STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunnyvale Post-Acute Center	1291 S Bernardo Avenue Sunnyvale, CA 94087

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42819 Based on observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) from misappropriation of property (unauthorized purchases from another person's account or using someone else's property) when the housekeeper (HK) cashed out Resident 1's check without Resident 1's permission. This failure compromised the resident's financial security and violated resident's rights. Findings: Review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (mental health disorder characterized by depressed mood or loss of interest in activities). Review of the facility's 5-day Investigation Summary, dated 6/16/24, indicated that on 6/12/24, the facility was notified via email by Resident 1's daughter that checks had been cashed out from Resident 1's account. On 6/10/24, Resident 1 received a call from her bank informing her that checks were being cashed in her name. The facility promptly reported the matter to the police on 6/10/24, the police advised the facility that no further action could be taken until more evidence was gathered. Upon receiving copies of the checks, the facility identified them as matching an employee's information. The police were notified again, and an investigation was started on 6/12/24. The HK in question was not allowed to work in the facility after the issue was discovered on 6/12/24. The HK was arrested on 6/14/24, just before his scheduled shift. During an interview on 6/18/24 at 1:30 p.m., Resident 1 was interviewed in her room. She was alert and oriented and stated that she usually kept her checks in her purse. Resident 1 stated she received a call from her bank about unauthorized use of her checks and immediately informed the administrator. During an interview with the administrator (ADM) on 6/18/24, at 1:50 p.m., the ADM stated that the bank contacted him regarding unauthorized checks cashed out. The ADM stated the police was notified and Resident 1's daughter. The ADM confirmed that Resident 1 kept her credit cards and checks in her purse. (continued on next page)

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the social service director (SSD) on 10/8/24 at 1:42 p.m., the SSD stated that the facility had offered Resident 1 the option to store her valuables, such as checks and credit cards, in a secure safe at the business office. However, Resident 1 declined, preferring to manage her own finances. When the surveyor inquired if the facility provided any other options after Resident 1 refused the communal safe, the SSD confirmed that no other options were offered. When asked if a locked cabinet at Resident 1's bedside was provided, the SSD explained that it was not a practice in the facility. The only secure option offered was the communal safe monitored by the business office. Review of facility's policy, Investigating Incident of Theft and/or Misappropriation of Resident Property revised on 4/2021, indicated, 1. Residents have the right to be free from exploitation, theft and/or misappropriation of personal property. 2. Our facility exercises reasonable care to protect the resident from property loss or theft, including: a. implementing policies that strictly prohibit, and pursue to the full extent of the law, staff or employee theft or misappropriation of resident property; b. providing measures to safeguard resident valuables from easy public access . Based on observation, interview, and record review, the facility failed to protect one of three sampled residents (Resident 1) from misappropriation of property (unauthorized purchases from another person's account or using someone else's property) when the housekeeper (HK) cashed out Resident 1's check without Resident 1's permission. This failure compromised the resident's financial security and violated resident's rights. Findings: Review of Resident 1's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (mental health disorder characterized by depressed mood or loss of interest in activities). Review of the facility's 5-day Investigation Summary, dated 6/16/24, indicated that on 6/12/24, the facility was notified via email by Resident 1's daughter that checks had been cashed out from Resident 1's account. On 6/10/24, Resident 1 received a call from her bank informing her that checks were being cashed in her name. The facility promptly reported the matter to the police on 6/10/24, the police advised the facility that no further action could be taken until more evidence was gathered. Upon receiving copies of the checks, the facility identified them as matching an employee's information. The police were notified again, and an investigation was started on 6/12/24. The HK in question was not allowed to work in the facility after the issue was discovered on 6/12/24. The HK was arrested on 6/14/24, just before his scheduled shift. During an interview on 6/18/24 at 1:30 p.m., Resident 1 was interviewed in her room. She was alert and oriented and stated that she usually kept her checks in her purse. Resident 1 stated she received a call from her bank about unauthorized use of her checks and immediately informed the administrator. During an interview with the administrator (ADM) on 6/18/24, at 1:50 p.m., the ADM stated that the bank contacted him regarding unauthorized checks cashed out. The ADM stated the police was notified and Resident 1's daughter. The ADM confirmed that Resident 1 kept her credit cards and checks in her purse. (continued on next page)

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