

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055968	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2024
NAME OF PROVIDER OR SUPPLIER Golden Heights Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 35 Escuela Drive Daly City, CA 94015	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from the use of physical restraint (any device, equipment or material that cannot be easily removed by the resident and limits his/her freedom of movement or normal access to his/her body) for discipline purposes and staff convenience when CNA (Certified Nursing Assistant) 1 placed a mitten on Resident 1's right hand and tied her right hand to her bed.</p> <p>This failure had the potential to cause physical harm, pain or mental anguish to Resident 1.</p> <p>Findings:</p> <p>Resident 1 was admitted on [DATE] and was readmitted on [DATE], with diagnoses that include dysphagia (difficulty swallowing), dementia (impairment in the ability to remember, think, or make decisions that interferes with doing everyday activities), rheumatoid arthritis (chronic swelling and tenderness of joints and other parts of the body), and osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time).</p> <p>Review of Resident 1's physician's Progress Notes, dated 12/12/23 at 5:49 PM indicated, NGT (nasogastric tube - a feeding tube that goes through the nose, down the throat, and into the stomach to deliver formula or medicine) via right nostril.</p> <p>Review of Resident 1's minimum data set (MDS - a standardized assessment of a resident 's functional capabilities and health needs), dated 12/13/23, indicated that Resident 1 was admitted with a feeding tube, had memory impairment, and was dependent on facility staff with activities of daily living.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Event Investigation Summary ([NAME]), dated 1/24/24, indicated that Resident 1 was found by staff to have her right hand bound with a mitten, surgical gloves, plastic bag and loosely secured to the side rail of her bed to prevent the resident from pulling her Nasogastric Tube (NGT) out. The [NAME] indicated that the incident occurred during the NOC shift (nocturnal/night shift - starts from 11 PM to 7:30 AM) from 1/12/24 to 1/13/24 at approximately 4:30 AM. Further review of the [NAME] indicated, Staff Interviews . (name of CNA 1) was the CNA on duty assigned at Noc (NOC) shift on 1/13/24 (starts at 11 PM on 1/12/24 and ends at 7:30 AM on 1/13/24). The resident was restless from the start of the shift, didn ' t sleep the whole night. She repositioned the resident and went to take vital signs of other residents, then stayed with the resident due to trying to remove her NGT and had episode of behavior, too. At about 4:30 AM, The resident was still restless with her hands. To prevent the resident from pulling out her NGT, (name of CNA 1) took the white mitten and placed it on her (Resident 1) right hand, which she uses in trying to remove her NGT and restrained it so she (CNA 1) could leave to make her final rounds. She (CNA 1) did not tell anyone about what she did. She did not endorse it to anyone.</p> <p>During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 3, on 2/1/24 at 9:45 AM, Resident 1 was in bed, covered with a blanket up to her chest. After requesting permission from Resident 1, LVN 3 lowered the blanket to show Resident 1's PEG tube (percutaneous endoscopic gastrostomy - the placement of a feeding tube through the skin and the stomach wall) that was loosely covered with a towel. LVN 3 stated, She (Resident 1) used to have NGT, now she's on g-tube (short for PEG tube).</p> <p>Review of Resident 1's history and physical, dated 1/29/24, indicated Resident 1 had recurrent problems with NGT feeding, now s/p (status post - after a procedure or surgery) PEG tube placement 1/25/24 for continued artificial nutrition.</p> <p>Review of Resident 1's Progress Notes, dated 1/13/24 at 4 PM, indicated CNA (referring to CNA 2, name redacted) found resident on [sic] restrained on right wrist tied on the side rail of bed; towel and plastic bag were used to restraint [sic] the right hand with mitten.</p> <p>During an interview on 2/1/24 at 11:31 AM, CNA 3 stated that on 1/13/24 during the AM shift (morning shift - work hours from 7 AM to 3:30 PM), I saw resident's (Resident 1) right wrist tied with a towel and plastic bag and tied to the side rail on the bed.</p> <p>During an interview on 2/1/24 at 2:10 PM, the Director of Staff Development (DSD) stated that during her phone interview with CNA 1 on 1/15/24, She (CNA 1) admitted it's her (CNA 1) fault, told me about her reason for tying the resident, wanted to prevent pulling of NGT and needed to do rounds of her residents before her shift ends.</p> <p>During an interview on 2/1/24 at 4:04 PM, CNA 2 stated that on 1/13/24, Around 4 PM, I saw she's (Resident 1) tied to the bed, right hand tied with plastic garbage bag, right hand in mitten (a soft padded device/s that covers the hand/s; used to restrict a person's use of their hands by placing either one or both hands within them), garbage bag wrapped around the right wrist, both ends of garbage bag tied to a towel, towel is tied to the rail (side rail). CNA 2 further stated, It's abuse when resident is tied to the bed, could cause bruising. She (CNA 1) should have asked for help or told the charge nurse.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 2/1/24 at 4:18 PM, Licensed Vocational Nurse (LVN) 1 stated that on 1/13/24 around 4 PM, she received a report from CNA 2 that she (CNA 2) found Resident 1 tied to her bed. LVN 1 stated that when she went to Resident 1's room, she found Resident 1's right hand with a mitten, right wrist tied to the bed's side rail with a plastic bag and a towel. LVN 1 stated, I know it's abuse. We (facility staff) should not do that; it could cause injury to the resident. LVN 1 reviewed Resident 1's physician's orders for January 2024 and stated, I don't see any order (for restraint).</p> <p>During an interview on 2/1/24 at 4:35 PM, the Interim Director of Nursing (IDON) stated, It was a restraint (referring to the use of a mitten and tying Resident 1's hand to the bed). Restraint without a doctor's order is abuse. There was no order for restraint (for Resident 1). The IDON also stated that the application of restraint to Resident 1 could result to either she (Resident 1) will end up with bruising or skin tear, or compromised skin integrity.</p> <p>During an interview on 2/20/24 at 8 AM, LVN 2 stated, I spoke with her (CNA 1) on 1/13/24. She (CNA 1) admitted she tied the resident (Resident 1) to her bed to prevent her (Resident 1) from pulling out her NGT. LVN 2 stated, They (CNAs) are not supposed to make such decisions by themselves, they have to report to the charge nurse. They should know what to do, they know they're not supposed to do that.</p> <p>During an interview on 2/23/24 at 11:17 AM, the Social Service Director (SSD) stated, Patient (Resident 1) will be at risk of trauma, it might affect her mentally, emotionally, as a potential result of tying Resident 1 to her bed.</p> <p>Review of the facility policy and procedure (P&P), titled, Use of Restraints, revised on 4/2017, indicated Policy Statement . Restraints shall only be used to treat the resident(s) medical symptoms and never for discipline or staff convenience, or for the prevention of falls. Policy Interpretation and Implementation: 1. 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 restricts normal access to one's body . 3. Examples of devices that are/may be considered physical restraints include . hand mitts, soft ties . that the resident cannot remove .</p> <p>Review of the facility P&P, titled, Resident Rights, revised on 12/2016, indicated Policy Statement - Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse . d. be free from .physical or chemical restraints not required to treat the resident's symptoms .</p> <p>Review of the facility P&P, titled, Bed Safety, revised on 12/2007, indicated Policy Interpretation and Implementation .12. The use of physical restraints on individuals in bed shall be limited to situations where they are needed to treat a resident's medical symptoms, and only after being reviewed by authorized individuals .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (CDPH) and the local Ombudsman within the required two-hour period for one of three sampled residents (Resident 1) when CNA (Certified Nursing Assistant) 1 placed a mitten on Resident 1's right hand and tied her right hand to her bed.</p> <p>This failure had the potential to cause delay in the abuse investigation and increased risk of harm to the residents by placing Resident 1 at risk for potential repeated abuse, and other residents at risk for potential abuse.</p> <p>Findings:</p> <p>Review of the facility's Event Investigation Summary ([NAME]), dated 1/24/24, indicated that Resident 1 was found by staff to have her right hand bound with a mitten, surgical gloves, plastic bag and loosely secured to the side rail of her bed to prevent the resident from pulling her Nasogastric Tube (NGT - a feeding tube that goes through the nose, down the throat, and into the stomach to deliver formula or medicine) out. The restraint was discovered by (name of staff redacted) at 4 PM on January 13, 2024 .</p> <p>Review of the facility's fax Transmission Verification Report to CDPH and the Ombudsman's Office, indicated that the facility reported the alleged incident to CDPH on 1/17/24 at 5:20 PM and the Ombudsman's Office on 1/17/24 at 5:23 PM, four (4) days after the facility discovered the alleged incident.</p> <p>Resident 1 was admitted on [DATE] and was readmitted on [DATE] with diagnoses that include dysphagia (difficulty swallowing), dementia (impairment in the ability to remember, think, or make decisions that interferes with doing everyday activities), rheumatoid arthritis (chronic swelling and tenderness of joints and other parts of the body), and osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time).</p> <p>During a concurrent interview and record review on 2/1/24 at 4:18 PM, Licensed Vocational Nurse (LVN) 1 stated that on 1/13/24, around 4 PM, she received a report from CNA 2 that she (CNA 2) found Resident 1 tied to her bed. LVN 1 stated that when she went to Resident 1's room, she found Resident 1's right hand with a mitten, right wrist tied to the bed's side rail with a plastic bag and a towel. LVN 1 stated that she immediately released Resident 1 from the restraint and immediately called the Director of Nursing (DON). LVN 1 stated, I know it's abuse. We (facility staff) should not do that; it could cause injury to the resident. LVN 1 reviewed Resident 1's physician's orders for January 2024 and stated, I don't see any order (for restraint).</p> <p>During an interview on 2/1/24 at 4:35 PM, the Interim Director of Nursing stated, It was a restraint (referring to the use of a mitten and tying Resident 1's hand to the bed). Restraint without a doctor's order is abuse. There was no order for restraint (for Resident 1).</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/20/24 at 8 AM, LVN 2 stated, On 1/13/24, past 4 PM, I was told by (CNA 2 and LVN 1, names redacted) that they found Resident 1 tied to her bed with a towel and a plastic bag. LVN 2 also stated, Around 5 PM, the DON called me and asked what was happening. I told her of the situation and since she is now aware, I asked her to do the reporting (to CDPH and other appropriate authorities).</p> <p>During an interview on 2/24/23 at 1:33 PM, the Administrator confirmed that the DON or any of the staff did not report the alleged incident to CDPH and the Ombudsman's Office within the required two-hour timeframe. The Administrator stated that it was not until 1/17/24 that he was informed by the DON that the alleged incident has not been reported to CDPH and the Ombudsman's Office.</p> <p>Review of the facility policy and procedure, titled Abuse Investigation and Reporting, revised on 7/2017, indicated Policy Statement - All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Policy Interpretation and Implementation .Role of the investigator: .3. The investigator will notify the ombudsman that an abuse investigation is being conducted . 4. The investigator will consult daily with the Administrator concerning the progress/findings of the investigations . Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property, will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman .2. An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury .</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612</p> <p>Based on interview and record review, the facility failed to provide protection to Resident 1 and other residents when Certified Nursing Assistant (CNA) 1 was not suspended immediately after an alleged abuse to Resident 1 was reported on 1/13/24.</p> <p>This failure placed Resident 1 at risk for further abuse and placed the other 15 residents assigned to CNA 1 for potential abuse.</p> <p>Findings:</p> <p>Resident 1 was admitted on [DATE] and was readmitted on [DATE], with diagnoses that include dysphagia (difficulty swallowing), dementia (impairment in the ability to remember, think, or make decisions that interferes with doing everyday activities), rheumatoid arthritis (chronic swelling and tenderness of joints and other parts of the body), and osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time).</p> <p>Review of Resident 1 ' s physician ' s Progress Notes, dated 12/12/23 at 5:49 PM indicated, NGT (nasogastric tube - a feeding tube that goes through the nose, down the throat, and into the stomach to deliver formula or medicine) via right nostril.</p> <p>Review of Resident 1 ' s minimum data set (MDS - a standardized assessment of a resident ' s functional capabilities and health needs), dated 12/13/23, indicated that Resident 1 was admitted with a feeding tube, had memory impairment and was dependent on facility staff with activities of daily living.</p> <p>Review of the facility ' s Event Investigation Summary ([NAME]), dated 1/24/24, indicated that Resident 1 was found by staff to have her right hand bound with a mitten, surgical gloves, plastic bag and loosely secured to the side rail of her bed to prevent the resident from pulling her Nasogastric Tube (NGT) out. The [NAME] indicated that the incident occurred during the NOC shift (nocturnal/night shift - starts from 11 PM to 7:30 AM) from 1/12/24 to 1/13/24 at approximately 4:30 AM. Further review of the [NAME] indicated, Staff Interviews . (name of CNA 1) was the CNA on duty assigned at Noc (NOC) shift on 1/13/24 (starts at 11 PM on 1/12/24 and ends at 7:30 AM on 1/13/24). The resident was restless from the start of the shift, didn ' t sleep the whole night. She repositioned the resident and went to take vital signs of other residents, then stayed with the resident due to trying to remove her NGT and had episode of behavior, too. At about 4:30 AM, The resident was still restless with her hands. To prevent the resident from pulling out her NGT, (name of CNA 1) took the white mitten and placed it on her (Resident 1) right hand, which she uses in trying to remove her NGT and restrained it so she (CNA 1) could leave to make her final rounds. She (CNA 1) did not tell anyone about what she did. She did not endorse it to anyone.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 2/1/24 at 4:18 PM, Licensed Vocational Nurse (LVN) 1 stated that on 1/13/24, around 4 PM, she received a report from CNA 2 that she (CNA 2) found Resident 1 tied to her bed. LVN 1 stated that when she went to Resident 1 ' s room, she found Resident 1 ' s right hand with a mitten, right wrist tied to the bed ' s side rail with a plastic bag and a towel. LVN 1 stated that she immediately released Resident 1 from the restraint and immediately called the Director of Nursing (DON). LVN 1 stated, I know it ' s abuse. We (facility staff) should not do that; it could cause injury to the resident. LVN 1 reviewed Resident 1 ' s physician ' s orders for January 2024 and stated, I don ' t see any order (for restraint).</p> <p>During an interview on 2/1/24 at 4:35 PM, the Interim Director of Nursing stated, It was a restraint (referring to the use of a mitten and tying Resident 1 ' s hand to the bed). Restraint without a doctor ' s order is abuse. There was no order for restraint (for Resident 1).</p> <p>During an interview on 2/20/24 at 8 AM, LVN 2 stated, On 1/13/24, past 4 PM, I was told by (CNA 2 and LVN 1, names redacted) that they found Resident 1 tied to her bed with a towel and a plastic bag. LVN 2 also stated, Around 5 PM, the DON called me and asked what was happening. I told her of the situation . LVN 2 added, I spoke with her (CNA 1) in person, during change of shift. She worked NOC shift on 1/13/24.</p> <p>During a concurrent interview and record review on 2/23/24 at 11:48 AM, the Director of Staff Development (DSD) reviewed a copy of CNA 1 ' s Individual Employee Time Cards (IETC), with dates ranging from 1/1/24 to 1/15/24. The IETC indicated CNA 1 worked during the NOC shift starting from 10:54 PM on 1/13/24 to 6:57 AM on 1/14/24 and from 10:57 PM on 1/14/24 to 6:56 AM on 1/15/24. The DSD stated that the IETC is an official record of the staff ' s actual hours worked. The DSD verified that the incident was discovered on 1/13/24 at 4 PM and CNA 1 worked for two consecutive NOC shifts thereafter (CNA 1 continued to have access to the alleged victim, Resident 1, and to the other 15 residents assigned to her care for two (2) consecutive days during the 11 PM to 7:30 AM shifts on 1/13/24 and 1/14/24). The DSD stated, When there ' s an allegation of abuse, staff needs to be suspended pending investigation. She (CNA 1) should have not been allowed to work anymore. That ' s the policy. We put them on admin (administrative) leave (temporary removal of an employee from the workplace to address a particular situation) right away.</p> <p>During an interview on 2/23/24 at 1:33 PM, the Administrator stated that he was informed of the suspected abuse incident on 1/15/24 by the DSD. The Administrator added, When abuse is reported, for the safety of the residents, staff involved should be suspended (from work) immediately, away from the residents; away from the building, pending completion of investigation.</p> <p>Review of the facility policy and procedure, titled, Abuse Investigation and Reporting, revised on 7/2017, indicated Policy Interpretation and Implementation, Role of the Administrator . 4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation .</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38612</p> <p>Based on interview and record review, the facility failed to ensure nursing staff had the knowledge and competency to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of one of three sampled residents (Resident 1) when:</p> <ol style="list-style-type: none"> Two Certified Nursing Assistants (CNA) failed to recognize inappropriate use of restraint after observing Resident 1's hand was tied to her bed; and Two nursing staff (Licensed Vocational Nurse [LVN] and CNA) were unaware that they could report instances or allegations of abuse to the state agency (which is CDPH - California Department of Public Health) and the local Ombudsman's Office. <p>These resulted in failure to recognize a situation that could indicate abuse and placed the residents' safety at risk.</p> <p>Findings:</p> <ol style="list-style-type: none"> Resident 1 was admitted on [DATE] and was readmitted on [DATE], with diagnoses that include dysphagia (difficulty swallowing), dementia (impairment in the ability to remember, think, or make decisions that interferes with doing everyday activities), rheumatoid arthritis (chronic swelling and tenderness of joints and other parts of the body), and osteoarthritis (degenerative joint disease, in which the tissues in the joint break down over time). <p>Review of the facility's Event Investigation Summary ([NAME]), dated 1/24/24, indicated that Resident 1 was found by staff to have her right hand bound with a mitten, surgical gloves, plastic bag and loosely secured to the side rail of her bed to prevent the resident from pulling her Nasogastric Tube (NGT - a feeding tube that goes through the nose, down the throat, and into the stomach to deliver formula or medicine) out. Further review of the [NAME] indicated, Staff Interviews . (name of CNA 4) worked on the night shift of 1/13/24. She was not assigned to (name of Resident 1) but assisted a nurse who was inserting a suppository. (CNA 4) saw the mitten on the right hand (but did not see the devises [sic] to restrain the resident's arm) . As a new CNA, orienting on the floor, (CNA 4) did not recognize the mitten as a restraint . (name of CNA 3) worked on am shift (AM shift - work hours from 7 AM to 3:30 PM) on 1/13/2. During her shift, she changed the resident's briefs twice. She saw the right hand tied but failed to report the restraint to nursing leadership due to her lack of knowledge that it was a restraint. Staff acknowledges oversight [sic] .</p> <p>During an interview on 2/1/24 at 11:31 AM, CNA 3 stated that on 1/13/24 during the AM shift, I saw resident's (Resident 1) right wrist tied with a towel and plastic bag and tied to the side rail on the bed. CNA 3 added, I did not report because I'm thinking she (Resident 1) used to take out the tube (NGT) and thought it was the reason her hand was tied to the bed. I did not know that the towel could be used as a restraint.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/1/24 at 4:35 PM, the Interim Director of Nursing stated, Most are saying they (CNAs) are new, but that is not reason to not report. They (CNAs) should be able to identify if something is used as restraint. It's expected for them to know if it's a restraint, it's part of their training.</p> <p>2. During an interview on 2/1/24 at 11:31 AM, CNA 3 stated that she did know that she could report allegations of abuse to CDPH and the Ombudsman's Office. CNA 3 stated, I don't have the phone number. I don't know where it is.</p> <p>During an interview on 2/1/24 at 4:18 PM, Licensed Vocational Nurse (LVN) 1 stated that CNA 3 reported to her on 1/13/24, around 4 PM that Resident 1 was found tied to her bed. LVN 1 stated, Resident (Resident 1) was tied to the bed. I know it's abuse. LVN 1 confirmed that she did not report the incident to CDPH and the Ombudsman's Office, stating, I did not know that.</p> <p>During a concurrent interview and record review on 2/23/24 at 8:55 AM, the Director of Staff Development (DSD) provided a copy of an undated facility document, titled, General Orientation Checklist (GOC), indicating topics that include Adult Abuse Reporting and Elder Justice Act and Resident Rights, which include a video presentation on abuse by the DOJ. The DSD stated that identifying devices that can be used as restraints is included in orientation program for all nursing staff. The DSD stated, They (CNAs) should know (how to identify restraints), it's part of their training upon hire. The DSD also stated that all staff receive training on reporting of abuse during their orientation to the facility and during subsequent abuse in-service trainings.</p> <p>During an interview on 2/23/24 at 1:33 PM, the Administrator stated, If they (staff) see anything that could be abuse, they need to report to their supervisor immediately. Everybody is trained that they are mandated reporters, they can report to the state (CDPH) and the Ombudsman.</p> <p>Review of the facility policy, titled, Abuse Investigation and Reporting, revised on 7/2017, indicated Policy Statement: All reports of resident abuse .mistreatment . shall be promptly reported to local, state, and federal agencies (as defined by current regulations) . Policy Interpretation and Implementation .Reporting .2. An alleged violation of abuse, neglect, exploitation, or mistreatment . will be reported immediately, but not later than: a. Two (2) hours if alleged violation involves abuse .</p>		