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 12/09/2015

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

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated survey for the investigation of entity reported incident #CA00455456. Representing the Department of Public Health: HFEN, 31979 The inspection was limited to the specific entity reported incident investigated and does not represent the findings of a full inspection of the facility.	F 000	**Golden Living Hypana 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 or its employees, agents, officers, directors or shareholders.**	ACCEPTED 12/21/15 GH
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical and facility record reviews, the facility failed to ensure each residents' right to be free from physical restraints imposed for the purpose of convenience for 1 of 5 sampled residents (1) when Resident 1 was found "wrapped up in a piece of linen around her waist" while in a wheelchair "against the wall, attached to a wooden base board of the wall." This had the potential for physical harm and mental anguish. Findings:	F 221	**The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third for evaluation and appropriate treatment modalities.** F221-Right to be Free from Physical Restraints Resident #1 restraint was removed by (2) licensed nurses (AM nurse and NOC nurse) and was assessed head to toe by both licensed nurses with no injuries noted. The resident had no signs or symptoms of any emotional distress due to the incident.	8/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/17/15

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 221	Continued From page 1 Resident 1 was admitted to the facility on 9/12/14 for paranoid schizophrenia (a mental disorder), and senile dementia (decline in mental functioning). The document titled "FACILITY REPORTED EVENT" dated 8/21/15 in reference to the actions of Certified Nurse Assistant (CNA) 4 included under item 1, "On 8/21/15, it was observed by AM CNA, while coming on to shift at 0630, saw resident wrapped up in a piece of linen around her waist, in her w/c [wheelchair], against the wall, attached to a wooden base board of the wall. CNA reported this to charge nurse who then reported to DSD [Director of Staff Development] who was present. ..." And, "NOC [night] CNA [CNA 4] reported that at approximately 0400, after the NOC nurse given resident her PRN [as needed] medications, resident continued to ambulate unsteadily on her feet and walking into other residents rooms hovering over them as they slept. CNA felt this was unsafe for all residents due to risk for falls for this resident and increase risk for altercation between her and other residents so she went and got a linen sheet and wrapped it around this residents waist while she was in her w/c and tied it to the wall of the wooden bar in resident room. NOC CNA stated she did not tell the nurse nor anyone else because everyone knows residents behaviors and she didn't think it was an issue because of safety." During an interview on 8/28/15 at 3:30 p.m. with the Director of Nursing (DON), she stated the night CNA (CNA 4) reported that at approximately 0400, after the night shift nurse had given Resident 1 her medications, the resident continued to ambulate unsteadily on her feet and	F 221	The Certified Nursing Assistant #4 was immediately placed on suspension on 8/21/2015 and was terminated on 8/25/2015. At the time of the incident, the DON did visual checks on all other residents to ensure no other residents had been restrained. No deficient practice was found among any of the residents in the facility. The Director of Staff Development (DSD) in-serviced the nursing staff on 8/21/15 (same day as event) on Policies pertaining to Preventing Abuse & Neglect, Reporting and Investigation of Alleged Violations involving Abuse and on Restraints. The DSD will conduct a follow up in-service for the Licensed Nurses, CNA's and Department Managers on Policies pertaining to Preventing Abuse & Neglect, Reporting and Investigation of Alleged Violations involving Abuse and Restraints, with an emphasis on ensuring every resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the residents medical symptoms by January 4, 2016.	8/21/15 8/25/15 8/21/15 1/4/16

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F 221	Continued From page 2 walked into other residents' rooms hovering over them as they slept. CNA 4 felt this was unsafe for all residents due to risk for falls for this resident, and increased risk for altercations between her and other residents. So she went and got a linen sheet and wrapped it around Resident 1's waist while she was in her wheelchair and tied it to a wooden bar on the wall in resident's room. The DON further stated that CNA 4 reported that she did not tell the nurse nor anyone else because everyone knows resident's behaviors and she didn't think it was an issue because of safety. The facility's Policy and Procedure titled "Restraint Devices, Physical" version #1 dated 2006 included under Procedure Purpose, "Restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff." Under Definition, the facility's policy included, "PHYSICAL RESTRAINTS are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." During an interview on 8/28/15 at 3:10 p.m. with LN (Licensed Nurse) 1, the LN was asked about the use of restraints on a resident he stated, "We are a facility that does not allow restraints." On 9/9/15 at 2:40 p.m. a telephone interview was conducted with CNA 3. The CNA stated she came on duty for her AM shift and on making her rounds, found Resident 1 backed up to the wall in her wheelchair. She was tied to a handrail with a sheet. When asked what Resident 1 was doing,	F 221	Charge Nurses will conduct room rounds every shift to ensure all residents are free from unnecessary restraints. Any findings will be immediately brought to the attention of the DON and Administrator. DON and/or Designee will conduct daily rounds to ensure all residents are free from unnecessary restraints. Any findings will be immediately brought to the attention of the Administrator. The DON and/or designee will provide the QAPI committee with their daily round findings. The QAPI committee will review all findings and provide recommendations as needed. The QAPI committee will evaluate the 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 221	Continued From page 3 the CNA stated the resident was leaning forward, and she immediately went to get the charge nurse.	F 221		