STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055512	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wolf Creek Care Center	107 Catherine Lane Grass Valley, CA 95945

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their Policy and Procedures (P&P) and ensure professional standards of practice were met for one of six sampled residents (Resident 3) when, Resident 3 was administered medications with possible drug interactions without clarification from the doctor.This failure had the potential to have caused adverse outcomes and worsen Resident 3's condition and decreased the potential to provide safe administration of medication.During a review of Resident 3's clinical record, Resident 3 was admitted [DATE] with diagnosis that included Nontraumatic Intracerebral Hemorrhage (ICH) (bleeding directly into the brain tissue from causes other than injury), Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), Transient Ischemic Attack (temporary blockage of blood flow to the brain), Cerebral Infarction (blood clot blocks an artery supplying the brain, leading to a lack of oxygen and nutrients, causing brain tissue death).During a review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 11/24/25, Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 00 out of 15 which indicated Resident 3 had severe cognitive impairment.During a review of Resident 3's physician orders dated 11/21/25, the order indicated Heparin Sodium (Porcine) Solution (blood thinner medication used to treat and prevent blood clots) 5000 Unit/Milliliter (ml) (the concentration of a substance within a liquid solution) subcutaneously (SQ) (under the skin) every 12 hours. Has triggered the following drug protocol alerts/warning(s) (a systems designed to prevent adverse drug events): Drug to Drug Interaction (when one drug changes the effect of another when taken together): The system identified a possible drug interaction with the following orders: Aspirin Oral Tablet (A drug taken by mouth that reduces pain, fever, inflammation, and blood clotting) 325 Milligrams (mg) (a unit of measurement) .Order: Aspirin Oral Tablet 325 mg. Give 1 tablet in the morning. Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction. The system identified a possible drug interaction with the following orders. Heparin Sodium (Porcine) Solution 5000 unit/ml . Both medications indicated the severity level as severe and the Interaction as Aspirin may enhance the anticoagulant effect of heparin. During a review of Resident 3's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for November 2025, the MAR indicated Aspirin 325 mg and Heparin 5000 units/ml SQ were given on 11/22/25. During an interview on 11/8/25 with Licensed Nurse (LN) 3 and LN 1 at 11:06 A.M. and 11:10 A.M., both stated they would call the doctor to clarify an order for Aspirin and Heparin for a resident with a diagnosis of ICH. Both stated they would obtain a new order if it was changed, and document in a progress note that the medication was clarified with the doctor. During a concurrent interview and record review on 11/8/25 at 11:14 a.m. with the Director of Nursing (DON), the DON confirmed Resident 3 had a diagnosis of ICH and had orders for Aspirin and Heparin. The DON confirmed Resident 3 was administered Aspirin and Heparin on 11/22/25. The DON confirmed the medications triggered a drug interaction warning. The DON stated the expectation for the nurse is if the doctors order it, give it. Providers review the medications on admission, and if they didn't want them to have it, they wouldn't have ordered it.During an interview on 11/8/25 at 2:09 a.m. with LN 4, LN 4 confirmed she medicated Resident 3 with Heparin and Aspirin despite the drug interaction warning. LN 4 was aware Resident 3 had a diagnosis of ICH but stated she only questioned what side effects to monitor. LN 4 stated the side effect of taking blood thinners with ICH are increased bleeding or possible death. LN 4 confirmed she did not call the doctor to clarify the order for Heparin and Aspirin as indicated on the warning and as per the P&P.During an interview on 12/15/25 at 12:04 p.m. with the Pharmacist, the Pharmacist stated that Aspirin and Heparin are a duplication (two or more identical medications or same therapeutic class) of anticoagulants (medications that stop your blood from clotting too easily) and could increase bleeding. The pharmacist stated that Aspirin and Heparin trigger warnings because they have a drug interaction and are contraindicated (not advised as a course of treatment). The Pharmacist confirmed the Aspirin and Heparin order for Resident 3 should have been clarified with the provider before being given because administering two anticoagulants with a diagnosis of ICH can cause increased bleeding and cause death. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications revised October 2024, the P&P indicated, If a dosage is believed to be inappropriate.or has been identified as having potential adverse consequences, . or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the resident 's Attending Physician/Nurse

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident safety for two out of six sampled residents (Resident 1 and Resident 2) when:1. Resident 1 left the facility without staff knowledge and was found at a gas station without her Wander Guard (wearable monitoring device that alerts caregivers when a resident leaves a protected area); and2. Resident 2 had an avoidable fall (unintentional fall that happens because of identifiable and correctable factors) when she was not properly secured during transportation to an appointment.This failure resulted in Resident 1 leaving the facility unsupervised and increased her risk for harm and injury and in Resident 2 sustaining a left femur (lower end of thigh bone) fracture (crack, break, or chip in bone) that required surgery. Findings:1. During a review of Resident 1's admission Record, it indicated, Resident 1 was admitted to the facility November 2025, with multiple diagnoses which included dementia (impaired ability to remember, think, or make decisions), bipolar disorder (mental health condition that causes extreme mood swings) and generalized anxiety disorder (apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external).A review of Minimum Data Set (MDS, an assessment tool), dated 10/1/25, the MDS indicated Resident 1 had moderate cognition impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). Resident 1's family member was listed as the responsible party.During a review of Resident 1's Order Summary Report, order date 11/3/25, it indicated, Resident does not have the capacity to make her decisions related to: Dementia.During a review of Resident 1's Order Summary Report, order date 11/4/25, it indicated, Wander Guard [wearable monitoring device that alerts caregivers when a resident leaves a protected area] right wrist For exit seeking [attempting to leave a building or secured area] behaviors.During a review of Resident 1's care plan (CP), initiated on 11/4/25, the CP indicated, Elopement: [Resident 1] is at risk for elopement/exit seeking/wandering related to dementia or other cognitive impairment, unsafe wandering [going about from place to place] .Will not leave the facility without a responsible person.During a review of Resident 1's Progress Note, effective date 11/29/25, it indicated, .around 9:15am, Resident as noted with attempting to exit from the front door of the facility, redirection, provided multiple times, noted with no wander guard. Resident had taken off her wander guard, writer applied New wander guard, checkedplacement [sic] and functioning well. Resident was found off facility grounds approx. around 9:45am by a CNA [Certified Nursing Assistant] .Resident had taken off her wander guard second time prior to the incident.During an interview on 12/8/25 at 11:36 a.m., with CNA 2, CNA 2 confirmed Resident 1 had a history of taking off her Wander Guard and exiting the building. CNA stated on 11/29/25 at approximately 10:30 a.m. , Resident 1 had left the building without staff knowledge and was found at a nearby gas station without her Wander Guard on. CNA 2 further stated Resident 1 could have gotten hurt while she was out of the building and was not sure how the Wander Guard was removed.During an interview on 12/8/25 at 11:46 a.m., with Licensed Nurse (LN) 2, LN 2 stated Resident 1 had removed her Wander Guard the morning of 11/29/25 and a new Wander Guard was put on. LN 2 confirmed Resident 1 later left the building without staff knowledge and was found down the street without her Wander Guard on. LN 2 further stated that contributing factors for Resident 1's elopement could have been not changing the Wander Guard location (to a place she could not reach on her body) and her poor safety awareness. During an interview on 12/8/25 at 12:29 p.m., with CNA 1, CNA 1 confirmed Resident 1 had left the building without staff knowledge on 11/29/25 and was found at a nearby gas station. CNA 1 stated Resident 1 did not have her Wander Guard when she returned to the facility and that Resident 1 could have potentially gotten hurt. CNA 1 confirmed the expectation for nursing staff was to keep residents safe and prevent elopement. During a review of the facility's policy and procedure (P&P) titled, Accident Prevention and Safety of Residents, revised 7/22, the P&P indicated, Resident safety and supervision are facility-wide priorities.Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring,.Employees shall be trained in potential accident hazards and try to prevent avoidable accidents.facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and adjust interventions accordingly .During a review of the facility's P&P titled, Wandering and Elopement, reviewed 10/24, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and provide interventions to decrease risk and keep residents safe.2. During a review of Resident 2's admission Record, it indicated, Resident 2