409-5096

www.publichealth.lacounty.gov

Letter 10a

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Administrator
Golden Cross Health Care
1450 N. Fair Oaks Avenue
Pasadena, CA 91103

Dear Administrator:

On May 27, 2020, an abbreviated survey for complaint incident no. CA00688967 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Region 1) to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found that your facility was not in substantial compliance with the participation requirements, and the conditions in your facility constituted **immediate jeopardy** to resident health or safety.

[ ] Isolated deficiencies that constitute actual harm that is immediate jeopardy as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (J).

[ ] A pattern of deficiencies that constitute actual harm that is immediate jeopardy as evidenced by the attached "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (K).

[x] Widespread deficiencies that constitute actual harm that is immediate jeopardy as evidenced by the attached "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (L).

On May 15, 2020, immediate jeopardy to resident health and safety was identified.

The immediate jeopardy to resident health and safety was removed on May 22, 2020.

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of

Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS-2567**. Failure to submit an acceptable POC by the due date may result in termination of your provider agreement or imposition of alternate remedies by the CMS and/or State Medicaid Agency.

Providers may now submit their lan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies
The remedies immediately imposed include the following:

[X] Immediate imposition of a civil money penalty.

The Regional Office or the State Medicaid Agency will impose a civil money penalty, and a notice of imposition will be sent to you.

[X] Termination of your provider agreement on November 27, 2020 if substantial compliance is not achieved by that time.

[X] State Monitoring

[ ] Directed Plan of Correction

[ ] Directed In-Service Training

The following remedy will also be recommended for imposition:

[ ] Temporary management effective November 27, 2020. (§488.415)

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective August 27, 2020. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Immediate Imposition of Remedies Required
Irrespective of a state recommendation to impose or not impose a remedy, the CMS RO must immediately impose, without permitting a facility an opportunity to correct deficiencies, one or more federal remedies.

FILING AN APPEAL
If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an

authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Naides Paule, Supervisor, California Department of Public Health, Licensing and Certification Program, Health Facilities Inspection Division 3400 Aerojet Ave. Suite 323. EL Monte, CA 91731.

We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon the subsequent revisit, it is determined your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter will be imposed by the CMS Regional Office beginning on May 27, 2020 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Suzette Leverett-Clark, Assistant Chief, California Department of Public Health, Licensing and Certification Program, Health Facilities Inspection Division 12400 Imperial Highway, Room 522. Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have any questions concerning the instructions contained in this letter, please notify Naides Paule, Supervisor, at (626) 312-1113

Sincerely,

Nwamaka Oranusi, Chief
Health Facilities Inspection Division

Naides Paule, RN, MSN, MPH, CNS
Supervisor Los Angeles Region 1 Complaint Unit

NP:rj

Enclosure: CMS-2567

cc: Mary Lee
Centers for Medicaid and Medicare Services

Exhibit C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey. Complaint Intake: CA00690106 Inspection was limited to the specific entity reported incident/complaint investigated and does not represent the findings of a full inspection of the facility. Census: 64 Highest Scope/Severity=L Representing the California Department of Public Health: Surveyor 36904, RN, HFEN Surveyor 36202, RN, HFEN Surveyor 39230, RN, HFEN Surveyor 37363, RN, HFEN Surveyor 41707, RN, HFEN Surveyor 38740, Dietitian Consultant Surveyor 40994, Pharmacy Consultant There were 13 deficiencies were issued for intake CA00690106.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and	F 583		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 1 telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure medical information by leaving Medication Administration Record (a legal record with list of drugs administered to a patient at a facility) open and unsupervised on top of medication chart in the hallway for one of three zones (Red Zone). This failure had the potential for residents,	F 583		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 2 unlicensed staffs, and visitors to have unauthorized access to the medical records of the residents and resulted to not protecting resident privacy and confidentiality. Findings: During an observation while doing rounds in the Red Zone, on 5/27/20, at 6:21 p.m., the Medication Adminsitration Record (MAR) for facility residents observed open on the top of the medication cart, in the hallway, unsupervised by the licensed nurse. There was no licensed nurse watching over the MAR. Residents and staffs were observed passing by the medication cart where the open MAR was placed. During an interview with the Director of Nursing (DON), on 5/27/20, at 7:19 p.m., DON stated, "Nurses know that they should keep their MAR closed." DON further stated, "I will do an in-service with the staffs tonight."	F 583		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure three of three sampled residents (Resident 1, Resident 2, and Resident 6) who had the Coronavirus (COVID-19, an illness caused by a virus that can spread from person to person) received the necessary care and services in accordance with the resident's care plans to maintain and improve their well-being, as indicated in the facility's policies and procedures. The facility failures included the following: 1. Failed to ensure Resident 1 had clean linen, clean fingernails, wound treatments, water available, and assistance to reposition in bed. 2. Failed to ensure Resident 2 had showers and clean clothes. 3. Failed to ensure Resident 6 received fresh clean drinking water. 4. Failed to ensure the facility had a knowledgeable department head staff and/or staff to oversee the care and treatment practices in the resident care areas specifically in the COVID-19 unit. These deficient practices resulted to Resident 2 stated feeling sad and forgotten, Resident 6 feeling emotionally distress, and had the potential for psychosocial harm that could lead to	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 a negative effect on the residents' health, well-being, and overall quality of care and life for Resident 1 and Resident 2 by the facility's lack to provide care for personal hygiene, clean clothes, and linen. Resident 1 and Resident 6 were at risk for dehydration for not being provided water. Resident 1's wounds at risk of not healing that can lead for worsening wound conditions and infection by not being turned and wound care treatments not being provided. On 5/27/20 at 12:27 a.m., an Immediate Jeopardy (IJ - a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Interim Administrator 1 (IADM1) and Director of Nursing (DON) for the facility's failure to maintain resident personal hygiene including clean clothes and bed linens and wound treatments which could increase the risk of the spread of infections (including COVID-19) to residents which could result in health complications likely resulting in hospitalization or death. Failure to maintain adequate personal hygiene could also result in psychosocial harm that could lead to a negative effect on the residents' health, well-being and overall quality of life. On 5/28/20 at 9:40 p.m., in the presence of the facility's Administrator and Interim Administrator 2 (IADM2), the survey team informed the facility the plan of action for the IJ was not acceptable, the immediate jeopardy was not abated, and the team conducted the exit conference.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5 Findings: a. A review of Resident 1's Admission Record indicated the facility admitted the resident, on 5/23/12, and readmitted, on 5/23/20, with diagnoses of dementia (decline in mental ability severe enough to interfere with daily life), hemiplegia (paralysis of one side of the body), and muscle weakness. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care planning tool), dated 5/31/19, indicated Resident 1 rarely/never makes himself understood and rarely/never able to understand others. During an observation, on 5/26/20 at 5:33 p.m., Resident 1 was lying in a bed had black particles in his fingernails, hair not combed, hospital gown soiled. Resident 1's linens were soiled and wrinkled. Resident 1 said derogatory words in Spanish and that he was thirsty and was uncomfortable. During the concurrent interview, Registered Nurse 2 (RN 2) and RN 3 stated Resident 1 had wounds (undescribed) on his buttocks and right hip. RN 2 and RN 3 stated Resident 1 had eight layers of linen under his buttocks. RN 2 and RN 3 stated the resident had black wound discolorations on his right and left toes and did not have physician treatment orders for the discoloration on his toes. RN 2 and RN 3 stated Resident 1 had pain (no description) earlier during the day from the wounds. RN 2 and RN 3 stated Resident 1 looked unkempt. RN 2 and	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 RN 3 stated they reported Resident 1's condition to multiple permanent staff (unidentified) and to their team leader (TL). During an interview on 5/26/20 at 5:30 p.m. RN 2 and RN 3 stated the Certified Nursing Assistants (CNAs in general) would not shower and reposition the residents and did not see them (CNAs) provide water to the residents. RN 2 and RN 3 stated they were not familiar with the facility's policies and procedures and they provided temporary support to the facility during the COVID-19 crisis. RN 2 and RN 3 stated the department heads would not enter the red zone (COVID area) to supervise resident care areas. During an interview on 5/26/20 at 6:30 p.m., DON stated Resident 1 did not have any treatments done for his black discolored toes and Resident 1's physician had not come to look at his wounds. DON stated she could not find Resident 1's medical record and could not tell the Department the wound sizes and descriptions. DON stated she did not know how long the resident had black discoloration on his toes. b. A review of Resident 2's Admission Record indicated the facility admitted the resident, on 4/8/11, and readmitted, on 3/19/20, with diagnoses of difficulty in walking, Type 1 diabetes Mellitus (a disease in which the body does not make enough insulin [helps balance the blood glucose levels]) to control blood sugar levels, and end stage renal disease (kidney failure)	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 A review of Resident 2's MDS, dated 3/26/20, indicated the resident was cognitively intact for daily decision making and required supervision for dressing, transfers, and walking. A review of Resident 2's untitled care plan, dated 7/5/13, with a revised date 5/26/20, indicated the resident had an Activities of Daily Living (ADL) self-care deficit related to weakness. The interventions included to provide Resident 1 limited assistance with bathing on bath day and as necessary. During an observation, on 5/26/20 at 6:06 p.m., Resident 2 was sitting in bed awake and had dark red stains on his T-shirt. During the concurrent interview, on 5/26/20 at 6:06 p.m., Resident 2 stated the dark red stains on his T-shirt were, "Old blood stains." Resident 2 stated he felt overwhelmed and sad that the staff would not let him take a shower due to COVID-19. The resident stated he had not showered in two weeks and the staff would not assist him to wash his clothes. The resident stated he bled from his dialysis (procedure to remove wastes or toxins from the blood) vascular access (used to access the blood for hemodialysis) on his right arm (could not remember the date) and since then no one assisted him to change his clothes. Resident 2 stated he felt forgotten and that the CNAs in general would not check on him. c. During a concurrent interview and observation, on 5/13/20 at 12:45 p.m., Resident 6 was sitting on a wheelchair and stated the facility staff did	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8 not provide drinking water routinely, and she would have to frequently ask staff and wait a long time (unspecified time). The resident stated she would like to drink cold fresh water. Resident 6 stated the sink water had an unpleasant taste. The resident stated she was sad and stressed. During the concurrent interview, CNA 5 stated the facility did not provide fresh water to the residents because the kitchen staff would not step inside the COVID area to bring water. CNA 5 stated she and other CNAs would get water from the hand washing sink when residents requested. CNA 5 did not respond to the Department's questions on how did they provide water to the residents who were bedbound or unable to ask for water. A review of Resident 6's Admission Record indicated the facility admitted the resident on 7/11/12 readmitted with diagnosis of muscle weakness. A review of Resident 6's MDS dated 5/10/20 indicated the resident was cognitively intact for daily decision making and required supervision while eating and required limited assistance for transfers. A review of Resident 6's untitled care plan with a revision date of 3/5/2020 indicated the resident had the potential for dehydration (excessive loss of body water) and the interventions were to ensure the resident had access to fluids such as cold water. During an interview, on 5/15/20 at 7:02 p.m., the	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 IADM 2 stated she could not go upstairs to oversee the resident care areas, because she did not want to infect herself with COVID-19. The Department attempted various interviews with facility staff (Infection Preventionist [IP], DON, RN1, RN 2, RN 3, LVN 4, LVN 6), from 5/13/20 to 5/28/20, to obtain verbal and documented information related to wound treatments, shower schedules, and hydration schedules, and none of the facility staff attempted to interview were able to answer the Department's questions. During a telephone interview on 5/21/20 at 10:55 a.m., the facility's Medical Director (MD 1) stated IADM 2 did not communicate any issues to him. MD 1 stated the facility was in "Bad shape, no leadership." A review of the facility's undated policy and procedure titled, "Activities of Daily Living (ADL), Supporting," indicated the facility would provide residents with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of ADLs and not diminish. A review of the facility's policy and procedure titled, "Abuse and Neglect-Clinical Protocol," with a revised date of 3/2018 indicated neglect was defined as, "The failure of the facility, its employees or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish or emotional distress."	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide nursing care and services for two of two sampled residents (Resident 1 and Resident 2) during the Coronavirus ([COVID-19]) an illness caused by a virus that can spread from person to person) crisis in accordance to the facility's policy and procedure. 1. For Resident 1, facility's staff did not provide the resident with grooming and personal care to keep the resident clean and comfortable. The facility's nursing staff also failed to assess the resident's skin when he developed wounds on the right hip, and discoloration on bilateral toes. 2. For Resident 2, facility's nursing staff did not provide nursing care when the resident had an abnormal low and high blood sugar levels. The facility's nursing staff also did not check the resident's blood sugar nor administer the right amount of insulin (hormone that helps balance the blood glucose levels). 3. For Residents 1 and 2, the facility's administrative staff did not oversee the nursing	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11 care and treatment practices for both residents due to the residents were residing in the COVID-19 area (area for residents who tested positive for COVID-19). These deficient practices resulted in Resident 1 and 2 received poor quality nursing care and placed the residents at risks for experiencing serious harm that could lead to death (Cross refer to F 686). On 5/27/20 at 12:27p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Interim Administrator 1 (IADM1) and Director of Nursing (DON) for the facility's failure to monitor blood sugar levels, respond to resident emergency calls, and perform wound assessments and care according to the current standard of care that could result in health complications including coma, amputations (the action of surgically cutting off a limb), and infections likely resulting in hospitalization or death. On 5/28/20 at 9:40 p.m., in the presence of the facility Administrator and the Interim Administrator 2 (IADM2), the survey team informed the facility did not submit an acceptable plan of action for the Immediate Jeopardy, the Immediate Jeopardy was not abated, and the team conducted the exit conference. Findings:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12	F 684		

1. A review of Resident 1's Admission Record indicated the facility admitted the resident on 5/23/12 and readmitted him on 5/23/20 with diagnoses including dementia (decline in mental ability severe enough to interfere with daily life), hemiplegia (paralysis of one side of the body), and muscle weakness.

A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/31/19 , indicated the resident's cognition (ability to understand and process information) was severely impaired. The MDS indicated Resident 1 was total dependent on staff for bed mobility, transfer, dressing, toilet use, and personal hygiene and required extensive assistance (resident involved in activity, staff member provides weight bearing support) for eating.

During an interview on 5/26/20 at 4:32 p.m., RN 2 stated the administrative staff would not go upstairs to oversee the nursing care for residents in the COVID area to supervise nursing staff and ensure the residents' received nursing care.

During a concurrent observation and interview on 5/26/20 at 5:30 p.m. Resident 1 was lying in a bed in the COVID-19 unit. The resident had black particles in his finger nails with disheveled appearance (person's hair and clothes are untidy and disordered). Resident 1's linens were soiled and wrinkled . Resident 1 had black discoloration on the resident's right big toe and the left big toe, the 2nd toe, the 3rd toe, and the 4th toe. Resident 1 had a wound of an unknown size with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 yellow exudate (mass of cells and fluid the has seeped out of the blood vessels) in the wound bed. The gauze that covered the wound was tainted with dark brown color and falling off from the wound. Resident 1 mumbled derogatory words in Spanish and stated that he was thirsty and uncomfortable. Registered Nurse 2 (RN 2) and RN 3 stated they were not familiar with the facility's policies and procedures because they are not the permanent staff. They were assigned to provide temporary support to the facility during the COVID-19 crisis. RN 2 and RN 3 stated Resident 1 had wounds on the right hip, discolorations on his right and left toes but the resident did not have a physician's order for wounds treatment. RN 2 and RN 3 stated Resident 1 had wound pain (no description regarding the severity of the pain) and they reported the resident's complaint of pain to multiple permanent staff (unidentified) and to their team leader (TL). RN 2 and RN 3 stated the facility's department heads (administrative staff) did not enter the COVID unit (area for residents who tested positive for COVID) because they did not want to infect themselves with COVID 19. During an interview on 5/26/20 at 6:30 p.m., the Director of Nursing (DON) stated Resident 1 did not receive any wound treatment. The DON stated the physician did not come to assess Resident 1's wounds and she could not find Resident 1's medical record. The DON stated she could not tell the wound sizes, shapes, descriptions and did not know how long Resident 1 had the wounds on his right hip and black discoloration on his toes.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14 During an interview on 5/26/20 at 9:46 p.m., the DON stated she could not locate Resident 1's treatment administration record. During a concurrent interview and review of Resident 1's Nursing Notes on 5/26/20 at 10 p.m., the Director of Staff Development (DSD) stated he could not locate Resident 1 nursing notes regarding the resident's wounds. The DSD stated he did not know about Resident 1's wounds on the right hip and the toes' discoloration. During an interview on 5/27/20 at 2:45 p.m., the DON stated she could not locate Resident 1's medical record. The DON stated Resident 1's primary physician had a new treatment order, but she could not provide the skin or body assessment including the size, shapes, description of the wounds and toes' discoloration. 2. A review of Resident 2's Admission Record indicated the facility admitted the resident on 4/8/11 and readmitted him on 3/19/20 with diagnoses including difficulty in walking, Type 1 diabetes Mellitus (a disease in which the body does not make enough insulin to control blood sugar levels), End stage renal disease (the gradual loss of kidney function). A review of Resident 2's MDS, dated 3/26/20, indicated the resident's cognition was intact for daily decision making and required supervision for dressing, transfers, and walking.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15 During an abbreviated survey from 5/26/20 to 5/28/20, multiple staff including Infection Preventionist (IP, nurse that specialized in infection control and prevention), DON, RN1, RN 2, RN 3, Licensed Vocational Nurse 4 (LVN 4), LVN 6 to obtain verbal and documented information related to resident's physician orders, clarification of insulin and blood sugars but the staff were not able to answer the questions or provide the physician's orders for review. During a telephone interview on 5/21/20 at 10:55 a.m., the facility's Medical Director (MD 1) stated IADM 2 did not communicate any issues at the facility to him. MD 1 stated the facility was in "Bad shape, no leadership." During a concurrent observation and interview, on 5/26/20 at 6:06 p.m., Resident 2 was sitting in bed and stated he felt forgotten. Resident 2 stated due to the COVID-19 crisis he was isolated and nursing staff in general did not check on him. Resident 2 stated that he had abnormal low and high blood sugar levels and that the nurses did not assess him. Resident 2 pulled out a glucometer (a medical device for determining the approximate concentration of glucose in the blood) and stated that a few days ago (could not remember the date), he checked his blood sugar because he was not feeling well and his blood sugar resulted was at 33 (abnormal low, the normal level is 70-100) milligrams per deciliter (mg/dl, unit of measurement). Resident 2 stated he called for help and no one came to assist him. The resident stated he was able to drink a juice that he had	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 near his bedside table. The resident stated the facility had many new nurses and he was not sure if these new nurses administered the right amount of insulin to him . Resident 2 stated some nurses did not come to check his sugar levels, so he checked his own blood sugar. The resident stated he did not feel safe in the facility. During a concurrent interview and review of Resident 2's Medication Administration Record (MAR) on 5/26/20 at 9:12 p.m., the DON stated the resident's MAR dated 5/1/2020 to 5/31/2020 had discrepancies on how nurses administered Lantus (long-acting insulin) and Novolog (fast-acting insulin). The DON stated that on 5/23/20, the resident's blood sugar was 504 mg/dl, (abnormal high) and that there was no documentation in the resident's MAR indicated that the licensed nurse (DSD, Director of staff Developer) contacted the resident's physician. The DON stated nurses need to contact the physician when the resident's blood sugar is abnormally high. The DON stated according to Resident 2's sliding scale (a chart prescribed by the physician for the licensed nurse to determine how much insulin to administer), the nurse need to notify the physician when the resident's blood sugar was more than 401 mg/dl. During an interview on 5/26/20 at 9:30 p.m., the DSD stated he checked Resident 2's blood sugar on 5/23/20 and he did not notify the physician regarding the resident's abnormal blood sugar level of 504 mg/dl. The DSD stated according to the sliding scale, he needs to inform the physician when Resident 2's blood sugar was more than 401 mg/dl.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 During the concurrent interview and a review of Resident 2's MAR, on 5/26/20, at 9:40 p.m., The DON reviewed Resident 2's MAR, dated 5/7/20 and stated the resident's blood sugar levels were 400 mg/dl and the nurse (unidentified) administered 12 units of Novolog insulin to the resident instead of 10 units. The DON reviewed Resident 2's MAR for the month of May and stated on 5/15, 5/19, 5/20, 5/22, 5/23, and 5/26, the assigned nurses did not check the resident's blood sugar levels as ordered by the physician. The DON stated she did not know who oriented the new nurses. The DON stated that the facility had many nurses from the registries (companies maintain lists of nursing personnel), who were not familiar with the facility's policy and residents' care. A review of the facility's policy and procedure, titled "Insulin Administration," with a revised date of September 2014, indicated the nurse should notify the Director of Nursing Services and Attending Physician of any discrepancies, before giving the insulin.	F 684		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 18 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide wound care treatments for seven of seven sampled residents (Residents 1, 4, 6, 7, 8, 9, and 10) as ordered by the residents' physician and according to the facility's policies and procedures by failing to: 1. Assess, notify Resident 1's physician of, implement a treatment, and provide care for Resident 1's black discolorations on his left big toe, left second toe, left third toe, left fourth toe, and on the top of his right big toe. 2. Assess for the location, stage, length, width and depth, presence of exudates (fluid) or necrotic tissue (medical condition in which there are dead cells) of, and provide treatment for Resident 1's pressure ulcer/injuries (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) to his sacrococcyx (buttocks) area and right hip that included location, stage, length, width and depth, presence of exudates (fluid) or necrotic tissue (medical condition in which there are dead cells). 3. Provide treatment and ensure Resident 4 had heel protectors (a medical device usually constructed of foam, air-cushioning, gel, or fiber-filling, and is designed to offload pressure from the heel) on to prevent pressure injury as	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19 ordered by the physician. 4. Provide treatment and ensure Resident 6 received wound treatment on the right hip ordered by the physician. 5. Provide treatment and ensure Resident 7 received skin treatment on her right heel and left lower leg as ordered by the physician. 6. Provide treatment and ensure Resident 8 received treatment for his left buttocks excoriation (scrape). 7. Provide treatment and ensure Resident 9 received treatment for his left foot toes (unidentified which toes) discoloration. 8. Provide treatment and ensure Resident 10 received treatment for superficial abrasions to all his left toes. These deficient practices resulted to Resident 1, 6, 7, 8, 9, and 10 to experience worsening of the wounds, experience pain, and at risk for infection that could lead to hospitalization and may lead to health complications which could result in death (Cross refer to F684). On 5/27/20 at 12:27 a.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility's Interim Administrator 1 (IADM1) and Director of Nursing (DON) for the facility's failure	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20 to provide wound care treatment of pressure injuries and other wound treatments that could result in infection and experience pain for Resident 1, 6, 7, 8, 9, and 10. On 5/28/20 at 9:42 p.m., in the presence of the facility Administrator and Interim Administrator 2 (IADM 2), the survey team informed the facility the plan of action for the six Immediate Jeopardies were not acceptable, the IJ for was not abated, and the team conducted the exit conference. Findings: a. A review of Resident 1's Admission Record indicated the facility admitted Resident 1, on 5/23/10, and was readmitted, on 5/20/20, with current diagnosis for functional quadriplegia (defined as the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the brain or spinal cord), dementia (brain diseases that cause a long-term and often gradual decrease in the ability to think and remember that affect a person's daily functioning), and dysphagia (is a condition of difficulty swallowing due to abnormal nerve or muscle control). A review of Resident 1's Initial History and Physical, dated 1/13/20 indicated Resident 1 able to follow simple command. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21	F 686		

planning tool), dated 5/31/19, indicated Resident 1 rarely/never makes himself understood and rarely/never able to understand others. The MDS indicated Resident 1 required total dependence with bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed), transfer (how resident moves between surfaces including to or from bed, chair, wheelchair, standing position), dressing (how resident puts on, fastens and takes off all items of clothing, includes putting on and or changing pajamas and housedresses), toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfer on/off toilet, cleanses self after elimination, and changes pad), and personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands). The MDS indicated Resident 1 required extensive assistance from staff with eating (how resident eats and drinks, regardless of skill). Resident 1 was always incontinent with urine and bowel. The MDS indicated Resident 1 was at risk for pressure ulcer/injuries.

A review of Resident 1's Braden Scale for Predicting Pressure Sore Risk form (a tool to help health professionals assess a patient's risk of developing a pressure injury dated 3/2/20, indicated Resident 1 assessment score was 14 (Score levels for developing pressure ulcer: 15 to 18 = at risk, 13 to 14 = moderate risk, high risk = 10-12, and very high risk 9 or below).

On 5/26/20 at 4:54 p.m., during an interview with Registered Nurse 2 (RN 2), stated Resident 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

had a "big wound," (unknown size and description) on the coccyx area and right hip. RN 2 stated Resident 1 had a black discoloration on the toes. RN 2 stated there was no treatment order for the Resident 1's black discoloration on the toes. RN 2 stated she unsure if the primary physician was notified of Resident 1's black discoloration on the toes.

On 5/26/20 at 5:30 p.m., during an initial tour on the Red Zone area (COVID 19 positive resident area), Resident 1 was observed awake lying in bed with 8 layers of sheet. Resident 1 right hip observed with unknown size of wound and a yellow colored in the wound bed (dressing was coming off and has dark brown color discharge from the wound). Resident 1's sacrococcyx area observed with unknown size of open wound. Resident 1 observed black discoloration on left big toe, 2nd toe, 3rd toes, 4th toe, and right tip big toe.

On 5/26/20 at 9:46 p.m., during an interview, DON stated she could not locate Resident 1's medical record. The DON stated she did not know about Resident 1's wound, pressure injuries, and black discoloration of the toes. DON stated she could not locate Resident 1's treatment administration record.

On 5/26/20 at 10 p.m., during concurrent interview and record review of Resident 1's medical records, the Director of Staff Development (DSD) stated, he could not locate Resident 1's medical record, and he did not know about Resident1's pressure injuries. DSD stated she verified Resident 1 had no treatment order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23	F 686		

for the right hip pressure injury and black discoloration of the toes. DSD stated no wound/pressure injuries measurement and description. DSD stated Resident 1's black discoloration of the toes did not have an assessment.

On 5/27/20 at 2 p.m., during an interview, the Infection Preventionist (IP) nurse stated they could not locate Resident 1 medical record and did not know where Resident 1 medical record could be located. IP stated she did not know the description and the measurement of Resident 1's pressure injury to right and left hip. IP stated right and left hip was stage 3, but did not know the measurement. IP stated no assessment of Resident 1's toes black discolorations. IP stated the DON did the assessment and report to the primary physician.

On 5/27/20 at 2:45 p.m., during an interview, DON stated she could not locate Resident 1's medical record. The DON stated Resident 1's primary physician had a new treatment order. The DON could not provide the skin and body assessment including the pressure injuries size and description. The DON could not provide her assessment for Resident 1's toes black discoloration.

On 5/27/20 at 2:50 p.m., during an observation, Resident 1 lying in bed on his back. Resident 1's dressing, dated 5/26/20, on the resident's right hip and sacrococcyx areas (the same dressing from placed by RN 2 5/26/20).

On 5/27/20 at 3:30 p.m., during an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24 the Medical Director (MD), who was Resident 1's primary physician, stated he came at the facility at 8:30 a.m. to evaluate other resident. MD stated he did not look and check Resident 1's wound. MD stated IP nurse will assess Resident 1's wound and will report the assessment to him. On 5/28/20 at 6:50 p.m., during an interview, the DON stated she could not provide information who provided the treatment for the residents. On 5/28/20 at 7 p.m., during an interview and concurrent record review of Resident 1's Treatment Administration Records (TAR), the DSD stated the TAR with no initial means treatment was not provided. DSD stated Resident 1 was not provided treatment in the morning. On 5/28/20 at 8:05 p.m., during an interview with the DON, the wound doctor came and checked on Resident 1's pressure injuries and the toes black discoloration. The DON stated there was no skin and wound assessment on Resident 1's medical record. The DON stated the wound doctor would come on Monday (6/1/20). b. A review of Resident 4's Admission Record indicated the facility admitted the resident, on 2/21/13, and readmitted, on 1/16/16, with diagnoses of paraplegia (paralysis of the legs and lower body), and restless legs syndrome (condition that causes an uncontrollable urge to move your legs, usually because of an uncomfortable sensation).	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 A review of Resident 4's MDS, dated 5/9/20, indicated the resident was moderately impaired in cognitive skills and was dependent on staff for transfers. The MDS indicated the resident was at risk for developing pressure ulcers. A review of Resident 4's untitled care plan, revised date of 5/27/20, indicated the resident had the potential for impairment skin integrity and the interventions were to apply bilateral heel protectors. On 5/26/29 at 6:30 a.m., during an interview and concurrent record review of Resident 4's TAR, dated 5/1/2020 to 5/31/2020, DON stated the staff did not apply the heel protectors to the residents heels at all times for skin management and the nurses failed to check for integrity and circulation from May 6 to May 28, 2020. The DON stated she did not know why the staff failed to provide the treatment for the resident. c. A review of Resident 6's Admission Record indicated the facility admitted Resident 6, on 7/11/12, and readmitted, on 10/26/12, with current diagnosis for muscle weakness, difficulty walking, and neuralgia (a stabbing, burning, and often severe pain due to an irritated or damaged nerve). A review of Resident 6's MDS, dated 5/10/20, indicated Resident 6 had moderate impairment with cognition (perception, thought, memory, and ways of processing and structuring information). Resident 6 MDS indicated, Resident 6 required limited assistance from staff with activities of daily living (ADLs) that included bed mobility,	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 26 transfer, dressing, toilet use, and personal hygiene. A review of Resident 6's Wound Consult Progress Notes form, dated 3/12/20, indicated right hip wound was originally created by surgical procedure (unknown) and currently has pressure component. The form indicated plan/orders to clean wound daily with wound cleanser and lightly pack with 0.25% Dakins solution (used to kill germs and prevent germ growth in wounds) and cover with dry dressing. A review of Resident 6's TAR, dated 5/27/20, indicated a treatment order to cleanse right hip wound with wound cleanser pat dry, apply collagen wound dressing (used for dressing for the treatment of partial to full thickness wounds) directly on wound bed, and cover with abdominal pads on the 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift. The TAR, dated 5/27/20 were blank on the 7 a.m. to 3 p.m. shift and 3 p.m. to 11 p.m. shift. The TAR, dated 5/28/20, were blank on the 7 a.m. to 3 p.m. shift. On 5/28/20 at 7 p.m., during an interview and concurrent record review, DSD stated the TAR that was blank and had no initial meant the treatment was not provided. DSD stated the treatment should be provided to Resident 6 on 5/27/20 and 5/28/20. The DSD stated the treatments were not provided to Resident 6. The DSD stated she did not know who was assigned to do the treatment in the morning. On 5/28/20 at 7:25 p.m., during an observation and concurrent interview, Resident 6 stated she	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 27 did not have pain but the wound was dirty because nobody cleaned the wound. Resident 6 right hip open wound unknown size did not have a dressing that cover the wound. d. A review of Resident 8's Admission Record indicated the facility admitted the resident on 5/3/19, with diagnoses of difficulty in walking and muscle weakness. A review of Resident 8's MDS, dated 2/29/20, indicated the resident was intact in cognitive skills for daily decision making and required extensive assistance for transfers and limited assistance with bed mobility. The MDS indicated the resident was at risk for developing pressure injuries. A review of Resident 8's care plan for Potential for pressure ulcer development related to (r/t) immobility and incontinence, initiated date 4/1/20, indicated the interventions that included follow policies and protocols for the prevention/treatment of skin breakdown. On 5/26/29 at 6:30 a.m., during an interview and concurrent record review of Resident 8's TAR, dated 5/1/20 to 5/31/20, DON stated the staff did not apply silvadene (a topical antimicrobial drug) cream 1% and apply a clean dressing every day on review of Resident 8's TAR for May 23 to May 26, 2020, on the resident's left buttock. e. A review of Resident 9's Admission Record indicated the facility admitted the resident on12/7/07 and readmitted him on 6/13/19 with diagnoses of dementia and difficulty in walking.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 28 A review of Resident 9's MDS, dated 5 /18/20, indicated the resident was severely impaired in cognitive skills for daily decision making and required extensive assistance for transfers and limited assistance with bed mobility and transfers. The MDS indicated the resident was at risk for developing pressure injuries. On 5/26/29 at 6:30 a.m., during an interview and concurrent record review of Resident 9's TAR, dated 5/1/20 to 5/31/20, DON stated the staff did not apply Arnica (reduces discolorations) cream daily to the resident's left foot toes as ordered by the physician on Resident 9's TAR from May 7 to May 28, 2020. f. A review of Resident 10's Admission Record indicated the facility admitted the resident, on 2/16/15, and readmitted, on 6/18/20, with diagnoses of muscle weakness and lack of coordination. A review of Resident 10's MDS, dated 5/19/20, indicated the resident was moderately impaired in cognitive skills for daily decision making and required extensive assistance for bed mobility. The MDS indicated the resident was at risk for developing pressure injuries. A review of Resident 10's Progress Notes, dated 5/21/20 and timed at 11:07 a.m., indicated the resident was noted with all left toes with superficial abrasions, and the physician ordered to apply betadine solution to cover with 4X4 (gauze, is used to describe a pre-measured square of gauze cloth, folded once in the middle,	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29 which surgeons and other medical professionals use during surgery or to dress wounds. Dressing). The Department requested multiple times copies of the Physician orders to IP nurse and did not provide. On 5/26/29 at 6:30 a.m., during an interview and concurrent record review of Resident 10's TAR, dated 5/1/20 to 5/31/20, DON stated the staff (in general) did not cleanse the resident's all left toes with normal saline and did not apply betadine daily on review of Resident 10's TAR from May 23 to May 28, 2020. The DON stated she did not know what happened during those dates and could not provide the Department further information. During an abbreviated survey between 5/26/20 and 5/28/20, at different times of the days, the surveyors conducted interviews with multiple facility staff members (IP, DON, RN1, RN 2, RN 3, Licensed Vocational Nurse (LVN 4), LVN 6, DSD) to obtain verbal and documented information related to the wounds, skin assessments, and treatment procedures for g. A review of Resident 7's Admission Record indicated the facility admitted the resident, on10/4/11, and readmitted her, on 2/13/17, with diagnoses of dementia and muscle weakness. A review of Resident 7's MDS dated 2/29/20 indicated the resident was severely impaired in cognitive skills for daily decision making and required extensive assistance for bed mobility and transfers. The MDS indicated the resident was at risk for developing pressure injuries.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 On 5/26/29 at 6:30 a.m., during an interview and concurrent record review of Resident 7's TAR, dated 5/1/20 to 5/31/20, DON stated the staff did not apply betadine (a topical antiseptic that provides infection protection against a variety of germs for minor cuts, scrapes, and burns) on Resident 7's left lower leg bluish discoloration daily as ordered by the physician, and the staff did not apply vitamin A&D ointment (a skin protectant ointment) daily as ordered by the physician on Resident 7's right heel blanchable redness from on May 23 to May 28, 2020. The DON stated she did not know why the treatment was not done. Resident 1, 4, 6, 7, 8, 9, and 10, and the facility staff members did not know the answers to who was supposed to provide wound treatments, the reason why the treatments were not done, assessments to the skin wounds and pressure injures, and they stated, "I don't know." Also, DON stated the facility had numerous number of staff who came from different nursing registries (a business that provides nurses) and were not familiar with the facility. The DON could not answer who was responsible to orient the new nurses to ensure skin treatments were done. A review of the facility's policy and procedure titled, "Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised date of 4/2018, indicated the nurses should describe and document/report the following full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue, pain assessment, current treatments. The policy	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31 and procedure indicated the physician would assist the staff to identify and define any complications related to pressure ulcers. A review of the facility's policy and procedure titled "Wound Care," with a revised date of October 2010, indicated to verify if there was a physician order for wound care	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: 1.Supervise one male resident (Resident X) smoking outside near the exit door of the red zone designated building, and, 2. Four unplugged oxygen concentrator (device used for delivering oxygen to individuals with breathing disorder) were found inside the shower room. This deficient practice had the potential to cause a fire accident of the surrounding areas or the building and placed the residents at risk of accident during shower. Findings:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 1.During an initial tour on May 28, 2020 at 6:10 p.m., Resident X was observed sitting in his wheelchair and smoking outside near the exit door of the red zone designated building alone and without supervision. During a continuous observation, the area which Resident X was found smoking had no sign posted as a " smoking area " and Resident X was not wearing a smoking apron, no ash tray and no fire cigarette butt receptacle can be found near his surroundings. During an interview with Licensed Vocational Nurse (LVN 4) on May 28, 2020 at 6:50p.m., LVN 4 did not know about the facility's smoking policy and could not identify the residents that are classified as independent or supervised smoker. A review of facility's policy titled "[name of facility] Smoking Policy" not dated, " indicated " ...C. Designated Smoking Areas...1. Smokers are allowed to smoke in designated areas within the building and outside the buildings only 2. Supervised smokers can smoke in the designated areas only when being supervised by a staff member or family member. Smoking hours are as follows: ...4:00 PM, 8:00 PM." 2.On May 28, 2020 at 7 p.m., four oxygen concentrators were observed cluttered and obstructing the area of Shower #2. During an interview with the Licensed Vocational Nurse (LVN 1) on May 28, 2020 at 7:10 p.m., LVN 1 confirmed the four oxygen concentrators	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33 should not be placed inside the shower rooms. During an interview with the Certified Nursing Assistant (CNA 2) on May 28, 2020 at 7:20 p.m., CNA 2 confirmed the four oxygen concentrators should not be placed inside the shower rooms. A review for facility policy on oxygen storage was requested on May 28, 2020 at 5:20 p.m.. The facility did not provide copy of their policy and procedure by the end of the survey exit.	F 689		
F 695 SS=K	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide oxygen treatment (oxygen supplement) as the physician ordered for eight of eight sampled residents (Residents 4, 6, 11, 12, 13, 14, 15, and 17), who had COVID-19 (coronavirus, an illness caused by a virus that spread from person to person). 1. For Residents 13 , 12, 6, and 14, the facility failed to provide oxygen treatment and monitor the oxygen saturation (an estimate of the amount of oxygen in the blood) to the residents as the	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 34 physician ordered. The facility also failed to label the resident's humidifier (a device for keeping the air moist) and tubing. 2. For Residents 4, 11, and 17, the facility failed provide oxygen treatment as the correct rate and monitor the residents' oxygen saturation as the physician ordered. The facility also failed to label the residents' oxygen humidifie r and tubing. 3. For Resident 15, the facility failed to provide oxygen treatment as the correct rate and monitor the oxygen saturation every shift as the physician ordered. The facility also failed to obtain an order to titrate the oxygen rate and label the residents' oxygen humidifier and tubing. These deficient practices placed residents 4, 6, 11, 12, 13, 14, 15, and 17 at risks for health complications from COVID-19 including respiratory distress (lack of oxygen in the lung) respiratory infection (infection causes by bacteria or virus in the nose, throat, chest and lung, chest), and hospitalization or death. An immediate jeopardy (IJ, immediate action to correct the deficient practices) was called on 5/27/2020, at 12:27 a.m., to ensure facility's nursing staff provide oxygen treatment, monitor the residents' oxygen saturation as the physician ordered and label the humidifiers the oxygen tubing to prevent complications from respiratory infection. On 5/28/20 at 9:40 p.m., in the presence of the facility Administrator (ADM) and Interim Administrator 2 (IADM 2), the survey team	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 35	F 695		

informed the facility that an acceptable plan of action was not provided, the immediate jeopardy was not abated, and the team conducted the exit conference.

Findings:

1a. A review of Resident 13's Admission Record indicated the resident was originally admitted to the facility on 12/30/16 with diagnosis that included COVID-19 positive.

A review of Resident 13's Minimum Data Set (MDS- a standardized resident assessment and care-screening tool), dated 4/16/20, indicated Resident 13's cognition (a mental process of acquiring knowledge and understanding) was severely impaired. Resident 13 required extensive assistance (staff provide weight-bearing support) with one-person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing, and limited assistance for eating.

A review of Resident 13's laboratory (lab/test) result, dated 5/2/20, indicated the resident was detected (positive) for 2019 nCoV (novel coronavirus- the virus causing coronavirus disease 2019 [COVID-19]).

A review of Resident 13's Physician's Order, dated 5/8/20, indicated for staff to provide the resident with oxygen (O2) inhalation at two liters per minute (LPM) via nasal cannula (NC, a device used to deliver supplemental O2 through the nose) continuously. The Physician's Order indicated for staff to titrate O2 rate up to five LPM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 36 to keep oxygen saturation (O2 sat) at 94 percent (%) and above as needed for shortness of breath (SOB), low O2 sat, wheezing (breathing with a whistling or rattling sound). A review of Resident 13's Physician's Order, dated 5/14/20, indicated for staff to check the resident's O2 sat every shift. During a concurrent observation, interview and record review on 5/26/20, at 6 p.m. with Licensed Vocational Nurse 1(LVN1), Resident 13 did not receive O2 treatment. Resident 13's O2 tubing was on the floor attached to the O2 concentrator (a device that concentrates that concentrates the oxygen in the air and delivers it to the patient) at the rate of two LPM. The resident's humidifier and tubing were not labeled to indicate when was the date that the humidifier and the tubing were changed. LVN 1 stated Resident 13 did not receive O2 treatment. LVN 1 stated the O2 humidifier and tubing were being changed every week but staff (unidentified) did not label them. LVN 1 stated nursing staff need to label the humidifier and oxygen tubing to ensure they are being changed weekly to prevent respiratory infection. LVN 1 reviewed Resident 13's Medication Administration Record (MAR) and stated the Physician Order indicated for staff to monitor the resident of O2 sat every shift and provide O2 at two LPM as needed (PRN). LVN 1 reviewed Resident 13's MAR for the month of May 2020 and indicated the O2 administration and O2 sat monitoring sections were blank. LVN 1 stated the O2 administration and O2 sat monitoring sections had no documentation indicating staff were providing O2 treatment and	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 37	F 695		

monitored O2 sat for Resident 13. LVN 1 stated facility's staff need to follow the Physician's order and provide continuous O2 treatment as prescribed to prevent respiratory distress.

1b. A review of Resident 2's Admission Record indicated the resident was originally admitted to the facility on 9/1/04 and readmitted on 11/10/15 with diagnoses that included COVID-19 and chronic obstructive pulmonary disease (COPD, chronic inflammatory lung disease that causes airway obstruction and increased shortness of breath).

A review of Resident 12's MDS, dated 4/18/20, indicated the resident's cognition was severely impaired. Resident 12 required extensive assistance with one-person physical assist for transfer, dressing, toilet use, personal hygiene, and bathing.

A review of Resident 12's lab result, dated 5/2/20, indicated the resident was tested positive for 2019 nCoV.

A review of Resident 12's Physician's Order, dated 5/8/20, indicated for staff to provide O2 inhalation at two LPM via NC continuously. The Physician's Order indicated staff may titrate O2 rate up to five LPM to keep the resident's O2 sat at 94 % and above as needed for SOB, low O2 sat, and wheezing.

During a concurrent observation, interview, and record review on 5/26/20, at 6:40 p.m., with the Infection Preventionist (IP, nurse that specialized in infection control and prevention),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 38	F 695		

Resident 12 did not receive O2 treatment. The IP reviewed Resident 12's Physician's Order and stated there is an order for staff to provide O2 treatment and monitor O2 sat for the resident. A reviewed of Resident 12's MAR for the month of May 2020 (5/1/2020 to 5/31/20) indicated the O2 administration section was blank. The IP stated Resident 12 did not receive continuous O2 treatment at two LPM as indicated in the Physician's Order . The IP stated there was no documentation indicating facility's staff monitored Resident 12's O2 sat to ensure the resident's O2 sat was at 94% and above.

1c. A review of Resident 6's Admission Record indicated the resident was originally admitted to the facility on 7/11/12 and readmitted on 10/26/12 with diagnoses that included COVID-19 and other respiratory disease.

A review of Resident 6's MDS, dated 5/4/20, indicated the resident's cognition was intact. Resident 6 required limited assistance with one-person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing.

A review of Resident 6's lab result, dated 5/3/20, indicated the resident was tested positive for 2019 nCoV.

A review of Resident 6's Physician's Order, dated 5/8/20, indicated for staff to provide O2 inhalation at two LPM via NC continuously. The Physician's Order indicated staff may titrate the O2 rate up to five LPM to keep the resident's O2 sat at 94 % and above as needed for SOB, low

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 39 O2 sat, and wheezing. During a concurrent observation, interview, and record review on 5/26/20, at 6:45 p.m., with the IP, Resident 6 did not receive O2 treatment. The O2 concentrator and the O2 tank were not at the bedside. Resident 6 denied any SOB at this time. The IP reviewed Resident 6's Physician's Order and stated that the Physician ordered for the resident to receive continuous O2 and to monitor the O2 sat. The IP reviewed Resident 6's MAR for the month of May 2020 and stated the O2 administration was blank. The IP stated there was no documentation indicating Resident 6's O2 sat was monitored to ensure the resident's O2 sat was at 94% and above. 1d. A review of Resident 14's Admission Record indicated the resident was originally admitted to the facility on 3/18/19 with diagnoses that included COVID-19 and other respiratory disease. A review of Resident 14's MDS, dated 5/31/20, indicated the resident's cognition was moderately impaired. Resident 14 required supervision with set up for bed mobility, transfer, dressing, toilet use, and bathing. Resident 14 was independent for eating and personal hygiene. A review of Resident 14's lab result, dated 5/3/20, indicated the resident was positive for 2019 nCOV. A review of Resident 14's Physician Order, dated 5/8/20, indicated for staff to provide O2 inhalation at two LPM via NC continuously. The	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 40	F 695		

Physician Order indicated staff may titrate O2 rate up to five LPM to keep O2 sat at 94 % and above as needed for SOB, low O2 sat, and wheezing.

A rereview of the Physician Order, dated 5/14/20, indicated for staf f to check O2 sat every four hours for O2 use.

During a concurrent observation, interview and record review on 5/26/20, at 6:50 p.m., with the IP, Resident 14 did not receive O2 treatment. The O2 concentrator and O2 tank were not at the bedside. Resident 14 denied any SOB at this time. The IP reviewed Resident 14's Physician Order and indicated for staff to provide continuous O2 treatment and monitor of O2 sat.

A review of Resident 14's MAR for the month of May 2020 indicated the O2 administration section was blank. The IP stated Resident 14 did not receive continuous O2 at two LPM as prescribed. The IP stated there was no documentation indicating the staff monitored Resident 14's O2 sat . The IP stated the staff needs to follow the Physician Order for O2 administration and O2 sat monitoring.

2a. A review of Resident 4's Admission Record indicated the resident was originally admitted to the facility on 2/21/13 and readmitted on 1/16/16 with diagnoses that included congestive heart failure (CHF, a chronic condition in which the heart does not pump blood as well as it should) and late onset cerebellar ataxia (a disorder that occurs when the area of the brain responsible for controlling gait and muscle coordination

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 41 becomes inflamed or damaged). A review of Resident 4's MDS, dated 5/9/20, indicated the resident's cognition was moderately impaired. Resident 4 was totally dependent on staff with one person physical assist for transfer, dressing, toilet use, personal hygiene, and bathing. A review of Resident 4's lab result, dated 5/11/20, indicated the resident was tested positive for SARS-COV-2 A review of Resident 4's Physician Order, dated 5/12/20, indicated for staff to start O2 treatment at two LPM via NC. The Physician Order indicated staff may titrate the O2 up to five LPM if O2 sat is below 90 %. During a concurrent observation, interview and record review on 5/26/20, at 6:05 p.m., with LVN 1, Resident 4 was receiving O2 treatment at four LPM via NC. The NC connected to a humidifier and O2 tubing were not labeled with a change date. LVN 1 stated the O2 humidifier and tubing were changed every week but there were no labels indicated the date they were changed. LVN 1 stated labels with dates need to be available for staff to change the O2 humidifier and tubing on time to prevent infection. LVN 1 reviewed Resident 4's Physician Order and MAR for the month of May 2020 and stated the Physician Order indicated for staff to provide O2 treatment at two LPM but the MAR indicated for staff to provide Oxygen treatment PRN. LVN 1 stated the MAR for the month of May 2020 indicated O2 administration was blank and there	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 42	F 695		

was no documentation indicated the staff was monitoring Resident 4's O2 sat to keep it at 90% and above. LVN 1 stated the staff need to provide O2 administration as prescribed by the Physician to prevent respiratory distress. LVN 1 stated the staff need to monitor Resident 4's O2 sat and document the O2 sat reading in the MAR. LVN 1 stated the staff need to know the O2 sat reading for Resident 4 in order to titrate the O2 administration as the Physician ordered.

2 b. A review of Resident 11's Admission Record indicated the resident was
originally admitted to the facility on 6/25/04 and readmitted on 5/22/18
with diagnoses that included COVID-19 and COPD.

A review of Resident 11's MDS, dated 5/9/20, indicated the resident's cognition was severely impaired. Resident 11 was totally dependent on staff with one-person physical assist for bed mobility, transfer, dressing, toilet use, personal hygiene, and bathing. The MDS indicated the resident received O2 therapy and on isolation (area for people with contagious or infectious diseases) or quarantine (a place for people have been exposed to infections are contagious disease are placed) for active infectious disease.

A review of Resident 11's lab result, dated 5/2/20, indicated the resident was tested positive for 2019 nCoV.

A review of Resident 11's Physician Order, dated 5/8/20, indicated for staff to provide O2 inhalation at two LPM via NC continuously. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 43 Physician Order indicated the staff may titrate the O2 rate up to five LPM to keep O2 sat at 94 % and above as needed for SOB, low O2 sat, and wheezing. During a concurrent observation, interview and record review on 5/26/20, at 6:35 p.m., with the IP, Resident 11 was receiving O2 at three and half LPM via NC. The O2 humidifier and tubing were not labeled with a change date. The IP reviewed the Physician Order and stated there was an order for O2 at two LPM. The IP reviewed Resident 11's MAR for the month of May 2020 and stated the O2 administration section was blank. The IP stated there was no documentation i ndicating the staff monitored Resident 11's O2 sat to ensure the resident O2 sat remain at 94% and above. 2c. A review of Resident 17's Admission Record indicated the resident was originally admitted to the facility on 8/5/19 with diagnoses that included COVID-19, cough, and other respiratory disease. A review of Resident 17's MDS, dated 5/2/20, indicated the resident's cognition was moderately impaired. Resident 17 required extensive assistance with one-person physical assist for bed mobility, transfer, dressing, toilet use, and personal hygiene. A review of Resident 17's lab result, dated 5/2/20, indicated the resident was tested positive for 2019 nCoV. A review of Resident 17's Physician Order, dated	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 44 4/29/20, indicated for staff to provide continuous O2 at two LPM via NC. The Physician Order indicated staff may titrate the O2 up to five LPM, to maintain O2 sat equal to or greater than 92%, and check O2 sat every shift. During a concurrent observation, interview and record review on 5/26/20, at 6:55 p.m., with the IP, Resident 17 was receiving O2 at four LPM via NC. The O2 humidifier and tubing were not labeled with the change date. The IP reviewed Resident 17's Physician Order and stated the resident had an order for continuous O2 at two LPM and to monitor O2 sat every shift. The IP reviewed Resident 17's MAR for the month of May 2020 and stated the O2 administration section was blank. The IP was unable to explain why Resident 17's O2 treatment was at four LPM and not at two LPM as indicated in the Physician's Order. The IP stated the staff did not monitor Resident 17's O2 sat to monitor how many liters of O2 to titrate and administer in order to keep the resident's O2 sat at 93% or greater. During an interview on 5/26/20, at 7:05 p.m., the IP stated the O2 humidifier and tubing were changed every week but there was no label indicating the date that they were changed. The IP stated O2 humidifier and tubing need to be labeled and changes timely to prevent infection. The IP stated the staff need to provide O2 administration at the correct rate, monitor O2 sat, and document the O2 sat reading in the MAR. The IP stated if the order for O2 indicated continuously, the O2 treatment need to be given continuously. The IP stated the staff need to	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 45 follow the Physician Order for O2 administration and O2 sat monitoring to prevent respiratory distress. The IP stated the O2 sat should be monitored for residents who were tested positive of COVID 19 and are on O2 to assess and know if needed to be titrated as ordered. The IP stated the residents diagnosed with COVID-19 should be monitored for O2 sat and administer O2 treatment with the correct rate due to potential for SOB. 3. A review of Resident 15's Admission Record indicated the resident originally admitted to the facility on 8/30/18 and readmitted on 1/12/19 with diagnoses that included COVID-19 and COPD. A review of Resident 15's MDS, dated 5/1/20, indicated the resident's cognitive skills for daily decision-making was moderately impaired. Resident 15 was totally dependent on staff for bed mobility and transfer, required extensive assistance with one-person physical assist for dressing, toilet use, and bathing. The MDS indicated Resident 15 received O2 therapy and on isolation or quarantine for active infectious disease. A review of Resident 15's lab result, dated 4/27/20, indicated the resident was tested positive for 2019 nCoV. A review of Resident 15's Physician Order, dated 4/22/20, indicated for staff to administer O2 treatment at two LPM via NC continuously for SOB. The Physician Order	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 46	F 695		

indicated the staff may titrate the O2 rate to keep O2 sat greater than 92 %, and check O2 sat every shift. The MD order had no specific O2 rate to be titrated.

A review of Resident 15's MAR for the month of May 2020, indicated the staff administer O2 to the resident at two LPM and O2 sat range from 92% to 98% as of 5/26/20. There was no documentation of O2 sat on 5/17/20 for day shift, 5/19/20 to 5/20/20 for day and evening shift, 5/21/20 for evening and night shifts, 5/22/20 for evening shift, and 5/23/20 for night shift. O2 sat was not monitored every shift as ordered by the Physician.

During a concurrent observation, interview, and record review on 5/26/20, at 7 p.m., with the IP, Resident 15 was receiving O2 at five LPM via NC. The O2 humidifier and tubing were not labeled with a change date. The IP stated the O2 humidifier and tubing were changed every week and it should be labeled to know when it was change. The IP reviewed Resident 15's Physician Order and stated the resident has an order for O2 at two LPM and to monitor O2 Sat every shift. The IP stated the staff need to follow the Physician order for O2 administration to prevent respiratory distress. The IP stated the O2 sat should be monitored every shift as ordered to assess and know if needed to be titrated. The IP stated there should be an order for how many liters of O2 to titrate and administer to Resident 15. The IP stated the residents who were diagnosed with COVID-19 need to be monitored for O2 sat due to potential for SOB. The IP was unable to explain why Resident 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 47 had O2 at five LPM and not at two LPM per the Physician ordered. A review of the facility's policy and procedure (P&P), titled "Oxygen Administration," effective date 1/1/18, indicated for staff to provide safe oxygen administration such as verify the Physician's order, review the physician's order or facility protocol for oxygen administration. The policy indicated before administering oxygen and while the resident is receiving oxygen therapy, staff to assess the resident for signs and symptoms of cyanosis (bluish or purplish discoloration of the skin or mucous membranes), hypoxia (inadequate supply of oxygen), oxygen toxicity (when a person is exposed to high level of oxygen in a short period of time), vital signs , lung sounds (Breath sounds come from the lungs when you breathe in and out), oxygen saturation. The policy indicated after completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record included all assessment data obtained before, during, and after the procedure and the signature and title of the person recording the data.	F 695		
F 698 SS=J	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 48 Based on observation, interview and record review, the facility's nursing staff failed to monitor and identify hemodialysis (process of purifying the blood of a person whose kidneys are not working normally) complications for one of one sampled resident (Resident 2) after the resident returned from the dialysis center (a place that provides hemodialysis treatment and services), by failing to: 1. Ensure licensed nurses assessed and monitored Resident 2's right upper arm arteriovenous fistula [AV fistula, a connection between an artery (blood vessel that carries oxygen and nutrients away from the heart) and vein (blood vessel that takes oxygen-poor blood back to the heart) made by the surgeon (physician qualified to practice surgery) used to remove and return blood during hemodialysis) for bleeding as indicated in the resident's care plans. 2. Monitor Resident 2's right upper arm AV fistula for bruit [a rumbling sound that the one can hear via a stethoscope (a medical instrument for listening to the action of someone's heart or breathing) at the AV site], and thrill (a rumbling sensation that one can feel by the fingertip at the AV site) as indicated in the facility's policy and procedure. 3. Ensure the dialysis emergency kit (emergency kit with supplies to stop the bleeding at the AV site such as gauzes and tape) was available at Resident 2's bedside for staff to use during a bleeding emergency.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 49 4. Ensure the facility had a knowledgeable department head staff to oversee Resident 2's nursing care while the resident is in the COVID-19 unit [a unit for residents who were tested positive for COVID-19 (COVID-19, a disease caused by a new coronavirus that was identified in 2019. It spread from person to person throughout the world. COVID-19 symptoms can range from mild or no symptom to severe illness including fever, cough, shortness of breath or death). These deficient practices placed Resident 2 at risk for life threatening emergencies due to bleeding from the AV fistula. On 5/27/20 at 12:27 a.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Interim Administrator 1 (IADM1) and Director of Nursing (DON) for the facility's failure to respond Resident 2's emergency situation that could have led to a significant bleeding event that likely would have resulted in harm or death. On 5/28/20 at 9:40 p.m., in the presence of the facility's Administrator (ADM) and IADM 2, the survey team informed the facility that they did not provide an acceptable plan of actions for the six immediate jeopardies, the six immediate jeopardies were not abated, and the team conducted the exit conference. Findings:	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 50 A review of Resident 2's Admission Record indicated the facility admitted the resident on 4/8/11 and readmitted him on 3/19/20 with diagnoses of difficulty in walking, Type 1 diabetes Mellitus [a disease in which the body can not balance the blood glucose levels), End Stage Renal Disease (ESRD, final stage of kidney failure), and dependence on hemodialysis. A review of Resident 2's Physician Order, dated 3/6/2020, indicated the resident was receiving hemodialysis at the dialysis center three times a week (Monday, Wednesday and Friday). A review of Resident 2's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/26/20, indicated the resident's cognition (ability to understand and process information) was intact for daily decision making. The MDS indicated Resident 2 required supervision for dressing, transfers, and walking. A review of Resident 2's untitled care plan dated 7/5/13 with a revision date of 5/26/20, indicated the resident was at risk for hemodialysis complications due to ESRD. The interventions were for staff to check the AV shunt site on the resident's right arm for signs and symptoms of redness, swelling, pain, discoloration, and bleeding especially after dialysis. The care plan indicated Resident 2 was tested positive for COVID-19. During an interview on 5/26/20 at 4:32 p.m., RN 2 stated the administrative staff would not go	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 51 upstairs to oversee the nursing care for residents in the COVID area to supervise nursing staff and ensure the residents' received nursing care. During a telephone interview on 5/27/20 at 3:29 p.m., the facility's Medical Director 1 (MD 1) stated IADM 2 did not communicate any issues regarding Resident 2 to him. MD 1 stated the facility was in "Bad shape, no leadership." During an interview on 5/26/20 at 5:30 p.m., Registered Nurse 2 (RN 2) and RN 3 stated they are not familiar with the facility's policies and procedures because they providing temporary support to the facility during the COVID-19 crisis. RN 2 and RN 3 stated the department heads did not enter the red zone (COVID area) to supervise residents' care areas. During a concurrent observation and interview on 5/26/20 at 6:06 p.m., Resident 2 was sitting in bed awake. Resident 2's T-shirt had dark red stains. Resident 2 stated the dark red stains on his T-shirt were "old blood stains." The resident stated a few days prior (could not remember the date), after he returned from the dialysis center, he bled from his AV fistula. Resident 2 stated he had to hold pressure with his bare hands for more than twenty minutes while staff were looking for supplies to stop the bleeding. Resident 2 stated staff had not assist him to change his clothes. Resident 2 stated he felt forgotten especially due to the Coronavirus crisis Resident 2 stated staff in general did not check on him and the licensed nurses did not check his AV fistula for bruit or thrill. Resident 2 stated he did not feel safe in the facility.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 52 During a concurrent observation and interview on 5/26/20, at 9:12 p.m., there was no dialysis emergency kit at Resident 2's bedside. The DON stated there was no dialysis emergency kit at Resident 2's bedside. The DON stated an emergency kit need to be accessible/available at the Resident 2's bedside for staff to use to stop the bleeding in case the resident's AV fistula bleeds again. During a concurrent interview and record review on 5/26/20, at 9:15 p.m., Resident 2's Medication Administration Record (MAR), dated 5/1/2020 to 5/31/2020, indicated the sections for staff to monitor the resident's AV fistula for bleeding, bruit and thrill, dated 5/14 (night shift), 5/15 (morning and evening shift), 5/20, 5/21, 5/22 (evening shift), and 23 (night shift) were left blank. The facility's Director of Nursing (DON) stated facility's licensed nurses did not monitor the resident's AV fistula for bleeding, bruit and thrill on those dates and shifts. The DON stated she could not find evidence that the licensed nurses assessed the resident before and after the resident received hemodialysis. The DON stated she could not find the "dialysis binder." She continued to state the facility was disorganized and had multiple new staff who did not receive orientation and training. During an interview on 5/28/20 at 7:16 p.m., Certified Nursing Assistant 2 (CNA 2) stated he was assigned to Resident 2 and he did not know where to find the resident's dialysis emergency kit.	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 53 A review of the facility's policy and procedure, titled "Hemodialysis Access Care," with a revised date of September 2010, indicated for staff to check the AV fistula for signs of infection, patency for bruit and thrill. The policy indicated if there was major bleeding from the AV site, staff need to apply pressure to the insertion site, contact emergency services and dialysis center. The policy indicated for staff to not leave the resident alone because it is a medical emergency.	F 698		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 54 §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that licensed and non-licensed nurses had the specific competencies to handle residents affected by corona virus disease (COVID-19 [a disease that cause a respiratory illness]). This deficient practice had the potential for the facility staff to provide improper care of the residents and spread the virus infection to all residents (universe of 65 residents) and staff. Findings: During an interview with the Certified Nursing Assistant 8 (CNA 8) on 5/27/20, at 6:32 p.m., CNA 8 confirmed that she was from a registry. CNA further stated that she was not oriented to the facility or in-serviced on procedures for handling COVID-19 residents. During an interview with the Director of Nursing (DON) on 5/27/20, at 7:30 p.m., the DON was not sure if the registry licensed and non-licensed nurses have undergone competencies on COVID-19. The DON stated "It's up to the DSD (Director of Staff Development) to check the competencies of the registries".	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 55 During an interview with the Licensed Vocational Nurse (LVN 3) on 5/27/20, at 8:40 p.m., LVN 7 confirmed that he was from registry and was not oriented or in-serviced for handling COVID-19 residents. A review of facility's record sheets for competency for COVID-19 indicated that CNA 8 and LVN 7's names were not found in the facility record for COVID-19 competencies.	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 56 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: 1. Check the blood pressure, heart rate, and respiratory rate before administering Morphine (a controlled substance that can treat moderate to severe pain) medication for one of five investigated residents during narcotic medication check (Resident 16). This failed practice had the potential of Resident 16 to experience adverse reactions, and 2. Reconcile controlled pain medications for one of five investigated residents during medication administration (Resident 16). The deficient practice had the potential for residents' pain level to not be alleviate or manage as ordred by the physician and cause unnecessary pain and psychosocial, mental, and physical discomfort. Findings: 1. A review of Resident 16's Morphine Bubble Pack (a small package containing designated sealed compartments for medications to be taken	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 57 at particular day) was conducted on 5/27/20 at 6:48 p.m. The instructions on the Morphine bubble pack indicated to take medication one tablet by mouth every twelve hours for pain management, and to hold if Resident 16 was lethargic, if respiratory rate was less than fifteen per minute, if heart rate was less than fifty, or if systolic blood pressure (the top number on the blood pressure that refers to the amount of pressure in the arteries during the contraction of heart muscle) was less than one hundred. During a review of Resident 16's Face Sheet (Admission Record) indicated Resident 16 was admitted to the facility on 12/31/19 with diagnoses which included Essential Hypertension (abnormal blood pressure). During an interview with the Licensed Vocational Nurse 1 (LVN 1), on 5/27/20, at 6:54 p.m., LVN 1 confirmed that they were not checking Resident 16's respiratory rate, heart rate, and blood pressure before administering the Morphine medication. LVN 1 stated, "We do not check the parameters, because it's not written in the medication sheet." During a review of the clinical record for Resident 16's Medication Administration Record. for 5/2020, indicated there were no instructions to check the blood pressure, heart rate, and respiratory rate before administering the Morphine medication. A review of the facility's policy and procedure titled, "Miscellaneous Special Situations", undated, indicated, "Black Box Warning	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 58 Medications: ...E. The nursing staff is expected to be knowledgeable concerning the use, usual side effects, and proper administration of medication ... G. Nursing Staff shall include the appropriate monitoring parameters on the resident specific care plan as appropriate ..." 2a. During a review of Resident 16's Narcotic and Hypnotic Record for medication, "Morphine Sulfate ER," (a controlled substance that can treat moderate to severe pain) 30 milligrams (a unit of weight equal to thousandth of gram), on May 26, 2020, at 6:39 p.m., indicated that there were fifty-five pills available for Resident 16 as dated and signed by licensed nurses. During a review of Resident 16's Morphine Sulfate, two bubble packs, on 5/26/20 at 6:44 p.m., indicated and counted on the first bubble pack that there were thirty pills available. On the second bubble pack, there were twenty-six pills available, for a total of fifty-six pills available for use by Resident 16. There was one extra pill in the bubble pack. The Morphine medication was signed off by the nurse as given on the Narcotic and Hypnotic Record, but there was an extra pill in the bubble pack that had not been given. b. Review of Resident 16's Narcotic and Hypnotic Record on 5/26/20, at 6:52 p.m., it was noted for medication "Hydrocodone-APAP (a controlled medication to treat moderate to severe pain) 5-325 milligrams (unit of measurment), indicated that there were seventeen pills available for Resident 16, as dated and signed by licensed nurses.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 59 During a review of Resident 16's Hydrocodone-APAP 5-325 milligrams bubble pack, on 5/26/20, at 6:56 p.m., sixteen pills were observed in the bubble pack available for use by Resident 16. There was one missing pill of Hydrocodone-APAP in the bubble pack that had been given to Resident 16, but not signed off by the nurse on the Narcotic and Hypnotic Record. During an interview with the Licensed Vocational Nurse 1 (LVN 1), on 5/27/20 at 7:08 p.m., LVN 1 stated that she did not do narcotic count when she came in for her shift because she was late. During an interview with the Director of Nursing (DON), on 5/27/20 at 7:23 p.m., DON stated, "The nurses should count the narcotic every shift, it's their responsibility to count it on the start and end of their shift."	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 60 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure medications, including narcotics (a drug affecting mood or behavior that may be sold or used illegally), by leaving medication carts unlocked in the hallway and by leaving the medication keys laying on top of the medication carts for two of three zones (Green and Red zone). This failure had the potential for residents, visitors, and unlicensed staffs to have access to the medications in the cart, and a potential for harm as a result of ingestion of unprescribed medications for residents, visitors, and unlicensed staffs. Findings: 1. During an observation while doing rounds in the Green Zone area, on 5/26/20, at 7:24 p.m., Licensed Vocational Nurse 2 (LVN 2) went inside resident's room and left the medication cart unlocked and placed the keys on top of the medication cart. Residents and staffs were observed passing by the unlocked medication	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 61 cart. During an interview with the LVN 2, on 5/26/20, at 7:31 p.m., LVN 2 stated, "I'm sorry I forgot to lock it but I'm supposed to lock it." 2. During an observation while doing rounds in the Red Zone area, on 5/27/20, at 6:12 p.m., it was found that one medication cart had been left unlocked and unsupervised by the licensed nurse. No licensed nurse was there and watching over the medication cart. Residents and staffs were observed passing by the unlocked medication cart. 3. Upon further observation in the Red Zone area, on 5/28/20, at 7:04 p.m., it was found that the medication keys, which included the keys for the narcotic medications were left unattended on top of one of the medication carts in the hallway. Several residents and staff were observed passing by the medication cart with the medication keys laying on top.	F 761		
F 812 SS=L	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 62 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to develop and implement a system to identify, report, monitor, and control unsafe food sanitation practices in the facility kitchen that provides food services for 65 of 65 residents in the facility. The facility failures included the following: 1. The dirty food cart from the COVID- 19 (an illness caused by a virus that can spread from person to person) positive resident care area was rolled back into the kitchen and placed next to food preparation area. Dietary Staff 2 (DS 2) started wiping the dirty food cart next to the food preparation area during dinner tray line service. 2. The evening nourishment snacks in tray cart that included cartons of milk, juice, Jell-O, peanut butter and jelly sandwiches, high protein shakes (nutritional supplement) were not labeled with time, date and resident name. The foods in the nourishment snacks in tray cart required Time and Temperature control for safety (a food that requires time/temperature control for safety (TCS) to limit pathogenic microorganism growth or toxin formation).	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 63 3. The two dietary staffs (Cook 1 and Dietary Staff 2), who were the only two staff in the kitchen did not practice personal hygiene and follow sanitary food preparation. The two staff were not wearing facial hair restrain (beard covers) and hair net in the kitchen. Dietary Staff 2 (DS 2) did not change gloves and wash hands when moving from dirty task to clean task. The facility had only one staff to accomplish task of tray delivery and assist in tray line. Staff personal belongings including empty bottle of alcoholic beverage was stored in the facility walk in refrigerator. This had the potential to cross contaminate resident food in the refrigerator and cause food borne illness. 4. The facility did not serve the dinner meals of the 10 residents in the timely manner 5. The facility kitchen staff did not check the food temperature prior to serving the food, did not wear gloves while serving facility residents' food, and were serving the food cold to the residents. These deficient practices had the potential to cross-contaminate food served to the 65 residents in the facility. The dirty trays carts that were brought in came from the COVID-19 positive care areas and sanitizing the tray carts next the other food preparation area placed the remaining residents being served at risk for exposure and/or developing infection from COVID-19. The residents receiving the unlabeled nourishment snacks were at risk for getting the wrong snacks, and at risk for food borne illness when serving foods that required	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 64 TCS, which could cause health complications leading to hospitalization or death. The two dietary staffs not wearing beard cover and hairnet in the kitchen, and the unsanitary food preparation practices placed the 65 residents at risk for cross-contamination and at risk for food borne illness that can be acquired from the dietary staffs serving the foods. On 5/27/20 at 12:27 a.m., the Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was called in the presence of the facility administrator, Interim Administrator and DON. The facility administrator and DON present were informed of the unsanitary dietary staff practices to clean the dirty cart, the lack of labeling and monitoring nourishment that required TCS to make sure the nourishment snacks were safe for consumption and were served to right residents. The facility was also informed of the two dietary staffs' unsanitary food preparation practices in the kitchen. On 5/28/20 at 9:40 p.m., in the presence of the facility Administrator and Interim Administrator 2 (IADM 2), the survey team informed the facility that an acceptable plan of action was not provided or reviewed, the immediate jeopardy was not removed, and the team proceeded with the exit conference. Findings: 1. During a kitchen tour observation, on 5/26/20	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 65 at 5:19 p.m., DS 2 brought in dirty food carts and placed them in the kitchen next to the steam table where dinner was being served. DS 2 proceeded to wipe the carts in the middle of the kitchen. DS 2 was using disposable cloth that was stored in the sanitizer bucket. DS 2 was wearing gloves, did not have a hairnet, and was carrying her personal backpack. During a concurrent interview, on 5/26/20 at 5:19 p.m., DS 2 stated she was covering the shift today, because a staff did not come to work. DS 2 stated she delivered the food and brought the cart back to the kitchen to clean and reload with trays. She stated the tray cart was brought in from the COVID-19 positive care area. She stated she was the only staff in the kitchen along with the cook. She stated she had to help with tray line and deliver the trays, return the trays, wipe them, and take more trays to residents. DS 2 stated that the nursing staff in the COVID-19 positive care areas wipe the food carts in the unit before returning. She stated she did not see the nursing staff wipe the carts. DS 2 stated she should clean the carts outside of the kitchen because the carts are dirty and should not clean the tray cart next to the tray line. She stated she does not know how to adequately clean the carts from the COVID-19 positive care areas. A review of the facility's policy and procedure for Food Preparation and Service, revised date 4/2019, indicated, "Areas for cleaning dishes and utensils are located in a separate area from the food service line to assure that a sanitary environment is maintained."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 66 A review of the 2017 U.S. Food and Drug Administration Food Code, indicated "to help prevent the transfer of viruses, bacteria, or parasites from hands to food The Centers for Disease Control and Prevention (CDC) Surveillance Report for 19931997, "Surveillance for Foodborne-Disease Outbreaks - United States," identifies the most significant contributing factors to foodborne illness. Five of these broad categories of contributing factors directly relate to food safety concerns within retail and food service establishments and are collectively termed by the FDA as, "Foodborne illness risk factors." These five broad categories are: Food from Unsafe Sources, Inadequate Cooking, Improper Holding Temperatures, Contaminated Equipment, and Poor Personal Hygiene." A review of the 2017 U.S. Food and Drug Administration Food Code (3-305.14 Food Preparation) indicated, "Food preparation activities may expose food to an environment that may lead to the food's contamination. Just as food must be protected during storage, it must also be protected during preparation. Sources of environmental contamination may include splash from cleaning operations, drips form overhead air conditioning vents, or air from an uncontrolled atmosphere such as may be encountered when preparing food in a building that is not constructed according to Food Code requirements." 2. During an observation of the tray cart located in the kitchen on 5/26/20 at 5:30 p.m., a tray cart had individual cartons of milk, juice, and Jell-O. A	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 67	F 812		

large bowl of nourishment snacks was stored at the bottom of the tray cart. The snacks on the tray cart included peanut butter and jelly sandwiches, high protein shakes (nutritional supplement). The nourishment snacks were not labeled with time, date, and resident name. The milk and high protein shakes required TCS.

During a concurrent interview on 5/26/20 at 5:30 p.m., DS 2 stated she prepared the nourishment snacks earlier because she was the only one working in the kitchen. DS 2 stated she does not remember when she placed the milk on the tray. DS 2 further stated it was probably around 3:30 p.m, when she prepared the snacks on the tray cart. DS 2 stated the snacks were served three times a day. DS 2 stated that every resident receives snack in the evening. She stated she had prepared the sandwiches and snacks, but she does not remember the time. She stated she does not know if there was specific snack for each resident. She stated the milk should be cold. DS2 stated she did not check the temperature of the milk and does not know what temperature the milk should be. DS2 further stated she had to prepare the snacks early, because she was alone in the kitchen. She also stated she will deliver the snacks with the dinner, because she has to leave. She stated the bowl of nourishment snacks will be left at the nurse's station.

During an observation, on 5/26/20 at 5:45 p.m., the tray cart containing the nourishment snacks was observed outside of the kitchen. The large bowl of nourishment snacks was on a tray with no ice. The nourishment bowl containing the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 68	F 812		

high protein shakes. The high protein shakes manufacture's label indicated the shake must be kept refrigerated. DS 2 stated she was taking the nourishments to nurse's station. DS2 stated she did not check the temperature of the high protein shakes, she also said she did not know what temperature the high protein shakes should be.

A review of facility policy and procedure for Food and Nutrition Services, revised date 10/2017, indicated, "Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded."

A review of facility policy and procedure for Food Preparation and Service, revised date 4/2019, indicated, "The longer foods remain in the "danger zone" the greater the risk for growth of harmful pathogens. Therefore, PHF (Potential hazardous food) must be maintained below 41degrees Fahrenheit or above 135degrees Fahrenheit. In addition snacks are not left on trays or countertops beyond the established safe time and temperature requirements."

A review of facility policy and procedure for Food Receiving and storage, revised date 7/2014, indicated, "All foods stored in the refrigerator or freezer will be covered, labeled and dated "use by date". Food items and snacks kept on the nursing units must be maintained as indicated: a. All food items to be kept below 41degrees F must be placed in the refrigerator located at the nurses station and labeled with a "use by" date."

3. During an observation in the kitchen, on 5/26/20, at 5:19 p.m., Cook 1 was wearing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 69	F 812		

surgical mask. Cook 1 observed with a long full beard and was not wearing a beard cover. Facial hair was hanging below the surgical mask and out from the sides. Cook 1 was observed in the food preparation area and tray line dinner service. Cook 1 was serving dinner.

During the observation in the kitchen, on 5/26/20 at 5:19 p.m., DS 2 entered the kitchen with a dirty food cart. DS 2 was wearing gloves, cloth mask, and proceeded to wipe the dirty food cart next to the food preparation and tray line area where dinner was served. DS 2 then moved to tray line dinner service to assist the Cook 1. DS 2 did not remove gloves or wash her hands, DS 2 was not wearing a hair net and was carrying her personal back pack.

During an interview, on 5/26/20 at 5:30 p.m., DS 2 stated she carries her bag with her, because she doesn't want to place her belongings in the facility due to fear of the COVID-19 (an illness caused by a virus that can spread from person to person.) DS 2 stated she was the only staff in the kitchen helping the cook. She has to do the tray line, deliver food carts, and clean the food carts. She was rushing and forgot to wash hands and wear a hair net.

During an observation in the facility walk in refrigerator, on 5/26/20 at 6:00 p.m., there was a large blue lunch bag stored on the floor. The lunch bag was open and the contents could be seen. There was an empty bottle of beer and labeled, "Heineken beer," red bull (a caffeinated beverage) and water bottles. Bottles of water, sodas, and other caffeinated beverages such as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 70 Red Bull were also stored on the shelves in the facility walk in refrigerator. During an interview, on 5/26/20 at 6:10 p.m., Cook 1 verified the blue bag was his lunch bag. Cook 1 stated the situation in the facility has been very bad, number of cases of COVID-19 has been increasing, staffs and nurses were not coming to work, kitchen staff call off out fear of the virus. Cook 1 stated there is no one to work. Cook 1 stated the Dietary Supervisor was not in the facility. Cook 1 stated he brings drinks to work because of the situation in the facility and shortage of staff. When asked about the empty bottle of alcohol in his lunch bag, Cook 1 did not respond. During a kitchen observation, on 5/27/20 at 5:00 p.m., Cook 1 was observed having a long beard that touched his chest area. Cook1 was wearing a surgical face mask, not wearing a beard cover, and his long beard was exposed. A review of facility policy and procedure for Employee Personal Items, Policy No.2.35 dated 2018, indicated, "Personal items brought in by staff from outside will not be kept in the kitchen. Employees brining in personal items from outside (such as jackets, cell phones, keys, purses, etc.) will not be kept in the kitchen area. These items will be kept in locker room.) A review of facility policy and procedure for Food Preparation and Service, revised date 4/2019, indicated, "Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 71	F 812		

Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays. Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single use items and are discarded after each use. Food and nutrition services staff wear hair restrains (hairnet, hat, beard restraint, etc.) so that hair does not contact food."

A review of facility policy and procedure for Preventing Foodborne Illness-Employee Hygiene and Sanitary Practice, revised date 10/2017, indicated, "Employees must wash their hands: whenever entering or re-entering the kitchen, before coming in contact with any food surfaces, after handling soiled equipment or utensils, after engaging in other activities that contaminate the hands." In addition the policy and procedure indicated, "Gloves are considered single use items and must be discarded after completing the task for which they are used. The use of disposable gloves do not substitute for proper handwashing. Hair nets or caps and beard restrains must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. Personnel may not smoke or use other tobacco products, eat or drink in the food preparation area."

4. During a kitchen observation tour, on 5/27/20 at 5 p.m., an open food cart with styrofoam meal containers for 10 residents were left unattended outside the kitchen door from 5:00 p.m. to 5:40 p.m. The food cart was left next to the exit door by the trash dumpster. The dumpster lid and exit door were both open. The open food cart was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 72 facing the restroom door that had been left open. On 5/27/20 at 5:40 p.m., the DON observed entering the kitchen and asked the cook why the food cart was left there and why the restroom door was left open. During an interview, on 5/27/20 at 5:40 p.m., Kitchen Staff 2 (KS 2) stated dinner for residents are served at 5:00 p.m. KS 2 stated the certified nursing assistants were paged to get the food tray outside the kitchen door once the food cart was ready. During an interview with Certified Nurse Assistant 8 (CNA 8), on 5/27/20, at 6:32 p.m., CNA 8 stated, "Once the food is ready, we have to wait until the kitchen staff loads the food cart in the elevator and then we get the food cart from the elevator and distribute the meals to residents and this takes time." 4. During an observation and concurrent interview, on 5/28/20 at 5:09 p.m., the facility had a metal food cart with wheels that contained nine residents' trays outside the kitchen. COOK 2 (CK 2) stated he placed the food cart ten to fifteen minutes prior and stated the nurses were supposed to pick up the cart and the nurses took a long time to pick it up to take it to the second floor (resident care area). CK 2 stated he did not check the food temperature for dinner. CK 2 stated he used the facility's census dated 5/23/20 to prepare the meals and that it was not matching the current census and the room numbers did not match the meal cards.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 73 During an interview, on 5/28/20 at 5:09 p.m., CK 2 used a thermometer without gloves and checked the food temperature. CK 2 stated the puree (foods were soft, moist, and smooth) ground beef's temperature was at 85 Fahrenheit (F, temperature scale), puree vegetables were at 100 F, and the hamburger meat's temperature was 85 F.CK2 stated he would deliver the food even though the temperatures were low. CK 2 stated the meat's temperature should be at 165 F and the vegetables should be at 160. During the concurrent interview, the facility's Administrator stated CK 2 would reheat the food before serving it to the residents. During an observation on 5/28/20 at 5:12 p.m., the facility's volunteer (VO) entered the kitchen without a hairnet. During an interview on 5/28/20 at 6 p.m., Licensed Vocational Nurse 4 (LVN 4) stated she did not check the trays with the diet orders prior to the staff serving the trays to the residents. During the concurrent observation one tray was in the meal cart and the meal card indicated the room number. LVN 4 stated there were no residents in that room as indicated in the meal card and LVN 4 stated the resident 17 was in a different room but did not know which room. During an interview on 5/28/20 at 7:18 p.m., Resident 2 stated he would receive his food cold 90% of the time. A review of the facility's Tray Line Holding	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 74 Temperature Log dated 5/28/20 Dinner time was blank. A review of Resident 2's Admission Record indicated the facility admitted the resident on 4/8/11 and readmitted him on 3/19/20 with diagnoses of difficulty in walking, Type 1 diabetes Mellitus (a disease in which the body does not make enough insulin [helps balance the blood glucose levels]) to control blood sugar levels, End Stage Renal Disease (ESRD, the gradual loss of kidney function), and dependence on renal dialysis. A review of Resident 2's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/26/20 indicated the resident was cognitively intact for daily decision making and required supervision for dressing, transfers, and walking. A review of facility policy and procedure for Preventing Foodborne Illness-Food handling, revised date 7/2014, indicated, "Food that has been served to residents without temperature controls (example trays, snacks, etc.) will be discarded if not eaten within two hours." A review of the 2017 U.S. Food and Drug administration Food Code (3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding), indicated bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature, "Danger Zone" of 5oCelcius (C, unit of measurement) to 57oC (41oFahrenheit [F, unit of measurement] to	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 75	F 812		

135oF) too long. Up to a point, the rate of growth increases with an increase temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth.

A review of the 2017 U.S. Food and Drug Administration Food Code indicated, "The FDA has identified poor personal Hygiene including hand washing as foodborne illness risk factor. Handwashing is a critical factor in reducing pathogens that can be transmitted from hands to food or to food contact surfaces." It further indicated "Food service workers should be careful not to contaminate clean and sanitized food contact-surfaces with unclean hands."

A review of the 2017 U.S. Food and Drug Administration Food Code, indicated, "Proper hygienic practices must be followed by food employees to ensure the safety of the food, prevent the introduction of foreign objects into the food, and minimize the possibility of transmitting disease through food. Smoking or eating by employees in food preparation areas is prohibited. Food is defined as raw, cooked, or processed edible substance, ice, beverage or chewing gum. The Food Code indicated, "Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized. Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contaminations. The handles of utensils

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 76 were particularly susceptible to contamination. The food Code defines gloves as a, "Utensil," and therefore gloves must meet the applicable requirements related to utensils." A review of the 2017 U.S. Food and Drug Administration Food Code "Hands and Arms 2-301.11 Clean Condition", indicated "The hands are particularly important in transmitting foodborne pathogens. Food employees with dirty hands and/or fingernails may contaminate the food being prepared. Therefore, any activity which may contaminate the hands must be followed by thorough handwashing in accordance with the procedures outlined in the Code. Even seemingly healthy employees may serve as reservoirs for pathogenic microorganisms that are transmissible through food. Staphylococci, for example, can be found on the skin and in the mouth, throat, and nose of many employees. The hands of employees can be contaminated by touching their nose or other body parts."	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 77 §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for-	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 78 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure Resident 1's medical records were complete, organize, and readily accessible upon request in accordance with facility's policy and procedure. The facility was unable to provide Resident 1's medical records that included assessments and Treatment Administration Records (TAR) of the pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) on the sacrococcyx (buttocks) area, left and right hip, and right, and left toes black discoloration as ordered by Resident 1's physician. This deficient practice had resulted not justification for Resident 1's treatment care was being provided to promoted healing for resident's wounds and care was provided as ordered by	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 79 Resident 1's physician order. Findings: A review of Resident 1's Admission Record indicated the facility admitted Resident 1, on 5/23/10, and was readmitted, on 5/20/20, with current diagnosis for functional quadriplegia (defined as the complete inability to move due to severe disability or frailty caused by another medical condition without physical injury or damage to the brain or spinal cord), dementia (brain diseases that cause a long-term and often gradual decrease in the ability to think and remember that affect a person's daily functioning), and dysphagia (is a condition of difficulty swallowing due to abnormal nerve or muscle control). A review of Resident 1's Minimum Data Set (MDS - standardized assessment and care planning tool) dated 5/31/19 indicated Resident 1 was severely impaired in cognitive skills and was dependent on staff with activities of daily living including; bed mobility, transfer, toilet use, dressing, and personal hygiene. The MDS indicated the resident was at risk for developing pressure ulcers. A review of Resident 1's Braden Scale for Predicting Pressure Sore Risk form (a tool to help health professionals assess a patient's risk of developing a pressure ulcer, dated 3/2/20, indicated Resident 1 assessment score was 14 (Score levels for developing pressure ulcer: 15 to 18 = at risk, 13 to 14 = moderate risk, high risk = 10-12, and very high risk 9 or below).	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 80 On 5/26/20 at 5:50 PM, during an interview, Registered Nurse 3 (RN 3) stated there were no documentation of the assessment of Resident 1's current skin condition (pressure ulcers). RN 3 stated the medical record, and the TAR was missing. RN 3 stated Resident 1's medical records could not be located. On 5/26/20 at 9:46 PM, during an interview, the DON stated Resident 1's medical record could not be located. The DON stated she did not know about Resident 1's wound, pressure ulcers, and black discoloration of the toes. DON stated she could not locate Resident 1's TAR. On 5/26/20 at 10 PM, during interview and concurrent record review with DSD stated, the DSD could not locate Resident 1's medical record anywhere in the facility. A review of the facility's policy and procedure titled, "Location and Storage of Medical Records," revised date 12/2006, indicated the facility shall protect and safeguard all medical records. A review of the facility's policy and procedure titled, "Retention of Medical Records," dated 12/2006, indicated, the medical records shall be retained by the facility in accordance with current applicable laws.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 81 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 82 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to: 1. Ensure 4 staff wearing gowns that covered their wrists. 2. Ensure one kitchen staff wear a beard net. 3. Prevent four ambulance staff to use the donning area before entering the red zone area (part of the building with high cases of infectious disease),	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 83 4. Prevent two female residents to wear their face mask while roaming around the red zone area, and 5. Prevent a resident from exiting the Red Zone section of the facility to smoke outside, near the exit door of building. Theses deficient practices has the potential to contaminate the food prepared for the 65 clinically compromised residents and the spread of the infectious disease among residents and staff. Findings: 1. During a concurrent observation and interview on 5/26/20, at 5:40 p.m., Certified Nurse Assistant (CNA) 1's and Licensed Vocational Nurse (LVN) 1's gloves were not covered the cuff (wrist) of disposable gown and their skins on the wrist were exposed. CNA 1 stated the Director of Staff Development (DSD) provided in-service for staff to wear gloves under the disposable gown. LVN 1 stated the gloves need to be over the gown and cover the cuff of the gown. LVN 1 stated she was in hurry to put on the gloves. During a concurrent observation and interview on 5/26/20, at 6:30 p.m., the Infection Preventionist's (IP, nurse who specialized in infection control and prevention) and the Director of Staff Developer's (DSD) gloves were not covered the cuff (wrist) of disposable gown and their skins on the wrist were exposed. The IP stated the gloves should be under the disposable gown. The DSD stated the gloves should be over the gown and cover the cuff of the gown. The	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 84 DSD stated this the way he provided in-service to staff and staff should wear the PPE properly according to the policy to prevent cross contamination and spread of infection. A review of the facility's policy and procedure, titled, "Policy on Donning and Doffing PPE Gear," dated 1/1/20, indicated, perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of gown. 2. During an initial tour in the kitchen on 5/27/20 at 5:00 p.m., one kitchen staff (CK 1) was observed having a long beard that touched his chest area. CK1 was wearing a surgical face mask, but no beard net and his long beard was exposed. During an interview with CK 1 on 5/27/20 at 5:25 p.m., CK 1 confirmed that all male kitchen staff with a beard must wear a beard net when working inside the kitchen. 3.During an observation tour in the red zone area on 5/28/20 at 7 p.m., two ambulance staff went inside the red zone area using the designated exit only door without passing the donning area (room to sanitize and wear complete personal protective equipment). During a concurrent observation, two other ambulance staff entered the designated exit only door without passing the donning area for proper suiting of Personal Protcetive Equipment (PPE), as required for the Red Zone. During an interview with the Administrator (ADM) on 5/28/20 at 8:40 p.m., ADM confirmed that all	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 85 persons going to the red zone designated building must first pass the donning area for Donning of PPE. 4. During an observation tour on 5/28/20 at 7:25 p.m., two female residents were roaming around the red zone area without wearing a facemask. One female resident without a facemask used the phone in the nurses station without sanitizing the phone and without staff supervision. During an interview with the Certified Nursing Assistant (CNA 2) on 5/28/20 at 7:35 p.m., CNA 2 confirmed that all residents walking inside the red zone designated area must wear a facemask. A request for the policy and procedure for outside staff going inside the red zone was requested on 5/28/20 at 8:45 p.m., but was not provided by the facility. 5. During an environmental tour on 5/28/20 at 6:10 p.m., a male resident was observed sitting in his wheelchair and smoking outside near the exit door of the Red Zone designated building alone and without supervision. The Red Zone is a part of the building with high cases of infectious diseases. During an interview with Licensed Vocational Nurse (LVN 4) on 5/28/20, at 6:50 p.m., LVN 4 stated that she did not know the policy regarding whether the COVID positive residents could go outside the (Red Zone) to smoke.	F 880		

Exhibit D

COUNTY OF LOS ANGELES
Public Health

LOS ANGELES COUNTY HEALTH AGENCY

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

NWAMAKA ORANUSI, RN
Chief, Health Facilities Inspection Division
12440 East Imperial Highway, Suite 522
Norwalk, CA 90650
Tel: (562) 345-6884
Fax: (562) 409-5096

www.publichealth.lacounty.gov
Tel: (562) 345-6884
Fax: (562) 409-5096

Date: June 9, 2020

To:	From:
NAME: **Administrator**	NAME: **Naiades Paule, Supervisor, HFEN**
ORGANIZATION: **Golden Cross Health Care**	**LA DPH Health Facilities Inspection Division Region 1/East District Office**
PHONE #: (626) 791-1948	PHONE #: (626) 312-1113
Fax #:	FAX #: (626) 288-7241
Email: joe@goldencrosshealthcare.com	PAGES, INCLUDING COVER PAGE - 37

NOTES TO ADDRESSEE:

Please find the attached CMS 2567, Administrator letter, and Signature Requirement Notice for abbreviated survey **for intake CA00689421** completed **on 5/31/2020.**

Please submit the plan of correction for the abbreviated survey with your supporting documents/evidences (see AFL 12-23) on or before **6/10/2020.**

Naiades Paule, Supervisor, HFEN
(626) 312-1187

SIGNATURE REQUIREMENT NOTICE
(For Plan of Correction)

Notice to Licensee/Designee

The surveying state agency is required to obtain a signed plan of correction for deficiencies noted on the Statement of Deficiencies and Plan of Correction (Code of Federal Regulations, Title 42, Section 489.13; State Operations Manual, Section 2612; and California Health and Safety Code, Section 1280). By signing a plan of correction, a licensee or designee does not necessarily admit guilt of any alleged violation nor does this interfere with the right to contest or appeal any alleged violations on which the plan of correction is based or the same period for correction. It does acknowledge responsibility for compliance with licensing requirements, with appropriate requirements of the Medicare and Medi-Cal programs, that an exit conference was held during which the items listed were discussed, and that a copy of the deficiency/report and plan of correction was received.

Name of facility		City
Golden Cross Health Care	CA00689421	Pasadena

Copy of this notice received:

Licensee or designee signature	Date

Copy of this notice presented to licensee or designee:

Licensing Evaluator signature	Date
	6/9/2020

Complaint Notice

If there should be disagreement between the Licensee or Designee and the Evaluator of the Survey Team on an interpretation of the regulations or a field decision, the Licensee of Designee may wish to call and discuss this with the District Licensing Supervisor.

Name of Licensing Supervisor	Telephone
Naiades Paule	(626) 312-1113

Instructions

This notice is to be used with Plans of Correction for Skilled Nursing Facilities, Intermediate Care Facilities, Intermediate Care Facilities/Developmentally Disabled, Intermediate Care Facilities/Developmentally Disabled-Habilitative, Intermediate Care Facilities/Developmentally Disabled-Nursing, Congregate Living Health Facilities, Pediatric Day Health and Respite Care Facilities, and Hospitals with Distinct Part Skilled Nursing Facilities or Intermediate Care Facilities. It is to be signed by the licensee/designee and the licensing evaluator. A copy is left with the licensee/designee and the original is kept in the district office licensing file.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigaiton of a complaint. Complaint number: CA00689421. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department: HFEN # 36901 and Pharmacist # 40994. Two deficiencies were written for complaint number CA00689421.	F 000		
F 755 SS=K	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 1 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 10 of 10 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) in the facility received pharmaceutical services to meet the needs of each resident in a consistent manner in accordance with physician orders and facility's policy and procedures by failing to: 1. Administer three doses of Levimir (insulin, helps balance the blood glucose levels) 30 units (a measure of dosage for insulin), two doses of Levimir 15 units, and four doses of Klonopin (medication to control or prevent seizures [a sudden, uncontrolled electrical disturbance in the brain] and reduce anxiety [feeling of worry, nervousness, or unease], from panic attacks) 0.5 milligrams ([mg] - a unit of measure for mass) for Resident 1. 2. Administer five doses of Haldol (used to treat certain mental/mood disorders) 2.5 mg, 10 doses of Depakote (used to treat seizure disorders, certain psychiatric conditions) 250 mg, five doses of benztropine mesylate (used to help control	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 2 extrapyramidal disorders [involuntary or uncontrollable movements]), 0.5 mg, five doses of rivaroxaban (a medication used to prevent blood clots) 10 mg, and four doses of atorvastatin calcium (medication to improve cholesterol [a type of fat found in the blood levels]) 10 mg for resident 2. 3. Administer four doses of Depakote 250 mg to Resident 3. 4. Administer four doses of Dilantin (medication used to treat or prevent seizures) 200 mg, five doses of Dilantin 150 mg, three doses of dorzolamide HCl solution 2 per cent (%) (eye drops for glaucoma [group of eye conditions that can cause blindness]), and one dose of Exelon (improves mental function such as memory and thinking) 4.5 mg for Resident 4. 5. Administer five doses of Namenda (medication used to treat moderate to severe confusion) 5 mg for Resident 5. 6. Administer two doses of Lipitor (medication to help lower blood levels of cholesterol) 40 mg for Resident 6. 7. Administer two doses of Plavix (a medication used to prevent blood clots) 75 mg for Resident 7. 8. Administer eleven doses of memantine HCL (medication used to treat moderate to severe confusion) 10 mg, nine doses of metformin (control blood sugar levels) 500 mg, three doses of pantoprazole (used to treat certain stomach and esophagus problems) 40 mg, five doses of Thera-M (supplement), four doses of Claritin (a	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 3 medication used to treat allergies), six doses of donepezil (medication to treat confusion)10 mg, two doses of escitalopram oxalate (medication to treat depression [mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life]) 10 mg, five doses of fenofibrate (to treat high cholesterol) 145 mg, two doses of ferrous sulfate (iron supplement) 325 mg, and two doses of folic acid (supplements) for Resident 8. 9. Administer one dose of Neurontin (medication used to prevent and control seizures, also used to relieve nerve pain) 100 mg, two doses of Pepcid (used to treat and prevent ulcers in the stomach and intestines) 20 mg, three doses of Prozac (used to treat depression panic attacks), 20 mg, two doses Revia (used to prevent people who have been addicted to certain drugs from taking them again) 50mg, three doses thiamine (vitamin)100 mg, and one dose of Zocor (used to lower cholesterol)20 mg for Resident 9. 10. Administer three doses of anastrozole (is used to treat breast cancer [a disease in which cells [basic unit of life] in the breast grow out of control]) 1 mg for Resident 10. These deficient practices of failing to administer medications for seizures, diabetes, and psychiatric conditions in accordance with physician's orders increased the risk for Residents 1, 2, 3, and 4 to experience serious health complications likely resulting in hospitalization or death, and had the potential for Residents 5, 6, 7, 8, 9, and 10 to experience health complications and harm.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 4 On 5/20/20 at 9:13p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Interim Administrator (IADM), temporary Administrator (TADM), temporary Director of Nursing (TDON), Medical Doctor 2 (MD 2), and the infection preventionist nurse (IP) for the facility's failure to ensure that all residents in the facility received medications timely and in a consistent manner in accordance with physicians orders that threatened the health and safety of the residents. On 5/22/20 at 1 p.m., the Department accepted the facility's Plan of Action (POA) which included the following additional summarized actions: Immediate Action: On May 21, 2020 a 100% three-way audit of medications consisting of comparing physician's orders with MAR and medication stock in medication cart was completed by pharmacy assistants. Medications needing refills were ordered from pharmacy. Attending physicians were notified of any medication errors. Medication error reports were completed. Affected residents were assessed for any adverse effects. In-service on Medication Administration/Documentation and refill ordering and med error procedure was provided by the DON/DSD initiated on May 21, 2020. No adverse change of condition related to the med errors were observed. How to identify other residents having the potential to be affected by the same deficient practice:	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 5 100 % medication audit was completed by pharmacy assistants on 05/21/2020. Measures/Systemic changes to ensure that the deficient practice will not recur: Licensed nurses will be assigned on night shift to complete a triple check medication form. Triple check audit will be completed nightly and results forwarded to DON/Designee. Pharmacy services will conduct a monthly triple check audit. The DON/Designee will verify accuracy of facility nurse triple check forms by random 20% monthly review of completed forms. Conduct monthly facility wide three-way audit. The Performance Improvement Project (PIP) titled Medication Administration. The PIP will focus on the availability of medications, administration and documentation. Orientation for non-facility employees (registry) will be provided by the DSD/off-going supervisor regarding medication procedures and pharmacy contact information prior to being assigned to med cart for administration of medication. Monitoring: The Director of Nursing will monitor the results of daily/monthly audits and appropriate follow up will be taken. The audit findings will be reviewed with Administrator and Medical Director monthly during the time of Medical Director visits. The findings will also be presented at the quarterly QAA whose members consist of Medical Director, Administrator, DON, Consulting Pharmacist and DSD. The study will continue for three months or until full compliance and consistency is accomplished as determined by the committee. On 5/22/2020 at 3:37 p.m., while onsite and after confirming the facility's implementation of the	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 6 immediate corrective actions, the Department accepted the plan of action and removed the Immediate Jeopardy, in the presence of the TADM and the TDON. *Cross reference F760 Findings: During an interview on 5/20/20 at 2:17 p.m., Licensed Vocational Nurse 1 (LVN 1), Registered Nurse 2 (RN 2) and RN 3 stated they could not find multiple medications for several days for Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10. RN 2 and RN 3 stated they did not inform the residents' physicians but they informed the facility's staff (unidentified) and that nothing was done to obtain the medications. During an interview on 5/20/20 at 2:19 p.m., the facility's Temporary Director of Nursing (TDON) stated she did not know where the residents' medications were and stated the facility was disorganized. Resident 1 A review of Resident 1's Admission Record indicated the facility admitted the resident on 12/23/09 and readmitted her on 5/11/20 with diagnoses of Type 2 diabetes Mellitus (a condition that affects the way the body absorbs sugar [glucose] an important source of fuel for the body), paranoid schizophrenia (mental illness with unreasonably suspicious of others), epilepsy (a broad term used for a brain disorder that causes seizures), bipolar disorder (a mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly) and hallucinations (a perception of having seen,	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 7 heard, touched, tasted, or smelled something that wasn't actually there). A review of Resident 1's Minimum Data Set ([MDS], a resident assessment and care-screening tool), dated 5/2/20 indicated the assessment was not yet completed. A review of Resident 1's Medication Administration Record dated 5/1/2020 to 5/31/2020 indicated the facility did not administer three doses of Levimir 30 units subcutaneously (SQ, under the skin) on May 18, 19, and 20, two doses of Levimir 15 units SQ on May 19, and four doses of Klonopin 0.5 mg one tablet by mouth on May 17, 18, 19, and 20 and that Resident 1's Klonopin was "not on hand." Resident 2 A review of Resident 2's Admission Record indicated the facility admitted the resident on 6/14/19 and readmitted him on 6/14/19 with diagnoses of schizophrenia, bipolar disorder and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). A review of Resident 2's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills (to make decisions) and required limited assistance for bed mobility and personal hygiene. During a review of Resident 2's Medication Administration Record dated 5/1/20 to 5/31/20 on 5/20/20 at 2:14 the facility's Temporary Director of Nursing (TDON) stated the facility's licensed nurses did not administer five doses of Haldol 2.5 mg by mouth one time a day for schizophrenia manifested by hallucinations on May 15, 16,18,	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 8 19, and 20, ten doses of Depakote 250 mg one tablet by mouth two times a day for bipolar disorder on May 13, 14, 15, 16, 18, 19, five doses of benztropine mesylate 0.5 mg one tablet by mouth one time a day by mouth for extrapyramidal symptoms (EPS) on May 15, 16,17, 18, 19, and 20, five doses of rivaroxaban 10 mg one tablet by mouth on May 13, 14, 15, 19, 20, and four doses of atorvastatin calcium 10 mg one tablet by mouth at bedtime for hyperlipidemia on May 14, 15, 19, 20. During the concurrent review of Resident 2's Medication Record, the TADON stated she did not find the resident's medications in the medication cart and that she did not know where the medications were placed. TADON stated the facility was disorganized. During an interview on 5/20/20 at 2:12 p.m., Licensed Vocational Nurse 1 (LVN 1), Registered Nurse 1 (RN 2), and RN 3 stated they could not find Resident 2's medication and that no one knew where the resident's medications were. RN 2 and RN 3 stated the resident had not received any of his medications for several days and that they (RN 2, RN 3, and LVN 1) did not inform the physician. During an observation on 5/20/20 at 3:38 p.m., Resident 2 was lying in bed and could not tell the Department his name or location. Resident 3 A review of Resident 3's Admission Record indicated the facility admitted the resident on 5/10/19 with diagnoses of bipolar disorder and major depressive disorder.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 9 A review of Resident 3's MDS dated 5/18/20 indicated the resident was moderately impaired in cognitive skills and required supervision for bed mobility and transfers. A review of Resident 3's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer four doses of Depakote 250 mg 1 tablet by mouth two times a day for bipolar disorder manifested by verbal and physical aggression on May 19 and 20. Resident 4 A review of Resident 4's Admission Record indicated the facility admitted the resident on 12/7/07 and readmitted him on 6/13/19 with diagnoses of epilepsy, dementia (decline in mental ability severe enough to interfere with daily life), and dry eye syndrome. A review of Resident 4's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills and required limited assistance for mobility and extensive assistance with dressing. A review of Resident 4's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer four doses of Dilantin 200 mg by mouth one time a day for seizure disorder on May 17, 18, 19, 20 , five doses of Dilantin 150 mg by mouth two times a day for seizure disorder on May 18, 19, 20, three doses of Dorzolamide HCl solution 2% one drop in both eyes two times a day for glaucoma on May 17, 18, 19, 20, and one dose of Exelon 4.5 mg one capsule by mouth in the morning for dementia on May 20. Resident 5	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 10 A review of Resident 5's Admission Record indicated the facility admitted the resident on 2/1/12 and readmitted her on 8/15/13 with diagnosis of dementia. A review of Resident 5's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills and required supervision for transfers and walking. A review of Resident 5's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer five doses of Namenda 5 mg one tablet by mouth twice a day on May 18, 19, and 20. Resident 6 A review of Resident 6's Admission Record indicated the facility admitted the resident on 3/18/19 with diagnoses of COVID-19 (Coronavirus, an illness caused by a virus that can spread from person to person) and hypertension (high blood pressure). A review of Resident 6's MDS dated 5/18/20 indicated the resident was moderately impaired in cognitive skills. A review of Resident 6's Medication Administration dated 5/1/2020 to 5/31/2020 indicated the facility did not administer one dose of Lipitor 40 mg 1 tablet by mouth at bedtime for hyperlipidemia on May 19. During an observation on 5/20/20 at 2:20 p.m., Resident 6 was awake in her room sitting on her bed. During an interview on 5/20/20 at 2:20 p.m.,	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 11 Resident 6 stated she did not receive all her medications and that she would ask the licensed nurses and no one would know why she did not receive her medications. Resident 7 A review of Resident 7's Admission Record indicated the facility admitted the resident on 6/26/19 and readmitted him on 1/4/20 with diagnoses of lack of coordination, hypertensive heart disease, and muscle wasting. A review of Resident 7's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills and required extensive assistance with bed mobility and transfers. A review of Resident 7's Medication administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer two doses of Plavix 75 mg one tablet by mouth one time a day for cerebrovascular accident (CVA, stroke occurs when the blood supply to part of the brain is interrupted) prophylaxis (action taken to prevent disease) on May 19 and 20. Resident 8 A review of Resident 8's Admission Record indicated the facility admitted the resident on 3/14/20 with diagnoses of dementia, Type 2 diabetes, and weakness. A review of Resident 8's MDS dated 5/5/20 indicated the resident was cognitively intact for daily decision making and required limited assistance for bed mobility and transfer. A review of Resident 8's Medication Administration Record dated 5/1/20 to 5/31/20	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 12 indicated the facility did not administer eleven doses of memantine HCL 10 mg one tablet by mouth two times a day on May 13, 14, 18,19, 20, nine doses of metformin 500 mg one tablet by mouth twice daily on May 13, 14, 15, 18, 19, 20, three doses of pantoprazole one tablet 40 mg one tablet daily by mouth on May 14 "not on hand," 15, 16, five doses of Thera-M one tablet by mouth daily on May 13, 14, 18, 19, 20, four doses of Claritin 10 mg one tablet by mouth one time a day for allergy on May 17, 18, 19, 20, six doses of donepezil 10 mg one tablet by mouth at bed time for dementia on May 13, 14, 15, 16, 17, 18, 19, 20, two doses of escitalopram oxalate 10 mg one tablet by mouth once a day for depression on May 13, 14, five doses of fenofibrate 145 mg one tablet by mouth one time a day for antihyperlipidemic, two doses of ferrous sulfate 325 mg one tablet once a day for supplement on May 13, 14, and two doses of folic acid one tablet by mouth one time a day on May 13, and 14. Resident 9 A review of Resident 9's Admission Record indicated the facility admitted the resident on 1/16/20 with diagnoses of hyperlipidemia, alcohol dependence, major depressive disorder, and gastro-esophageal reflux disease (GERD, is a digestive disorder). A review of Resident's 9's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer one dose of Neurontin 100 mg one capsule 100 mg on May 18 for alcohol cravings, two doses of Pepcid 20 mg one tablet by mouth daily on May 19, 20, three doses of Prozac 20 mg one capsule by mouth one time a day for depression on May 18, 19, 20, two doses Revia 50mg ½ tablet (25 mg)	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 13 at bedtime for alcohol cravings on May 19 and 20 , three doses thiamine 100 mg one tablet by mouth once a day on May 18, 19, 20, and one dose of Zocor 20 mg one tablet by mouth at bedtime. Resident 10 A review of Resident 10's Admission Record indicated the facility admitted the resident on 11/4/13 and readmitted on 5/6/20 with diagnoses of COVID-19 and malignant neoplasm (disease in which abnormal cells divide uncontrollably and destroy body tissue). A review of Resident 10's Medication Administration dated 5/1/20 to 5/31/20 indicated the resident did not receive three doses of anastrozole 1 mg one tablet by mouth a day for hormone-based chemotherapy on May 18, 19, and 20. During an interview on 5/20/20 at 1:20 p.m., Registered Nurse 1 (RN 1) stated Resident 10 did not receive three doses of anastrozole. RN 1 stated the resident's medication was not available in the facility because the licensed nurse did not reorder from the pharmacy and that she (RN 1) did not notify the resident's physician that the resident did not receive anastrozole. During the abbreviated survey on 5/20/20 the Department attempted various interviews with multiple staff (Infection Preventionist [IP], TDON, RN 1, RN 2, RN 3, LVN 1, LVN 2) to obtain verbal and documented information related to the missing medications and the staff stated they did not know where to find the information. During a telephone interview on 5/21/20 at 10:55	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 14 a.m., the facility's Medical Director (MD 1) stated the Interim Administrator (IADM) did not communicate any issues to him. MD 1 stated he expected the licensed nurses to administer medications as ordered by the residents' physicians unless the residents refused. MD 1 stated that he expected the nurses to notify each residents' primary physicians when they could not find the medications or if the medications were not given so the physicians could determine if any interventions were necessary. MD 1 stated the facility was in "Bad shape, no leadership." References According to the U.S. Food and Drug Administration (FDA) abrupt withdrawal of phenytoin (Dilantin) in epileptic patients may precipitate status epilepticus (is a medical emergency associated with significant morbidity and mortality). https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/084349s060lbl.pdf According to the FDA, the abrupt withdrawal of Klonopin, particularly in those patients on long-term, high-dose therapy, may precipitate status epilepticus. https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/017533s053,020813s009lbl.pdf According to the FDA, glucose monitoring is essential for all patients receiving insulin therapy. Changes to an insulin regimen should be made cautiously and only under medical supervision. https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021536s037lbl.pdf A review of the facility's policy and procedure titled "Administering Medications," with a revised	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 15 date April 2019 indicated medications were administered in a safe and timely manner, as prescribed. A review of the facility's policy titled "Medication and Treatment Orders," with a revised date of 2016 indicated drugs and biologicals that were required to be refilled must be reordered from issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills were readily available.	F 755		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 10 of 10 sampled residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) in the facility received medications timely and in a consistent manner in accordance with physician orders and facility's policy and procedures by failing to: 1. Administer three doses of Levimir (insulin, helps balance the blood glucose levels) 30 units (a measure of dosage for insulin), two doses of Levimir 15 units, and four doses of Klonopin (medication to control or prevent seizures [a sudden, uncontrolled electrical disturbance in the brain] and reduce anxiety [feeling of worry, nervousness, or unease], from panic attacks) 0.5 milligrams (a unit of measure for mass) for Resident 1.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 16 2. Administer five doses of Haldol (used to treat certain mental/mood disorders) 2.5 mg, 10 doses of Depakote (used to treat seizure disorders, certain psychiatric conditions) 250 mg, five doses of Benztropine Mesylate (used to help control extrapyramidal disorders [involuntary or uncontrollable movements]), 0.5 mg, five doses of Rivaroxaban (blood thinner) 10 mg, and four doses of Atorvastatin Calcium (medication to improve cholesterol [a type of fat found in the blood levels]) 10 mg for resident 2. 3. Administer four doses of Depakote 250 mg to Resident 3. 4. Administer four doses of Dilantin (medication used to treat or prevent seizures) 200 mg, five doses of Dilantin 150 mg, three doses of Dorzolamide HCl solution 2% (eye drops for glaucoma [group of eye conditions that can cause blindness]), and one dose of Exelon (improves mental function such as memory and thinking) 4.5 mg for Resident 4. 5. Administer five doses of Namenda (medication used to treat moderate to severe confusion) 5 mg for Resident 5. 6. Administer two doses of Lipitor (medication to help lower blood levels of cholesterol) 40 mg for Resident 6. 7. Administer two doses of Plavix (blood thinner) 75 mg for Resident 7. 8. Administer eleven doses of Memantine HCL (medication used to treat moderate to severe confusion) 10 mg, nine doses of metformin (control blood sugar levels) 500 mg, three doses	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 17 of Pantoprazole (used to treat certain stomach and esophagus problems) 40 mg, five doses of thera-M (supplement), four doses of Claritin (non-drowsy allergy relief of sneezing, runny nose, itchy, watery eyes and itchy nose or throat), six doses of donepezil (medication to treat confusion)10 mg, two doses of escitalopram oxalate (medication to treat depression [mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life]) 10 mg, five doses of fenofibrate (to treat high cholesterol) 145 mg, two doses of ferrous sulfate (supplement) 325 mg, and two doses of folic acid (supplements) for Resident 8. 9. Administer one dose of Neurontin (medication used to prevent and control seizures, also used to relieve nerve pain) 100 mg, two doses of Pepcid (used to treat and prevent ulcers in the stomach and intestines) 20 mg, three doses of Prozac (used to treat depression panic attacks), 20 mg, two doses Revia (used to prevent people who have been addicted to certain drugs from taking them again) 50mg, three doses Thiamine (vitamin)100 mg, and one dose of Zocor (used to lower cholesterol)20 mg for Resident 9. 10. Administer three doses of Anastrozole (is used to treat breast cancer [a disease in which cells [basic unit of life] in the breast grow out of control]) 1 mg for Resident 10. These deficient practices of failing to administer medications for seizures, diabetes, and psychiatric conditions in accordance with physician's orders increased the risk for Residents 1, 2, 3, and 4 to experience serious health complications likely resulting in	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 18 hospitalization or death, and had the potential for Residents 5, 6, 7, 8, 9, and 10 to experience health complications and harm. On 5/20/20 at 9:13p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified in the presence of the facility's Interim Administrator (IADM), temporary Administrator (TADM), temporary Director of Nursing (TDON), Medical Doctor 2 (MD 2), and the infection preventionist nurse (IP) for the facility's failure to ensure that all residents in the facility received medications timely and in a consistent manner in accordance with physicians orders that threatened the health and safety of the residents. On 5/22/20 at 1 p.m., the Department accepted the facility's Plan of Action (POA) which included the following additional summarized actions: Immediate Action: On May 21, 2020 a 100% three-way audit of medications consisting of comparing physician's orders with MAR and medication stock in medication cart was completed by Pharmacy Assistants. Medication needing refills were ordered from pharmacy. Attending physicians were notified of any medication errors. Medication error reports were completed. Affected residents were assessed for any adverse effects. In-service on Medication Administration/Documentation and refill ordering and med error procedure was provided by the DON/DSD initiated on May 21, 2020. No adverse change of condition related to the med error were observed.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 19 How to identify other residents having the potential to be affected by the same deficient practice: 100 % medication audit was completed by Pharmacy Assistants on 05/21/2020. Measures/Systemic changes to ensure that the deficient practice will not recur: Licensed nurses will be assigned on night shift to complete a triple check medication form. Triple check audit will be completed nightly and results forwarded to DON/Designee. Pharmacy services will conduct a monthly triple check audit. The DON/Designee will verify accuracy of facility nurse triple check forms by random 20% monthly review of completed forms. Conduct monthly facility wide three-way audit. The Performance Improvement Project (PIP) titled Medication Administration. The PIP will focus on the availability of medications, administration and documentation. Orientation for non-facility employees (registry) will be provided by the DSD/off-going supervisor regarding medication procedures and pharmacy contact information prior to being assigned to med cart for administration of medication. Monitoring: The Director of Nursing will monitor the results of daily/monthly audits and appropriate follow up will be taken. The audit findings will be reviewed with Administrator and Medical Director monthly during the time of Medical Director visits. The findings will also be presented at the quarterly QAA whose members consist of Medical Director, Administrator, DON, Consulting Pharmacist and DSD. The study will continue for three months or until full compliance and consistency is	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 20 accomplished as determined by the committee. On 5/22/2020 at 3:37 p.m., while onsite and after confirming the facility's implementation of the immediate corrective actions, the Department accepted the plan of action and removed the Immediate Jeopardy, in the presence of the TADM and the TDON. *Cross reference F755 Findings: During an interview on 5/20/20 at 2:17 p.m., Licensed Vocational Nurse 1 (LVN 1), Registered Nurse 2 (RN 2) and RN 3 stated they could not find multiple medications for several days for Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10. RN 2 and RN 3 stated they did not inform the residents' physicians but they informed the facility's staff (unidentified) and that nothing was done to obtain the medications. During an interview on 5/20/20 at 2:19 p.m., the facility's Temporary Director of Nursing (TDON) stated she did not know where the residents' medications were and stated the facility was disorganized. Resident 1 A review of Resident 1's Admission Record indicated the facility admitted the resident on 12/23/09 and readmitted her on 5/11/20 with diagnoses of Type 2 diabetes Mellitus (a condition that affects the way the body absorbs sugar [glucose] an important source of fuel for the body), paranoid schizophrenia (mental illness with unreasonably suspicious of others), epilepsy (a broad term used for a brain disorder that causes	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 21 seizures), bipolar disorder (a mental illness that causes dramatic shifts in a person's mood, energy and ability to think clearly) and hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there). A review of Resident 1's Minimum Data Set ([MDS], a resident assessment and care-screening tool), dated 5/2/20 indicated the assessment was not yet completed. A review of Resident 1's Medication Administration Record dated 5/1/2020 to 5/31/2020 indicated the facility did not administer three doses of Levimir 30 units subcutaneously (SQ, under the skin) on May 18, 19, and 20, two doses of Levimir 15 units SQ on May 19, and four doses of Klonopin 0.5 mg one tablet by mouth on May 17, 18, 19, and 20 and that Resident 1's Klonopin was "not on hand." Resident 2 A review of Resident 2's Admission Record indicated the facility admitted the resident on 6/14/19 and readmitted him on 6/14/19 with diagnoses of schizophrenia, bipolar disorder and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). A review of Resident 2's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills (to make decisions) and required limited assistance for bed mobility and personal hygiene. During a review of Resident 2's Medication Administration Record dated 5/1/20 to 5/31/20 on 5/20/20 at 2:14 the facility's Temporary Director of	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 22 Nursing (TDON) stated the facility's licensed nurses did not administer five doses of Haldol 2.5 mg by mouth one time a day for schizophrenia manifested by hallucinations on May 15, 16,18, 19, and 20, ten doses of Depakote 250 mg one tablet by mouth two times a day for bipolar disorder on May 13, 14, 15, 16, 18, 19, five doses of Benztropine Mesylate 0.5 mg one tablet by mouth one time a day by mouth for Extrapyramidal symptoms (EPS) on May 15, 16,17, 18, 19, and 20, five doses of Rivaroxaban 10 mg one tablet by mouth on May 13, 14, 15, 19, 20, and four doses of Atorvastatin Calcium 10 mg one tablet by mouth at bedtime for hyperlipidemia on May 14, 15, 19, 20. During the concurrent review of Resident 2's Medication Record, the TADON stated she did not find the resident's medications in the medication cart and that she did not know where the medications were placed. TADON stated the facility was disorganized. During an interview on 5/20/20 at 2:12 p.m., Licensed Vocational Nurse 1 (LVN 1), Registered Nurse 1 (RN 2), and RN 3 stated they could not find Resident 2's medication and that no one knew where the resident's medications were. RN 2 and RN 3 stated the resident had not received any of his medications for several days and that they (RN 2, RN 3, and LVN 1) did not inform the physician. During an observation on 5/20/20 at 3:38 p.m., Resident 2 was lying in bed and could not tell the Department his name or location. Resident 3 A review of Resident 3's Admission Record	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 23 indicated the facility admitted the resident on 5/10/19 with diagnoses of bipolar disorder and major depressive disorder. A review of Resident 3's MDS dated 5/18/20 indicated the resident was moderately impaired in cognitive skills and required supervision for bed mobility and transfers. A review of Resident 3's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer four doses of Depakote 250 mg 1 tablet by mouth two times a day for bipolar disorder manifested by verbal and physical aggression on May 19 and 20. Resident 4 A review of Resident 4's Admission Record indicated the facility admitted the resident on 12/7/07 and readmitted him on 6/13/19 with diagnoses of epilepsy, dementia (decline in mental ability severe enough to interfere with daily life), and dry eye syndrome. A review of Resident 4's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills and required limited assistance for be mobility and extensive assistance with dressing. A review of Resident 4's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer four doses of Dilantin 200 mg by mouth one time a day for seizure disorder on May 17, 18, 19, 20 , five doses of Dilantin 150 mg by mouth two times a day for seizure disorder on May 18, 19, 20, three doses of Dorzolamide HCl solution 2% one drop in both eyes two times a day for glaucoma on	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 24 May 17, 18, 19, 20, and one dose of Exelon 4.5 mg one capsule by mouth in the morning for dementia on May 20. Resident 5 A review of Resident 5's Admission Record indicated the facility admitted the resident on 2/1/12 and readmitted her on 8/15/13 with diagnosis of dementia. A review of Resident 5's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills and required supervision for transfers and walking. A review of Resident 5's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer five doses of Namenda 5 mg one tablet by mouth twice a day on May 18, 19, and 20. Resident 6 A review of Resident 6's Admission Record indicated the facility admitted the resident on 3/18/19 with diagnoses of COVID-19 (Coronavirus, an illness caused by a virus that can spread from person to person) and hypertension (high blood pressure). A review of Resident 6's MDS dated 5/18/20 indicated the resident was moderately impaired in cognitive skills. A review of Resident 6's Medication Administration dated 5/1/2020 to 5/31/2020 indicated the facility did not administer one dose of Lipitor 40 mg 1 tablet by mouth at bedtime for hyperlipidemia on May 19.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 25 During an observation on 5/20/20 at 2:20 p.m., Resident 6 was awake in her room sitting on her bed. During an interview on 5/20/20 at 2:20 p.m., Resident 6 stated she did not receive all her medications and that she would ask the licensed nurses and no one would know why she did not receive her medications. Resident 7 A review of Resident 7's Admission Record indicated the facility admitted the resident on 6/26/19 and readmitted him on 1/4/20 with diagnoses of lack of coordination, hypertensive heart disease, and muscle wasting. A review of Resident 7's MDS dated 5/18/20 indicated the resident was severely impaired in cognitive skills and required extensive assistance with bed mobility and transfers. A review of Resident 7's Medication administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer two doses of Plavix 75 mg one tablet by mouth one time a day for cerebrovascular accident (CVA, stroke occurs when the blood supply to part of the brain is interrupted) prophylaxis (action taken to prevent disease) on May 19 and 20. Resident 8 A review of Resident 8's Admission Record indicated the facility admitted the resident on 3/14/20 with diagnoses of dementia, Type 2 diabetes, and weakness. A review of Resident 8's MDS dated 5/5/20 indicated the resident was cognitively intact for	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 26 daily decision making and required limited assistance for bed mobility and transfer. A review of Resident 8's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer eleven doses of Memantine HCL 10 mg one tablet by mouth two times a day on May 13, 14, 18,19, 20, nine doses of metformin 500 mg one tablet by mouth twice daily on May 13, 14, 15, 18, 19, 20, three doses of Pantoprazole one tablet 40 mg one tablet daily by mouth on May 14 "not on hand," 15, 16, five doses of thera-M one tablet by mouth daily on May 13, 14, 18, 19, 20, four doses of Claritin 10 mg one tablet by mouth one time a day for allergy on May 17, 18, 19, 20, six doses of donepezil 10 mg one tablet by mouth at bed time for dementia on May 13, 14, 15, 16, 17, 18, 19, 20, two doses of escitalopram oxalate 10 mg one tablet by mouth once a day for depression on May 13, 14, five doses of fenofibrate 145 mg one tablet by mouth one time a day for antihyperlipidemic, two doses of ferrous sulfate 325 mg one tablet once a day for supplement on May 13, 14, and two doses of folic acid one tablet by mouth one time a day on May 13, and 14. Resident 9 A review of Resident 9's Admission Record indicated the facility admitted the resident on 1/16/20 with diagnoses of hyperlipidemia, alcohol dependence, major depressive disorder, and gastro-esophageal reflux disease (GERD, is a digestive disorder). A review of Resident's 9's Medication Administration Record dated 5/1/20 to 5/31/20 indicated the facility did not administer one dose of Neurontin 100 mg one capsule 100 mg on	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 27 May 18 for alcohol cravigs, two doses of Pepcid 20 mg one tablet by mouth daily on May 19, 20, three doses of Prozac 20 mg one capsule by mouth one time a day for depression on May 18, 19, 20, two doses Revia 50mg ½ tablet (25 mg) at bedtime for alcohol cravings on May 19 and 20 , three doses Thiamine 100 mg one tablet by mouth once a day on May 18, 19, 20, and one dose of Zocor 20 mg one tablet by mouth at bedtime. Resident 10 A review of Resident 10's Admission Record indicated the facility admitted the resident on 11/4/13 and readmitted on 5/6/20 with diagnoses of COVID-19 and malignant neoplasm (disease in which abnormal cells divide uncontrollably and destroy body tissue). A review of Resident 10's Medication Administration dated 5/1/20 to 5/31/20 indicated the resident did not receive three doses of Anastrozole 1 mg one tablet by mouth a day for hormone based chemotherapy on May 18, 19, and 20. During an interview on 5/20/20 at 1:20 p.m., Registered Nurse 1 (RN 1) stated Resident 10 did not receive three doses of Anastrozole. RN 1 stated the resident's medication was not available in the facility because the licensed nurse did not reorder from the pharmacy and that she (RN 1) did not notify the resident's physician that the resident did not receive Anastrozole. During the abbreviated survey on 5/20/20 the Department attempted various interviews with multiple staff (Infection Preventionist [IP], TDON, RN1, RN 2, RN 3, LVN 1, LVN 2) to obtain verbal	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1450 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 28 and documented information related to the missing medications and the staff stated they did not know where to find the information. During a telephone interview on 5/21/20 at 10:55 a.m., the facility's Medical Director (MD 1) stated the Interim Administrator (IADM) did not communicate any issues to him. MD 1 stated he expected the licensed nurses to administer medications as ordered by the residents' physicians unless the residents refused. MD 1 stated that he expected the nurses to notify each residents' primary physicians when they could not find the medications or if the medications were not given so the physicians could determine if any interventions were necessary. MD 1 stated the facility was in "Bad shape, no leadership." References According to the U.S. Food and Drug Administration (FDA) abrupt withdrawal of phenytoin (Dilantin) in epileptic patients may precipitate status epilepticus (is a medical emergency associated with significant morbidity and mortality). https://www.accessdata.fda.gov/drugsatfda_docs/label/2009/084349s060lbl.pdf According to the FDA, the abrupt withdrawal of Klonopin, particularly in those patients on long-term, high-dose therapy, may precipitate status epilepticus. https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/017533s053,020813s009lbl.pdf According to the FDA, glucose monitoring is essential for all patients receiving insulin therapy. Changes to an insulin regimen should be made cautiously and only under medical supervision.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555096	A. BUILDING _____ B. WING _____	C 05/31/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN CROSS HEALTH CARE	1460 N. FAIR OAKS AVENUE PASADENA, CA 91103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 29 https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/021536s037lbl.pdf A review of the facility's policy and procedure titled "Administering Medications," with a revised date April 2019 indicated medications were administered in a safe and timely manner, as prescribed. A review of the facility's policy titled "Medication and Treatment Orders," with a revised date of 2016 indicated drugs and biologicals that were required to be refilled must be reordered from issuing pharmacy not less than three days prior to the last dosage being administered to ensure that refills were readily available.	F 760		

COUNTY OF LOS ANGELES
Public Health

BARBARA FERRER, Ph.D., M.P.H., M.Ed.
Director

MUNTU DAVIS, M.D., M.P.H.
County Health Officer

NWAMAKA ORANUSI, RN, MPH, REHS
Chief, Health Facilities Inspection Division
12440 East Imperial Highway, Suite 522
Norwalk, CA 90650
Tel: (562) 345-6884
Fax: (562)409-5096

www.publichealth.lacounty.gov

June 9, 2020 Letter 10a

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Administrator
Golden Cross Health Care
1450 N. Fair Oaks Avenue
Pasadena, CA 91103

Dear Administrator:

On May 31, 2020, an abbreviated survey for complaint incident no. CA00689421 was conducted at your facility by the California Department of Public Health, Licensing and Certification Program (Los Angeles Region 1) to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found that your facility was not in substantial compliance with the participation requirements, and the conditions in your facility constituted **immediate jeopardy** to resident health or safety.

[ ] Isolated deficiencies that constitute actual harm that is immediate jeopardy as evidenced by the enclosed "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (J).

[X] A pattern of deficiencies that constitute actual harm that is immediate jeopardy as evidenced by the attached "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (K).

[ ] Widespread deficiencies that constitute actual harm that is immediate jeopardy as evidenced by the attached "Statement of Deficiencies and Plan of Correction" form, whereby significant corrections are required (L).

On May 20, 2020, immediate jeopardy to resident health and safety was identified.

The immediate jeopardy to resident health and safety was removed on May 22, 2020.

The enclosed Centers for Medicare and Medicaid Services (CMS) form, entitled "Statement of

Deficiencies and Plan of Correction" (CMS–2567), documents the deficiencies of participation requirements identified during this visit. All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations (CFR).

Plan of Correction (POC)
A POC for the deficiencies must be submitted within **ten (10) days from receipt of the CMS-2567**. Failure to submit an acceptable POC by the due date may result in termination of your provider agreement or imposition of alternate remedies by the CMS and/or State Medicaid Agency.

Providers may now submit their lan of correction (POC) as a separate document attachment or may continue to document the POC on the right side of the CMS Form 2567- "Statement of Deficiencies and Plan of Correction" and must contain the following:

- How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur;
- How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system; and
- Include dates when corrective actions will be completed. The corrective action completion dates must be acceptable to the State Agency.

Remedies
The remedies immediately imposed include the following:

[X] Immediate imposition of a civil money penalty.

The Regional Office or the State Medicaid Agency will impose a civil money penalty, and a notice of imposition will be sent to you.

[X] Termination of your provider agreement on November 30, 2020 if substantial compliance is not achieved by that time.

[X] State Monitoring

[X] Directed Plan of Correction

[X] Directed In-Service Training

The following remedy will also be recommended for imposition:

[ ] Temporary management effective - . (§488.415)

Denial of Payment for New Admissions (DPNA)
Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory DPNA effective August 31, 2020. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit. This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time.

CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid.

Immediate Imposition of Remedies Required
Irrespective of a state recommendation to impose or not impose a remedy, the CMS RO must immediately impose, without permitting a facility an opportunity to correct deficiencies, one or more federal remedies.

FILING AN APPEAL
If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an

authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Allegation of Compliance
If you believe these deficiencies have been corrected, you may submit your POC as your allegation of compliance to Naiades Paule, Supervisor, California Department of Public Health, Licensing and Certification Program, Health Facilities Inspection Division 3400 Aerojet Ave

Suite 323. El Monte, CA 91731.

We may accept your POC as your allegation of compliance and presume compliance until substantiated by a revisit. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy(ies) at that time.

If, upon the subsequent revisit, it is determined your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter will be imposed by the CMS Regional Office beginning on November 30, 2020 and continue until substantial compliance is achieved. Additionally, the CMS Regional Office may impose revised remedy(ies), based upon changes in the seriousness of the noncompliance at the time of the revisit, if appropriate.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and relevant information (evidence) as to why you are disputing those deficiencies, to Suzette Leverett-Clark, Assistant Chief, California Department of Public Health, Licensing and Certification Program, Health Facilities Inspection Division 12440 Imperial Highway Room 522. Norwalk, CA 90650.

This request must be sent during the same ten (10) days you have for submitting a POC for the cited deficiencies. An informal dispute resolution for the cited deficiencies will not delay the imposition of the recommended enforcement actions. A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Should CMS determine that termination or any other remedy is warranted, they will provide you with a separate formal notification of that determination.

If you have any questions concerning the instructions contained in this letter, please notify Naides Paule, Supervisor, at (626) 312 -1113

Sincerely,

Nwamaka Oranusi, Chief
Heath Facilities Inspection Division

Naides Paule, RN, MSN, MPH, CNS
Supervisor Los Angeles Region 1 Complaint Unit,

Enclosure: CMS-2567

cc: Mary Lee
Centers for Medicaid and Medicare Services

Exhibit E

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

June 2, 2020

HAND-DELIVERED

Jose Arevalo, Administrator
Golden Cross Health Care
1450 N Fair Oaks Ave
Pasadema, CA 91103

Re: Statement of Cause and Concerns

Dear Mr. Arevalo:

Pursuant to the requirements of Health and Safety Code section 1325.5, subdivision (e)(2), the Department of Public Health (Department) is providing you with a Statement of Cause and Concerns and supporting declaration that specifies the factual and legal bases for the Department's appointment of a temporary manager (TM) to Golden Cross Health Care. Also included is information regarding your right to contest the Department's appointment of a TM along with the appropriate form to file the petition.

STATEMENT OF CAUSE AND CONCERNS

The licensee for Golden Cross Health Care is named 1450 North Fair Oaks LLC. The property owner for 1450 N Fair Oaks Ave, Pasadena, CA 91103, is EBDMZR, LLC, where Golden Cross Health Care is located. The facility has 96 licensed skilled nursing beds. The current facility census is 64.

On May 26, 2020, the Department received a complaint regarding the Licensee's failure to provide quality care to residents. During the complaint investigation, the Department found that the Licensee is failing to provide sufficient pericare or medication documentation and counts, and personal protective equipment (PPE) is not being properly worn by staff, in addition to other concerns for the facility and its staffing. On May 27, 2020, at 12:25 am, the survey team returned and continued the investigation. The Department called six immediate jeopardies under the following federal tags: F695, F812, F698, F684, F686, and F600.

The Department has identified the following concerns: 1) insufficient pericare and wound management, including one resident not recieving adequate wound care putting the resident at risk for limb amputation; 2) medication documentation is not being completed; 3) medication counts have not been done by two licensed nurses; 4) staff are not properly wearing PPE; 5) a blown circuit due to over-use of oxygen devices, resulting in a resident becoming hypoxic; 6) fruit flies in the facility; 7) residents not receiving adequate water and snacks; 8) a resident was bleeding from a dialysis port and had to hold pressure for 30 minutes before help was provided; and 9) registry staff are lacking accountability. The immediate need for a TM is to ensure residents are safe and receiving quality care, including medical treatment, medication management, and proper nutrition and hydration. In addition, the safety and cleanliness of the facility needs to be immediately improved to remove the fruit flies and ensure proper power management for oxygen devices. Further, a TM is needed to ensure staff are wearing PPE properly and that registry staff are held accountable.

Consequently, on May 26, 2020, the Department found two Immediate Jeopardy's and then on May 27, 2020, the Department found another six Immediate Jeopardy's exist at this facility. The Licensee's "noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR 489.3.).

Licensee has no plans in place and has not proposed a sufficient plan to provide for the continued care of its residents.

The Department has determined the following:

1) The residents are not receiving adequate care, putting their health and safety at risk through wound management, medication management, facility cleanliness, and staff protective gear

2) Absent the appointment of a TM, the Licensee's failure to provide quality standards of care has caused, or is likely to cause, serious injury, harm, impairment or death to residents.

PETITION FOR HEARING

Pursuant to section 1325.5, subdivision (f), a Licensee may contest the appointment of the TM within 60 days of the date the Statement of Cause and Concerns was mailed, by filing a petition for an order to terminate the appointment of the TM with the Office of Administrative Hearings in the Department of General Services (OAH). Enclosed is a form and information for your use in requesting a hearing, if you choose to do so. Please note that on the same day that the petition is filed with OAH, section 1325.5, subdivision (f)(1), provides that you shall also deliver a copy of the petition to OAH to the Assistant Deputy Director, Center for Health Care Quality, Scott Vivona, at 1615 Capitol Avenue, P.O. Box 997377, Mail Stop 0512, Sacramento, California 95899-7413.

Section 1325.5, subdivision (f), further provides that when the petition is received, OAH will set a date and time for the hearing that is within five (50 days, and shall promptly notify both you and the Department of the date, time, and place of the hearing. At the hearing, each party may present relevant evidence, pursuant to Government Code section 11513. Section 1325.5 requires the administrative law judge to issue a written decision on the petition within five (5) business days of the conclusion of the hearing. However, the statute provides that the five-day time period for holding the hearing and rendering a decision may be extended by agreement of the parties.

Section 1325.5, subdivision (f)(3), provides that the administrative law judge shall uphold the appointment of the TM if the Department proves, by a preponderance of the evidence, that the circumstances specified in section 1325.5, subdivision (c), applied to the facility at the time of appointment. If the Department does not present evidence to satisfy the burden of proof, the administrative law judge shall terminate the TM.

The decision of the administrative law judge is subject to judicial review as provided in Code of Civil Procedure section 1094.5 by the superior court sitting in the county where the facility is located.

Sincerely,

Scott Vivona Digitally signed by Scott Vivona
Date: 2020.06.01 13:31:33
-07'00'

T. Scott Vivona
Assistant Deputy Director

cc: Nwamaka Oranusi, District Manager
Los Angeles District Office
Licensing & Certification Program
California Department of Public Health

Attachments

Please attach a copy of the Statement of Allegations, Statement of Cause and Concerns, and Declaration in Support that were submitted to you by the Department of Public Health.

This Petition should be mailed to the following address:

Office of Administrative Hearings
California Department of General Services
2349 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
916.263.0550

PETITION FOR HEARING
FOR ORDER TO TERMINATE THE APPOINTMENT OF A TEMPORARY MANAGER
UNDER
SECTION 1325.5 OF THE HEALTH AND SAFETY CODE

1. Date of Petition:

2. Petitioner Name:

3. Petitioner Mailing Address:

4. Telephone Number:

5. Name and Address of Facility where Temporary Manager Imposed:

6. Facility Telephone Number:

7. Reason for Petition:*

8. Legal Basis for Petition:*

9. Factual Basis for Petition:*

*Attach additional sheets if necessary.

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

ACKNOWLEDGMENT OF RECEIPT OF STATEMENT OF CAUSE AND CONCERNS

By signing below, I certify that I am an authorized representative of Golden Cross Health Care, and I am authorized to both accept and acknowledge receipt of the Statement of Cause and Concerns. I was served with, and acknowledge receipt of, the Statement of Cause and Concerns, dated 06/02/2020, on the date indicated below.

DATED: 06/02/2020

Signature of Golden Cross Health Care, representative

Mailing address of Golden Cross Health Care representative:

1450 North Fair Oaks Avenue
Pasadena, CA 91103

Telephone: (626) 791-1948

Email: joe@goldencrosshealthcare.com

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

June 2, 2020

HAND-DELIVERED

Jose Arevalo, Administrator
Golden Cross Health Care
1450 N Fair Oaks Ave
Pasadena, CA 91103

Dear Mr. Arevalo:

NOTIFICATION OF TEMPORARY MANAGEMENT APPOINTMENT

By this letter, the California Department of Public Health (Department) is notifying you that it is appointing a Temporary Manager (TM) under Health and Safety Code section 1325.5 for Golden Cross Health Care, a skilled nursing facility licensed by the Department. The Department found that the "residents of the long-term health care facility are in immediate danger of death or permanent injury by virtue of the failure of the facility to comply with federal or state requirements applicable to the operation of the facility."

The Department also found that "as a result of the change in the status of the license or operation of a long-term care facility, the facility is required to comply with section 1336.2, but that it is failing to comply with section 1336.2," and "the facility is unwilling or unable to meet the requirements of section 1336.2."

This appointment is effective June 2, 2020.

This letter also contains the Statement of Allegations required by section 1325.5, subdivision (e)(2).

BACKGROUND

1450 North Fair Oaks LLC, is the licensee for Golden Cross Health Care. EBDMZR, LLC, is the property owner for 1450 N Fair Oaks Ave, Pasadena, CA 91103, where Golden Cross Health Care is located. The facility has 96 licensed skilled nursing beds. The current facility census is 64.

On May 26, 2020, the Department received a complaint regarding the Licnesee's failure to provide quality care to residents. During the complaint investigation, the Department found that the Licensee is failing to provide sufficient pericare or medication documentation and counts, and staff is not properly wearing personal protecetive equipment (PPE), in addition to other concerns the facility and its staffing.

The Department has identified the following concerns: 1) insufficient pericare and wound management, including one resident not recieving adequate wound care putting the resident at risk for limb amputation; 2) medication documentation is not being completed; 3) medication counts have not been done with two licensed nurses; 4) staff is not properly wearing PPE; 5) a blown circuit due to over-use of oxygen devices, resulting in a resident becoming hypoxic; 6) fruit flies in the facility; 7) residents not receiving adequate water and snacks; and 8) registry staff lacking accountability. The immediate need for a TM is to ensure residents are safe and receiving quality care, including medical treatment, medication management, and proper nutritiation and hydration. In addition, the safety and cleaniness of the facility needs to be immediately improved to remove the fruit flies and ensure proper power management for oxygen devices. Further, a TM is needed to ensure staff is wearing PPE properly and that registry staff is held accountable.

Consequently, on May 26, 2020, the Department found that Immediate Jeopardy exists at this facility. The Licensee's "noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR 489.3.).

Licensee has no plans in place and has not proposed a sufficient plan to provide for the continued care of its residents.

The Department has determined the following:

1) The residents are not receiving adequate care, putting their health and safety at risk through wound management, medication management, facility cleanliness, and staff protective gear, and

2) Absent the appointment of a TM, the Licensee's failure to provide quality standards of care has caused, or is likely to cause, serious injury, harm, impairment or death to residents.

STATEMENT OF ALLEGATIONS

The Licensee cannot continue to care for the residents.

Due to the Licensee's inability to provide quality care to residents, provide a clean a safe facility, and ensure staff is accountable and properly wearing protective gear, the

Licensee has failed to meet professional standards of care for residents and necessitates the appointment of a TM to protect the residents.

You will be provided with a Formal Statement of Cause and Concerns as required in section 1325.5, subdivision (e)(2), within 48 hours of the appointment of the TM's appointment.

Sincerely,

Scott Vivona Digitally signed by Scott Vivona
Date: 2020.06.01 13:35:01 -07'00'

Scott Vivona
Assistant Deputy Director

cc: Nwamaka Oranusi, District Manager
Los Angeles District Office
Licensing & Certification Program
California Department of Public Health

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

ACKNOWLEDGMENT OF RECEIPT OF NOTIFICATION OF APPOINTMENT OF TEMPORARY MANAGER

By signing below, I certify that I am an authorized representative of Golden Cross Health Center, and have authority to both accept and acknowledge receipt of the Notification of Appointment of Temporary Manager, dated 06/02/2020 On 06/02/2020 at 11:45 a.m., a representative of the California Department of Public Health served, and I received, the Notification of Appointment of Temporary Manager addressed to Golden Cross Health Care

DATED: 06/02/2020

Signature of Golden Cross Health Care, representative

Mailing address of Golden Cross Health Care, representative:

1450 North Fair Oaks Avenue
Pasadena, CA 91103

Telephone: (626) 791-1948

Email: joe@goldencrosshealthcare.com

DECLARATION OF T. SCOTT VIVONA

I, T. Scott Vivona, declare as follows:

I am currently employed as the Assistant Deputy Director, Center of Health Care Quality, by the California Department of Public Health (CDPH). I currently oversee the management and supervision of the Licensing and Certification Field Operations which is primarily responsible for ensuring that health care facilities, including skilled nursing facilities, comply with State licensing laws. As the state survey agency acting for the Centers for Medicare and Medicaid Services, CDPH Licensing and Certification is also responsible for certifying that health care facilities that receive Medicare and Medicaid payments meet federal participation requirements.

If called upon to testify, I could competently testify to the following facts as they are personally known to me.

I am designated to act on behalf of the Director of CDPH for the purposes of appointing a Temporary Manager (TM) under Health and Safety Code section 1325.5. I have reviewed and concur with the Statement of Cause and Concerns and support the appointment of a TM at Golden Cross Health Care at 1450 N Fair Oaks Ave, Pasadena, California 91103.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct of my own knowledge, except for those statements that are alleged on information and belief, and as to those statements, I am informed and believe that they are correct and true.

Executed this 1st the day of June, 2020 at Sacramento, CA.

By: Scott Vivona

Digitally signed by Scott Vivona
Date: 2020.06.01 13:34:15 -07'00'

T. Scott Vivona
Assistant Deputy Director
Center for Health Care Quality
California Department of Public Health

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

June 3, 2020

HAND-DELIVERED

Jose Arevalo, Administrator
Golden Cross Health Care
1450 N Fair Oaks Ave
Pasadema, CA 91103

Re: Amended Statement of Cause and Concerns

Dear Mr. Arevalo:

On June 2, 2020, The California Department of Public Health (Department) appointed a temporary manager (TM) at Golden Cross Health Care and provided you with a statement of cause and concerns and supporting documentation. Pursuant to the requirements of Health and Safety Code section 1325.5, subdivision (e)(2), the Department is providing you with an amended Statement of Cause and Concerns and supporting declaration that specifies the factual and legal bases for the Department's appointment of a temporary manager (TM) to Golden Cross Health Care. Also included is information regarding your right to contest the Department's appointment of a TM along with the appropriate form to file the petition.

STATEMENT OF CAUSE AND CONCERNS

The Licensee for Golden Cross Health Care is named 1450 North Fair Oaks LLC. The property owner for 1450 N Fair Oaks Ave, Pasadena, CA 91103, is EBDMZR, LLC, where Golden Cross Health Care is located. The facility has 96 licensed skilled nursing beds. The current facility census is 64.

On May 15, 2020, the Department found three Immediate Jeopardies, two for infection control and one for pharmacy services. The Department found that the Licensee failed to administer medications as ordered by the physician, failed to document medication and counts, and staff failed to properly wear personal protective equipment (PPE), in addition to other concerns including infection control training and staffing concerns.

Then, on May 26, 2020, the Department received a complaint regarding the Licensee's failure to provide quality care to residents. On May 27, 2020, during the complaint investigation, the Department called six Immediate Jeopardies under the following areas: pressure care and wound management, dialysis, medication management, neglect, oxygen not provided as ordered by the physician, and the food prepararation area was not maintained in a safe and sanitary manner. (Federal tags: F695, F812, F698, F684, F686, and F600.)

Based upon the above, the Department has identified the following concerns: 1) insufficient wound management, including one resident not recieving adequate wound care putting the resident at risk for limb amputation; 2) medication documentation not being completed; 3) medication counts were not done by two licensed nurses; 4) staff not properly wearing PPE; 5) a blown circuit due to over-use of oxygen devices, resulting in a resident becoming hypoxic; 6) food preparation is unsanitary with fruit flies in the food area; 7) residents not receiving adequate water and snacks; 8) a resident bleeding from a dialysis port and holding pressure for 30 minutes before help was provided; 9) three residents were neglected when they did not receive showers for two weeks and were not provided with clean clothes and linens; and 10) registry staff are lacking accountability. The immediate need for a TM is to ensure residents are safe and receiving quality care, including medical treatment, medication management, and proper nutrition and hydration. In addition, the safety and cleanliness of the facility needs to be immediately improved to remove the fruit flies and ensure proper power management for oxygen devices. Further, a TM is needed to ensure staff are wearing PPE properly and that registry staff are held accountable.

Consequently, on May 15, 2020, the Department found three Immediate Jeopardies, which were abated on May 22, 2020. On May 27, 2020, the Department found another six Immediate Jeopardyies, which were unabated and the plan of actions were not accepted. The Department conducted an exit conference on May 28, 2020, and the facility was given a continued non-compliance with federal regulations. The Licensee's "noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR 489.3).

Licensee has no plans in place and has not proposed a sufficient plan to provide for the continued care of its residents.

The Department has determined the following:

1) The residents are not receiving adequate care which is putting their health and safety at risk through wound management, medication management, facility cleanliness for food safety and personal hygien, and infectin control practices related to PPE.

2) Absent the appointment of a TM, the Licensee's failure to provide quality standards of care has caused, or is likely to cause, serious injury, harm, impairment or death to residents.

PETITION FOR HEARING

Pursuant to section 1325.5, subdivision (f), a Licensee may contest the appointment of the TM within 60 days of the date the Statement of Cause and Concerns was mailed, by filing a petition for an order to terminate the appointment of the TM with the Office of Administrative Hearings in the Department of General Services (OAH). Enclosed is a form and information for your use in requesting a hearing, if you choose to do so. Please note that on the same day that the petition is filed with OAH, section 1325.5, subdivision (f)(1), provides that you shall also deliver a copy of the petition to OAH to the Assistant Deputy Director, Center for Health Care Quality, Scott Vivona, at 1615 Capitol Avenue, P.O. Box 997377, Mail Stop 0512, Sacramento, California 95899-7413.

Section 1325.5, subdivision (f), further provides that when the petition is received, OAH will set a date and time for the hearing that is within five (50 days, and shall promptly notify both you and the Department of the date, time, and place of the hearing. At the hearing, each party may present relevant evidence, pursuant to Government Code section 11513. Section 1325.5 requires the administrative law judge to issue a written decision on the petition within five (5) business days of the conclusion of the hearing. However, the statute provides that the five-day time period for holding the hearing and rendering a decision may be extended by agreement of the parties.

Section 1325.5, subdivision (f)(3), provides that the administrative law judge shall uphold the appointment of the TM if the Department proves, by a preponderance of the evidence, that the circumstances specified in section 1325.5, subdivision (c), applied to the facility at the time of appointment. If the Department does not present evidence to satisfy the burden of proof, the administrative law judge shall terminate the TM.

The decision of the administrative law judge is subject to judicial review as provided in Code of Civil Procedure section 1094.5 by the superior court sitting in the county where the facility is located.

Sincerely,

Scott Vivona Digitally signed by Scott Vivona
Date: 2020.06.02 16:55:26
-07'00'

T. Scott Vivona
Assistant Deputy Director

cc: Nwamaka Oranusi, District Manager
Los Angeles District Office
Licensing & Certification Program
California Department of Public Health

Attachments

PETITION FOR HEARING
FOR ORDER TO TERMINATE THE APPOINTMENT OF A TEMPORARY MANAGER
UNDER
SECTION 1325.5 OF THE HEALTH AND SAFETY CODE

1. Date of Petition:

2. Petitioner Name:

3. Petitioner Mailing Address:

4. Telephone Number:

5. Name and Address of Facility where Temporary Manager Imposed:

6. Facility Telephone Number:

7. Reason for Petition:*

8. Legal Basis for Petition:*

9. Factual Basis for Petition:*

*Attach additional sheets if necessary.

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

ACKNOWLEDGMENT OF RECEIPT OF STATEMENT OF CAUSE AND CONCERNS

By signing below, I certify that I am an authorized representative of Golden Cross Health Care, and I am authorized to both accept and acknowledge receipt of the Statement of Cause and Concerns. I was served with, and acknowledge receipt of, the Statement of Cause and Concerns, dated 06/03/20, on the date indicated below.

DATED: 06/03/20

Signature of Golden Cross Health Care, representative

Mailing address of Golden Cross Health Care representative:

1450 North Fair Oaks Avenue
Pasadena, CA 91103

Telephone: (626) 791-1948

Email: joe@goldencrosshealthcare.com

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

June 3, 2020

HAND-DELIVERED

Jose Arevalo, Administrator
Golden Cross Health Care
1450 N Fair Oaks Ave
Pasadena, CA 91103

Dear Mr. Arevalo:

RE: AMENDED NOTIFICATION OF TEMPORARY MANAGEMENT APPOINTMENT

On June 2, 2020, The California Department of Public Health (Department) appointed a temporary manager (TM) at Golden Cross Health Care and provided you with a statement of cause and concerns and supporting documentation. By this amended letter, the Department is notifying you that it is appointing a TM under Health and Safety Code section 1325.5 for Golden Cross Health Care, a skilled nursing facility licensed by the Department. The Department found that the "residents of the long-term health care facility are in immediate danger of death or permanent injury by virtue of the failure of the facility to comply with federal or state requirements applicable to the operation of the facility."

The Department also found that "as a result of the change in the status of the license or operation of a long-term care facility, the facility is required to comply with section 1336.2, but that it is failing to comply with section 1336.2," and "the facility is unwilling or unable to meet the requirements of section 1336.2."

This appointment is effective June 2, 2020.

This letter also contains the Statement of Allegations required by section 1325.5, subdivision (e)(2).

BACKGROUND

The Licensee for Golden Cross Health Care is named 1450 North Fair Oaks LLC. The property owner for 1450 N Fair Oaks Ave, Pasadena, CA 91103, is EBDMZR, LLC,

where Golden Cross Health Care is located. The facility has 96 licensed skilled nursing beds. The current facility census is 64.

On May 15, 2020, the Department found three Immediate Jeopardies, two for infection control and one for pharmacy services. The Department found that the Licensee failed to administer medications as ordered by the physician, failed to document medication and counts, and staff failed to properly wear personal protective equipment (PPE), in addition to other concerns including infection control training and staffing concerns.

Then, on May 26, 2020, the Department received a complaint regarding the Licensee's failure to provide quality care to residents. On May 27, 2020, during the complaint investigation, the Department called six Immediate Jeopardies under the following areas: pressure care and wound management, dialysis, medication management, neglect, oxygen not provided as ordered by the physician, and the food prepararation area was not maintained in a safe and sanitary manner. (Federal tags: F695, F812, F698, F684, F686, and F600.)

Based upon the above, the Department has identified the following concerns: 1) insufficient wound management, including one resident not recieving adequate wound care putting the resident at risk for limb amputation; 2) medication documentation not being completed; 3) medication counts were not done by two licensed nurses; 4) staff not properly wearing PPE; 5) a blown circuit due to over-use of oxygen devices, resulting in a resident becoming hypoxic; 6) food preparation is unsanitary with fruit flies in the food area; 7) residents not receiving adequate water and snacks; 8) a resident bleeding from a dialysis port and holding pressure for 30 minutes before help was provided; 9) three residents were neglected when they did not receive showers for two weeks and were not provided with clean clothes and linens; and 10) registry staff are lacking accountability. The immediate need for a TM is to ensure residents are safe and receiving quality care, including medical treatment, medication management, and proper nutrition and hydration. In addition, the safety and cleanliness of the facility needs to be immediately improved to remove the fruit flies and ensure proper power management for oxygen devices. Further, a TM is needed to ensure staff are wearing PPE properly and that registry staff are held accountable.

Consequently, on May 15, 2020, the Department found three Immediate Jeopardies, which were abated on May 22, 2020. On May 27, 2020, the Department found another six Immediate Jeopardyies, which were unabated and the plan of actions were not accepted. The Department conducted an exit conference on May 28, 2020, and the facility was given a continued non-compliance with federal regulations. The Licensee's "noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR 489.3).

Licensee has no plans in place and has not proposed a sufficient plan to provide for the continued care of its residents.

The Department has determined the following:

1) The residents are not receiving adequate care which is putting their health and safety at risk through wound management, medication management, facility cleanliness for food safety and personal hygien, and infectin control practices related to PPE.

2) Absent the appointment of a TM, the Licensee's failure to provide quality standards of care has caused, or is likely to cause, serious injury, harm, impairment or death to residents.

STATEMENT OF ALLEGATIONS

The Licensee cannot continue to care for the residents.

Due to the Licensee's inability to provide quality care to residents, provide a clean a safe facility, and ensure staff is accountable and properly wearing protective gear, the Licensee has failed to meet professional standards of care for residents and necessitates the appointment of a TM to protect the residents.

You will be provided with a Formal Statement of Cause and Concerns as required in section 1325.5, subdivision (e)(2), within 48 hours of the appointment of the TM's appointment.

Sincerely,

Scott Vivona Digitally signed by Scott Vivona
Date: 2020.06.02 16:56:37 -07'00'

Scott Vivona
Assistant Deputy Director

cc: Nwamaka Oranusi, District Manager
Los Angeles District Office
Licensing & Certification Program
California Department of Public Health

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

ACKNOWLEDGMENT OF RECEIPT OF NOTIFICATION OF APPOINTMENT OF TEMPORARY MANAGER

By signing below, I certify that I am an authorized representative of Golden Cross Health Center, and have authority to both accept and acknowledge receipt of the Notification of Appointment of Temporary Manager, dated 06/03/20. On 06/03/20 at 1:30 p.m., a representative of the California Department of Public Health served, and I received, the Notification of Appointment of Temporary Manager addressed to Golden Cross Health Care

DATED: 06/03/20

Signature of Golden Cross Health Care, representative

Mailing address of Golden Cross Health Care, representative:

1410 North Fair Oaks Avenue
Pasadena, CA 91103

Telephone: 626 791-1948

Email: joe@goldencrosshealthcare.com

DECLARATION OF T. SCOTT VIVONA

I, T. Scott Vivona, declare as follows:

I am currently employed as the Assistant Deputy Director, Center of Health Care Quality, by the California Department of Public Health (CDPH). I currently oversee the management and supervision of the Licensing and Certification Field Operations which is primarily responsible for ensuring that health care facilities, including skilled nursing facilities, comply with State licensing laws. As the state survey agency acting for the Centers for Medicare and Medicaid Services, CDPH Licensing and Certification is also responsible for certifying that health care facilities that receive Medicare and Medicaid payments meet federal participation requirements.

If called upon to testify, I could competently testify to the following facts as they are personally known to me.

I am designated to act on behalf of the Director of CDPH for the purposes of appointing a Temporary Manager (TM) under Health and Safety Code section 1325.5. I have reviewed and concur with the Amended Statement of Cause and Concerns and support the appointment of a TM at Golden Cross Health Care at 1450 N Fair Oaks Ave, Pasadena, California 91103.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct of my own knowledge, except for those statements that are alleged on information and belief, and as to those statements, I am informed and believe that they are correct and true.

Executed this the 2nd day of June, 2020 at Sacramento, CA.

By: Scott Vivona

Digitally signed by Scott Vivona
Date: 2020.06.02 16:54:44 -07'00'

T. Scott Vivona
Assistant Deputy Director
Center for Health Care Quality
California Department of Public Health

State of California—Health and Human Services Agency
California Department of Public Health

SONIA Y. ANGELL, MD, MPH
State Public Health Officer & Director

GAVIN NEWSOM
Governor

June 10, 2020

HAND-DELIVERED

Jose Arevalo, Administrator
Golden Cross Health Care
1450 N Fair Oaks Ave
Pasadema, CA 91103

Re: Amended Statement of Cause and Concerns

Dear Mr. Arevalo:

On June 2, 2020, The California Department of Public Health (Department) appointed a temporary manager (TM) at Golden Cross Health Care and provided you with a statement of cause and concerns and supporting documentation. Pursuant to the requirements of Health and Safety Code section 1325.5, subdivision (e)(2), the Department is providing you with an amended Statement of Cause and Concerns and supporting declaration that specifies the factual and legal bases for the Department's appointment of a temporary manager (TM) to Golden Cross Health Care. Also included is information regarding your right to contest the Department's appointment of a TM along with the appropriate form to file the petition.

STATEMENT OF CAUSE AND CONCERNS

The Licensee for Golden Cross Health Care is named 1450 North Fair Oaks LLC. The property owner for 1450 N Fair Oaks Ave, Pasadena, CA 91103, is EBDMZR, LLC, where Golden Cross Health Care is located. The facility has 96 licensed skilled nursing beds. The current facility census is 64.

On May 15, 2020, the Department found three Immediate Jeopardies, two for infection control and one for pharmacy services. The Department found that the Licensee failed to administer medications as ordered by the physician, failed to document medication and counts, and staff failed to properly wear personal protective equipment (PPE), in addition to other concerns including infection control training and staffing concerns.

Then, on May 26, 2020, the Department received a complaint regarding the Licensee's failure to provide quality care to residents. On May 27, 2020, during the complaint investigation, the Department called six Immediate Jeopardies under the following areas: pressure care and wound management, dialysis, medication management, neglect, oxygen not provided as ordered by the physician, and the food prepararation area was not maintained in a safe and sanitary manner (Federal tags: F695, F812, F698, F684, F686, and F600.)

Based upon the above, the Department has identified the following concerns: 1) insufficient wound management, including one resident not recieving adequate wound care putting the resident at risk for limb amputation; 2) medication documentation not being completed; 3) medication counts were not done by two licensed nurses; 4) staff not properly wearing PPE; 5) a blown circuit due to over-use of oxygen devices, resulting in a resident becoming hypoxic; 6) food preparation is unsanitary with fruit flies in the food area; 7) residents not receiving adequate water and snacks; 8) a resident bleeding from a dialysis port and holding pressure for 30 minutes before help was provided; 9) three residents were neglected when they did not receive showers for two weeks and were not provided with clean clothes and linens; and 10) registry staff are lacking accountability. The immediate need for a TM is to ensure residents are safe and receiving quality care, including medical treatment, medication management, and proper nutrition and hydration. In addition, the safety and cleanliness of the facility needs to be immediately improved to remove the fruit flies and ensure proper power management for oxygen devices. Further, a TM is needed to ensure staff are wearing PPE properly and that registry staff are held accountable.

Consequently, on May 15, 2020, the Department found three Immediate Jeopardy's, which were abated on May 22, 2020. On May 27, 2020, the Department found another six Immediate Jeopardy's exist, which were unabated and the plan of actions were not accepted. The Department conducted an exit conference on May 28, 2020, and the facility was given a continued non-compliance with federal regulations. The Licensee's "noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR 489.3).

Licensee has no plans in place and has not proposed a sufficient plan to provide for the continued care of its residents.

The Department has determined the following:

1) The residents are not receiving adequate care which is putting their health and safety at risk through wound management, medication management, facility cleanliness for food safety and personal hygien, and infectin control practices related to PPE.

2) Absent the appointment of a TM, the Licensee's failure to provide quality standards of care has caused, or is likely to cause, serious injury, harm, impairment or death to residents.

PETITION FOR HEARING

Pursuant to section 1325.5, subdivision (f), a Licensee may contest the appointment of the TM within 60 days of the date the Statement of Cause and Concerns was mailed, by filing a petition for an order to terminate the appointment of the TM with the Office of Administrative Hearings and Appeals in the Department of Health Care Services General Services (OAHA), as required by the Department's contract with OAHA. Enclosed is a form and information for your use in requesting a hearing, if you choose to do so. Please note that on the same day that the petition is filed with OAHA, section 1325.5, subdivision (f)(1), provides that you shall also deliver a copy of the petition to the Assistant Deputy Director, Center for Health Care Quality, Scott Vivona, at 1615 Capitol Avenue, P.O. Box 997377, Mail Stop 0512, Sacramento, California 95899-7413.

Section 1325.5, subdivision (f), further provides that when the petition is received, OAHA will set a date and time for the hearing that is within five (5) days, and shall promptly notify both you and the Department of the date, time, and place of the hearing. At the hearing, each party may present relevant evidence, pursuant to Government Code section 11513. Section 1325.5 requires the administrative law judge to issue a written decision on the petition within five (5) business days of the conclusion of the hearing. However, the statute provides that the five-day time period for holding the hearing and rendering a decision may be extended by agreement of the parties.

Section 1325.5, subdivision (f)(3), provides that the administrative law judge shall uphold the appointment of the TM if the Department proves, by a preponderance of the evidence, that the circumstances specified in section 1325.5, subdivision (c), applied to the facility at the time of appointment. If the Department does not present evidence to satisfy the burden of proof, the administrative law judge shall terminate the TM.

The decision of the administrative law judge is subject to judicial review as provided in Code of Civil Procedure section 1094.5 by the superior court sitting in the county where the facility is located.

Sincerely,

Scott Vivona

Digitally signed by Scott Vivona
Date: 2020.06.10 16:34:17 -07'00'

T. Scott Vivona
Assistant Deputy Director

cc: Nwamaka Oranusi, District Manager
Los Angeles District Office
Licensing & Certification Program
California Department of Public Health

Attachments

Please attach a copy of the Statement of Allegations, Statement of Cause and Concerns, and Declaration in Support that were submitted to you by the Department of Public Health.

This Petition should be mailed to the following address:

Office of Administrative Hearings and Appeals
California Department of Health Care Services
3831 N. Freeway Blvd., Suite 200
Sacramento, CA 95834
916-322-5603

PETITION FOR HEARING
FOR ORDER TO TERMINATE THE APPOINTMENT OF A TEMPORARY MANAGER
UNDER
SECTION 1325.5 OF THE HEALTH AND SAFETY CODE

1. Date of Petition:

2. Petitioner Name:

3. Petitioner Mailing Address:

4. Telephone Number:

5. Name and Address of Facility where Temporary Manager Imposed:

6. Facility Telephone Number:

7. Reason for Petition:*

8. Legal Basis for Petition:*

9. Factual Basis for Petition:*

*Attach additional sheets if necessary.

Exhibit F

DECLARATION OF KAREN LAPCEWICH

I, Karen Lapcewich, declare as follows:

1. On June 2, 2020, the California Department of Public Health (CDPH) appointed me as the Temporary Manager (TM) for Golden Cross Health Care, at 1450 N Fair Oaks Ave, Pasadena, California, 91103. As such, I oversee the management and operation of Golden Cross Health Care and am acting as the facility's administrator pursuant to Health and Safety Code section 1325.5. If called upon to testify, I could and would competently testify to the following facts as they are personally known to me.

2. There are numerous ongoing and serious quality of care issues at Golden Cross. For example, an outside nurse consultant identified that at least 13 residents are suffering from dehydration because there is no existing hydration program monitoring. Outside consultants and I, as TM, have had to provide intravenous (IV) hydration. To date, the facility has not initiated the IVs. Before I was appointed as TM, staff was not timely providing water to patients throughout the day.

3. Additionally, there is no skin management program to prevent residents from getting pressure ulcers. There are no preventative measures for skin break down including proper care planning and pressure relieving devices to address ongoing pressure ulcer problems. And residents are not being turned on a regular basis. Consequently, residents are continuing to develop pressure ulcers and existing ones are worsening.

4. Similarly, residents are not changed and often lay in their urine for hours.

5. There is no current maintenance manager and no logs or maintenance program could be provided when sought. Of concern is the air filter system, which is not working properly, and dirt and heavy dust were observed on facility air vents.

6. Overall infection control is also of grave concern. Not only is there is no basic functioning infection operational control program, but there is also not one specific to COVID-19. Thus, there are infection control issues related to donning and doffing personal protective equipment (PPE), handwashing, cross-contamination, and food transport. Moreover, there is no basic infection surveillance tracking and trending, no COVID-19 surveillance and tracking, and staff are moving in and out of red and green zones (COVID-19 positive and negative areas) without taking the proper precautions.

7. The facility is not addressing or preventing resident abuse by the facility staff. Bruises are not being investigated or reported, so incident reports are not being generated to understand the origin of the injuries. Cases of abuse are not reported timely, investigated, and are difficult to prevent. This includes the recent alleged physical abuse where a staff member allegedly slapped and pushed a resident into his bed. The owner and director of nursing were notified of this event shortly after it occurred. They did not report the event within two hours, and they allowed the staff to continue working through the shift. The staff member was not taken off the schedule and returned the next day. The police were not notified until several days later. I provided the information to the police rather than the facility reporting the incident. To date there has been no investigation, no notes in the patient's chart of the events, and no incident report has been generated.

8. There is no weight management program. Approximately 90 percent of residents have recently lost weight. The dietary department is not following menus or portion control. Also, it was observed that staff remove meals from the residents prior to the resident completing the meal and are not allowing the residents to eat their entire meal. Residents were not offered evening snacks, so the CalMat team (Medical Assistance Teams (CAL-MATs) are a group of highly trained medical professionals and other specialists organized and coordinated by the State Emergency Medical Services Authority (EMSA) for rapid field medical response in disasters) have been assisting by preparing snacks for residents because the facility failed to address this issue.

9. There is inadequate supervision of patients. One resident has been identified as a risk for elopement. The resident's care plan is clearly not effective to prevent this resident from eloping. The National Guard (brought in after CalMat was demobilized) found the resident just before the resident ran into the street.

10. Nurses are failing to identify when a resident has a change of condition and failing to report a change of condition.

11. The facility is not conducting interdisciplinary team care plan meetings to meet and address the residents' needs.

12. There is no full-time staff developer working during day hours to conduct in-service trainings and monitor staff.

13. The Registered Nurse Supervisor's keys are left out and unsupervised. These keys include those that secure the narcotics.

14. There is no existing activity program. Though COVID-19 may prevent community activities and room visits, activities can still be easily scheduled for residents. Residents

just watched TV all day with nothing to do and remain isolated.

15. There is no Quality Assessment and Improvement Program or even basic quality assurance.

I declare under penalty of perjury under the laws of the State of California, that the foregoing is true and correct of my own knowledge.

Executed on June 10, 2020, in Pasadena, California.

6/10/20

Karen Lapcewich
Temporary Manager
Principal
Greater Vision Healthcare Services

BEFORE THE
DEPARTMENT OF PUBLIC HEALTH

In the Matter of the Accusation Against: GOLDEN CROSS HEALTH CARE 1450 N. Fair Oaks Avenue Pasadena, CA 91103 License Number: 970000082 Facility ID: 970000171 Respondent.	CDPH Case No.: 20-AL-LNC-39848 **NOTICE OF DEFENSE**

By signing below, I acknowledge receipt of a copy of the Statement to Respondent, Accusation, Government Code sections 11507.5, 11507.6, and 11507.7 and this Notice of Defense. I hereby request a hearing in this proceeding to permit me to present my defense to the charges.

DATED: _____

_____
Respondent:

Mailing address of Respondent:

_____

_____

_____

Telephone: (___) _____

Email: _____

( ) I will not be represented by counsel.

( ) I will be represented by counsel.
My counsel's name, address and telephone number are:

_____

_____

_____

Telephone: (___) _____

Email: _____

COPY OF GOVERNMENT CODE SECTIONS 11507.5, 11507.6 AND 11507.7 PURSUANT TO GOVERNMENT CODE SECTIONS 11504 AND 11505

11507.5 Discovery; exclusive provisions

The provisions of Section 11507.6 provide the exclusive right to and method of discovery as to any proceeding governed by this chapter.

11507.6 Request for discovery; statements; writings; investigative reports

After initiation of a proceeding in which a respondent or other party is entitled to a hearing on the merits, a party, upon written request made to another party, prior to the hearing and within 30 days after service by the agency of the initial pleading or within 15 days after the service of an additional pleading, is entitled to (1) obtain the names and addresses of witnesses to the extent known to the other party, including, but not limited to, those intended to be called to testify at the hearing, and (2) inspect and make a copy of any of the following in the possession or custody or under the control of the other party:

(a) A statement of a person, other than the respondent, named in the initial administrative pleading, or in any additional pleading, when it is claimed that the act or omission of the respondent as to this person is the basis for the administrative proceeding;

(b) A statement pertaining to the subject matter of the proceeding made by any party to another party or person;

(c) Statements of witnesses then proposed to be called by the party and of other persons having personal knowledge of the acts, omissions or events which are the basis for the proceeding, not included in (a) or (b) above;

(d) All writings, including, but not limited to, reports of mental, physical and blood examinations and things which the party then proposes to offer in evidence;

(e) Any other writing or thing which is relevant and which would be admissible in evidence;

(f) Investigative reports made by or on behalf of the agency or other party pertaining to the subject matter of the proceeding, to the extent that these reports (1) contain the names and addresses of witnesses or of persons having personal knowledge of the acts, omissions or events which are the basis for the proceeding, or (2) reflect matters perceived by the investigator in the course of his or her investigation, or (3) contain or include by attachment any statement or writing described in (a) to (e), inclusive, or summary thereof.

For the purpose of this section, "statements" include written statements by the person signed or otherwise authenticated by him or her, stenographic, mechanical, electrical or other recordings, or transcripts thereof, of oral statements by the person, and written reports or summaries of these oral statements.

Nothing in this section shall authorize the inspection or copying of any writing or thing which is privileged from disclosure by law or otherwise made confidential or protected as the attorney's work product.

11507.7 Motion to compel discovery

(a) Any party claiming the party's request for discovery pursuant to Section 11507.6 has not been complied with may serve and file with the administrative law judge a motion to compel discovery, naming as respondent the party refusing or failing to comply with Section 11507.6. The motion shall state facts showing the respondent party failed or refused to comply with Section 11507.6, a description of the matters sought to be discovered, the reason or reasons why the matter is discoverable under that section, that a reasonable and good faith attempt to contact the respondent for an informal resolution of the issue has been made, and the ground or grounds of respondent's refusal so far as known to the moving party.

(b) The motion shall be served upon respondent party and filed within 15 days after the respondent party first evidenced failure or refusal to comply with Section 11507.6 or within 30 days after request was made and the party has failed to reply to the request, or within another time provided by stipulation, whichever period is longer.

(c) The hearing on the motion to compel discovery shall be held within 15 days after the motion is made, or a later time that the administrative law judge may on the judge's own motion for good cause determine. The respondent party shall have the right to serve and file a written answer or other response to the motion before or at the time of the hearing.

(d) Where the matter sought to be discovered is under the custody or control of the respondent party and the respondent party asserts that the matter is not a discoverable matter under the provisions of Section 11507.6, or is privileged against disclosure under those provisions, the administrative law judge may order lodged with it matters provided in subdivision (b) of Section 915 of the Evidence Code and examine the matters in accordance with its provisions.

(e) The administrative law judge shall decide the case on the matters examined in camera, the papers filed by the parties, and such oral argument and additional evidence as the administrative law judge may allow.

(f) Unless otherwise stipulated by the parties, the administrative law judge shall no later than 15 days after the hearing make its order denying or granting the motion. The order shall be in writing setting forth the matters the moving party is entitled to discover under Section 11507.6. A copy of the order shall forthwith be served by mail by the administrative law judge upon the parties. Where the order grants the motion in whole or in part, the order shall not become effective until 10 days after the date the order is served. Where the order denies relief to the moving party, the order shall be effective on the date it is served.

END

DECLARATION OF SERVICE
PROOF OF SERVICE

Golden Cross Health Care
CDPH Case No. 20-AL-LNC-39848

I declare that I am employed in the County of Sacramento, California. I am over the age of eighteen years and not a party to the within cause. My business address is 1415 L Street, Suite 500, Sacramento, California 95814.

On the date indicated below, I served the forgoing document(s) described as:

TEMPORARY SUSPENSION ORDER, ACCUSATION, NOTICE OF DEFENSE, AND GOVERNMENT CODE SECTIONS 11507.5, 11507.6 AND 11507.7

on the interested parties in this action, in a sealed envelope addressed as follows:

Joseph R. LaMagna
Stanton J. Stock
Hooper, Lundy & Bookman, P.C
101 W. Broadway, Suite 1200
San Diego, CA 92101-8214

[ ] BY MAIL: I am readily familiar with California Department of Public Health's practice of collection and processing mail. Under the practice, it would be deposited with U.S. Postal Service on the same day with postage thereon fully prepaid at Sacramento, California in the ordinary course of business. I am aware that on Motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing in affidavit. Said envelope was placed, on this date, in the California Department of Public Health mail system to be processed, and deposited in the United States Mail at Sacramento, CA, with postage thereon fully prepaid.

[**X**] BY OTHER SERVICE: I caused such envelope(s) to be delivered to the office of the addressee(s) listed above by:
[**X**] Certified Mail Return Receipt Requested Parcel No.: 7018 3090 0000 5242 5440
[ ] Overnight Delivery (GSO/FedEx)
[**X**] Electronic Mail Delivery (By Agreement)

[ ] PERSONAL SERVICE: By delivering by hand and leaving a true copy with the person(s) and/or secretary at the above listed address(es).

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed and served on June 10, 2020, at Sacramento, California.

Britney Toft