STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	C 09/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - HY-PANA	4545 SHELLEY COURT STOCKTON, CA 95207

(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 for the investigation of three (3) entity reported incidents #CA00545129, #CA00545989, and #CA00545992. Representing the Department of Public Health: HFEN, 31640 The inspection was limited to the specific entity reported incidents investigated and does not represent the findings of a full inspection of the facility. The Department substantiated a violation of the regulations for entity reported incident #CA00545129. The Department was unable to substantiate a violation of the regulations for entity reported incidents #CA00545989 and #CA00545992.	F 000	Golden Living Center – Hy-pana submits this Plan of Correction as part of the requirements under State and Federal law. The Plan of Correction is submitted in accordance with specific requirements; it shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this Plan of Correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors, or shareholders. The provider reserves the right to challenge the cited findings if at anytime the provider determines that the disputed findings are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third party for evaluation and appropriate treatment modalities.	POC accepted 10.25.17 jw
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 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 symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of	F 224	**F224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION** The Certified Nursing Assistant #2 was immediately placed on suspension on 7/21/2017 pending investigation of the allegation. CNA #2 was terminated on 7/22/2017. In-service was conducted by DSD on 10/13/2017 and will be completed by 11/10/2017 regarding Policy and procedure on Reporting and Investigation of Alleged Violations of Federal and State Laws, Involving Mistreatment, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property focusing on Misappropriation of Resident Property.	

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

Teresa Mendoza — Administrator — 10/18/2017

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.

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F 224	Continued From page 1 resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interviews and document review, the facility failed to protect 1 of 4 sampled residents' (Resident 4) personal properties when a certified nursing assistant (CNA) took Resident 4's wallet and removed the money without Resident 4's consent. This failure increased the potential for theft of residents' money and belongings. Findings: According to the clinical record, Resident 4 was admitted to the facility with multiple diagnoses including kidney disease. Resident 4 was his own responsible party. A review of the facility's investigation report of the incident, dated 7/20/17, indicated "...[Resident 4 was heard] yelling for help from his room. When writer entered room, [CNA 2] and resident were arguing. Resident claims that the CNA was going through his wallet and stole money from him. The CNA claims that she was trying to get her money back that was stolen from her by the resident. The CNA explains that she left her purse in the closet of the resident...Afterwards, as the CNA was walking past the room of the resident, she noticed that the resident was going though her purse and found her wallet in the resident's trash can. After retrieving her purse and wallet and	F 224	The Administrator and Social Service Director interviewed all other residents in CNA 2's group on 7/21/2017 to ensure no other residents had concerns with regard to care, dignity and respect or customer service from any staff member. There were no other residents identified with the same deficient practice. The DSD and/or designee will conduct in-service to all staff on Policies pertaining to Reporting and Investigation of Alleged Violations of Federal and State Laws, Involving Mistreatment, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property focusing on Misappropriation of Resident Property by 11/10/2017. The facility will monitor compliance through the monthly resident council meeting by adding an agenda item to review any concerns related to dignity and respect, care and or customer service. Concerns will be reported to the ED immediately, for follow up and resolution. Additionally, Department Managers will once per week randomly interview residents during their Guardian Angel rounds to ensure they feel safe and that their property is maintained. Concerns will be addressed immediately to the ED for further review and follow up during morning Stand-Up. The ED or designee will provide the QAPI committee with any trends for further review and recommendations. The QAPI committee will evaluate any findings for the next quarter and if no deficient practice has been found, they will decide if further evaluation is needed.	

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F 224	Continued From page 2 checking the contents, the CNA claims that money was stolen by the resident. Resident claims that he found the purse in his room and did not know who it belonged to. Approximately [8:30 p.m.], the resident states he saw the CNA going through his wallet. After checking the contents of his wallet, he claims that money was missing and was stolen by the CNA..." A progress note written by the social services assistant, dated 7/21/17 at 4:30 p.m., indicated, "...Resident stated a girl he had not seen before left a bag in his room closet, so he got the bag and started going through it. [Resident 4] stated he did not take anything out of the bag or throw anything away, he only wanted to see what was inside the bag. Resident stated [CNA 2] went back in his room and became upset because he had her bag. [Resident 4] stated "it got loud"... [Resident 4] also stated the girl [CNA 2] thought he took her money so CNA grabbed his wallet from his bed and "stole" his money. [Resident 4] then said CNA returned his money..." During an interview with the Administrator on 8/1/17 at 9:45 a.m., she stated that on 7/20/17 at 5:30 p.m. CNA 2 was running late that day and decided to store her purse on the top shelf of Resident 4's closet instead of storing her purse in the locker located at the employee lounge. CNA 2 then proceeded to do her work. Afterwards, when CNA 2 was passing Resident 4's room, she saw Resident 4 with her purse on his lap and looking through it. When CNA 2 entered the resident's room to retrieve the purse and to inform him that the purse was hers, the CNA saw her identification card and wallet in the resident's garbage can. After she took her purse and belongings out of the resident's room, CNA 2	F 224		

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F 224	Continued From page 3 discovered there was money missing from her wallet. CNA 2 was instructed by the licensed nurses in charge that day not to confront Resident 4, but to wait for the facility's administrator to settle the situation with Resident 4. CNA 2 did not follow the given instruction. She proceeded to go back to Resident 4's room and confront the resident. The Administrator acknowledged CNA 2 should not have approached the resident on her own, and she should have listened to the [nurse in charge] when she was instructed to wait for the [facility's] administrator. The Administrator acknowledged employees needed to store their personal belongings in lockers provided to them and not at a resident's room.	F 224		