

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 05/21/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>31922</p> <p>Based on interview and record review, the facility failed to conduct a thorough investigation into an allegation of abuse for Resident 1, one of one sample resident. Review of the facility ' s investigation indicated only staff were interviewed regarding this allegation. Facility stated no residents were interviewed because all residents of interest were non-interviewable. The investigation was not thorough because the facility failed to:</p> <ol style="list-style-type: none"> 1. Attempt to interview responsible parties of non-interviewable residents 2. Conduct assessments of non-interviewable residents for signs and symptoms of abuse (defensive bruising, bruising in private areas, change in social behavior etc.). <p>The lack of a thorough investigation did not ensure all residents were protected from abuse.</p> <p>Findings:</p> <p>During an interview on 05/21/2025 at 11:40 AM, the Administrator was made aware of an allegation of abuse by Resident 1. The Administrator stated he would look into the allegation.</p> <p>On 06/02/2025 at 1:24 PM, the Administrator was asked to provide all documents, including raw data, related to his investigation regarding this allegation.</p> <p>Review of an untitled facility investigation document, dated 05/23/2025, indicated .A CNA (Certified Nursing Assistant) allegedly performed pericare (cleaning the genital/anal area) in a rough manner, causing pain but no injury. The resident stated she asked the CNA to not do that again but he did it again anyway. Resident doesn't remember name of the aide.the alleged victim, was a resident from 2/1/25-3/8/25. She was alert, responsive in conversation, and capable of expressing her needs clearly.Administrator interviewed the resident on 5/21/25. She stated that the CNA was male, .(Filipino), and had black hair.She stated that it was the same person that helped her on day shift all week, that it was on Thursday before she discharged , and that it was before lunch. From the assignment sheets it was determined that five different day shift aides worked with her that week .so it was not possible to narrow down a single aide that took care of her all week. The Administrator interviewed ten nurses and CNA's that worked with . (Resident 1) during that time, and none recall the event .(Resident 1) described, and none recall hearing any complaints about rough pericare. Summary of investigation: Based on interviews, available information, and lack of witnesses, the investigation is unable to substantiate abuse.</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
---	-------	-----------

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 05/21/2025
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/02/2025 at 2:55 PM the Administrator was made aware he investigated the care provider side of the allegation. The Administrator was asked if he investigated the care recipients ' /residents ' side of the allegation? The Administrator then provided a new document from his investigation file indicating residents of interest such as roommates and other residents on Resident 1 ' s assignment were not interviewable. The Administrator was asked if he attempted to interview the family/responsible parties of these residents. The Administrator did not answer.</p> <p>During a communication on 06/03/2025 at 3:02 PM, the Administrator responded, One could interview families or additional staff; I don ' t believe any residents from the resident ' s time, interviewable or not were in the building anymore, so I chose (to interview) additional staff.</p> <p>During a communication on 06/04/2025 at 11:48 AM, the Administrator responded that assessing non-interviewable residents for</p> <ol style="list-style-type: none"> 1. defending bruising 2. bruising around the private areas 3. behavioral changes 4. sleep pattern changes 5. social interaction changes <p>were reasonable tools to incorporate into an allegation of abuse investigation.</p> <p>During a telephone interview on 06/04/2025 11:51 AM, the Administrator was reminded even though Resident 1 was discharged , the alleged perpetrator may still be working at his facility. Therefore, not assessing the current group of residents within Resident 1 ' s assignment did not ensure the facility had investigated to rule out if other residents were affected.</p> <p>Review of a facility policy titled Abuse, Neglect, or Exploitation, updated on November 2016, .Initiate an investigation. Staff on duty at the time the alleged abuse occurred are interviewed prior to leaving their respective shift. This applies to staff as well as other residents in the area. Remind these individuals that they report facts rather than opinions or speculation. Written statements by staff are not advised unless directed otherwise by legal staff. Such statements may lack adequate information or objectivity. Instead, the investigator takes written notes about the facts reported during the interview.</p> <p>Review of the facility ' s abuse policy indicated there no language directing staff how to investigate if residents in the area were not interviewable.</p>		