STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555736	A. Building B. Wing	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50716 Based on observation, interview, and record review, the facility failed to protect one of four sampled residents' (Resident 1) property from loss. This failure resulted in Resident 1 having lost property and had the potential to cause Resident 1 emotional distress. Findings: During an interview on 1/29/25, at 9:39 AM, with Resident 1's Responsible Party (RP), the RP stated while in the facility on 1/5/25, she noticed Resident 1 wearing an adult brief (worn for a lack of bowel/bladder control). The RP explained Resident 1 was fully continent (ability to control bladder and bowels) and used the restroom on his own. During the visits, the RP assisted Resident 1 with dressing and noticed all his boxer briefs the RP purchased and brought to the facility a few months ago were missing. The RP also stated he was missing a forest green, charcoal gray, light gray, and red crew neck sweatshirts and matching sweatpants, and about 10-12 assorted colored boxer briefs. During a concurrent interview and record review on 1/29/25, at 12:21 PM, at the East Nurse Station with Licensed Nurse (LN) 1, LN 1 stated on admission an inventory list (a list of property, goods or contents) was completed by a Certified Nurse Assistant (CNA) and signed by the nurse and resident, then it was scanned into the resident's electronic health record (EHR). LN 1 searched Resident 1's EHR and was unable to locate the inventory list. LN 1 stated they ask the family to label all clothing. LN 1 further stated when the clothing was not labeled the facility policy was to use a facility provided sharpie to label on the inside of the clothing items with the resident's name for the laundry room to keep track of resident belongings. During a concurrent observation and interview on 1/29/25, at 12:54 PM, in Resident 1's room, CNA 1 observed Resident 1's closet and drawers with the permission of the resident's RP and confirmed Resident 1 did not have any boxer briefs. Resident 1's closet was observed. Resident 1 had the following items hanging in the closet: Light blue and dark blue jeans, maroon and [NAME] colored crewneck sweatshirt, 3 pair of pajama bottoms that were red checkered, blue, and green, black sweats, 1 royal blue t-shirt, 1 grayish blue t-shirt, one navy t-shirt and one red t-shirt, confirmed by CNA 1. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 1/29/25, at 1:23 PM, CNA 2 stated she was familiar with Resident 1 and his clothing. CNA 2 confirmed Resident 1 normally has boxer briefs in his drawers and has assisted him when getting dressed on multiple occasions. CNA 2 further explained the inventory process on admission and stated when a resident arrives to the facility the CNAs document on the inventory sheet in writing all belongings with the resident. The facility provides sharpie markers to label clothing, if not already labeled, including socks and underwear. CNA 2 also stated staff were supposed to label residents clothing if it was not already labeled, prior to taking it down to laundry services. CNA 2 confirmed Resident 1 did not have any underwear with his clothing. During a concurrent observation and interview on 1/29/25, at 1:38 PM, the Housekeeping Manager (HM) stated nursing was responsible for labeling, collecting, and delivering dirty laundry to the laundry services department. The HM further stated once received the laundry was sorted into dirty bins by personal clothes, and facility linens. The dirty clothes are then washed, dried and folded. The turn around time for the clean laundry back to the residents was about 24 hours. During observation of the clean portion of the laundry room, a rolling cart filled with about 20 folded blankets and comforters were different from facility linens. The HM stated those blankets were resident's personal blankets and not labeled. The blankets stay there until someone complains their personal item was missing. The HM further explained the residents must describe the blanket and then it will be returned to them. A second observation of an area of clean laundry in a hallway in the laundry room there were approximately 5-6 large clear plastic bags full of clothes. The HM stated all the clothing in the bags were not labeled and could not be returned. The HM further stated when a resident would complain about missing an item, they would send a bag or two down for the resident or family to look through. The HM stated his staff did not attempt to locate the owner of the clothing. During an interview on 1/29/25, at 4 PM, with the Director of Nursing (DON), the DON explained her expectation related to residents' property on admission, or when brought in by family later. The DON explained the inventory sheet was part of the admission packet. The CNAs were responsible to perform inventory on the belongings, and they were expected to label all clothing with the resident's name. The units were supplied with plenty of black sharpie pens to use for labeling. The property inventory sheet was then scanned by medical records to each resident's chart. The DON further stated her expectation was every resident had a scanned record of their belongings in the resident's medical record. The DON further stated the inventory must be updated when new belongings enter the facility. The DON explained the CNAs were expected to make sure each clothing item was labeled before they took it down to laundry services. The DON stated she was aware of missing items for Resident 1. The DON further stated labeling was important to protect the resident's property and stated it was part of their resident rights and the facility's policy. During a concurrent interview and record review on 1/29/25, at 4:25 PM, with the Administrator (ADM), the ADM stated it was her expectation all residents would get their clothing back from laundry. The ADM stated it was important for the staff to educate families about labeling belongings and if not done, the CNAs should be doing it. The ADM confirmed there was no inventory sheet found in Resident 1's medical record. The lost belongings located in laundry services were reviewed with the ADM. The ADM confirmed there needed to be a better process for labeling and getting the residents missing items back to them. The ADM stated she also provided a labeler to laundry services to use. The ADM stated her expectation was each resident has an inventory sheet of their belongings completed and uploaded into the resident's medical record. The ADM further stated residents not having their personal belongings could cause emotional distress. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Personal Property, revised 8/22, indicated, .2. Resident belongings are treated with respect by facility staff, regardless of perceived value .3. Residents are encouraged to use personal belongings to maintain a homelike environment and foster independence .10. The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary .11. The facility promptly investigates any complaints of misappropriation or mistreatment of resident property .