

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055640	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/30/2025
NAME OF PROVIDER OR SUPPLIER  Grass Valley Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  355 Joerschke Dr 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 0551  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights.  (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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<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure that Resident 1's rights were protected when: 1. Licensed Nurse (LN) B administered a PPD test (purified protein derivative, injected under the skin to determine if a person had tuberculosis, a contagious bacterium that had the potential to cause death) after Resident 1's responsible party (RP, decision maker) had declined administration of the PPD test. 2. The facility provided medication to Resident 1 based on the RP's decisions rather than assessment data and concerns regarding Resident 1's appearance of being sedated. These failures violated Resident 1's rights. Findings: 1. A review of the Resident [NAME] of Rights, dated 12/1/12, indicated, residents had the right to refuse any treatment or procedure. A review of the facility's policies and procedures (P&amp;P) titled, Requesting, Refusing, and/or Discontinuing Care or Treatment, revised 2/1/21, indicated, the resident and or the residents RP had the right to refuse treatment. A review of the Client Resident Profile, dated 8/5/24, indicated, Resident 1 was admitted to the facility on [DATE] and Resident 1 was not her own RP. A review of the Medical Diagnosis, dated 8/5/24, indicated, Resident 1 was admitted to the facility with the diagnoses of pressure ulcer of sacral region, unstageable (a painful wound that was caused by pressure, located at the tail bone area. The wound was unstageable because dead tissue covered the wound making wound depth measurements and visual inspection impossible), depression (a sad mood), and dementia (memory loss). During an interview on 7/24/25 at 10:10 am, Resident 1's RP stated, on August 11th Resident 1 was given a TB shot [PPD test] without my permission. During a concurrent interview and record review on 7/29/25, at 2:10 pm, with LN B, Resident 1's Medication Administration Record (MAR), dated 8/11/24 was reviewed. LN B confirmed, the MAR indicated, LN B performed a PPD skin test on Resident 1 and stated, when he [RP] came back to the room, I alerted him I gave the PPD, I did not know it was refused previously, and the order to give the PPD was still in the computer. LN B reviewed the MAR, dated 8/5/24, and confirmed the MAR indicated the PPD had been refused. LN B stated, my view of the MAR was not of the entire month, it only showed what was due that day, so I couldn't see that it had been refused. During an interview on 7/29/25 at 10:15 am, Director of Nursing (DON) confirmed, Resident 1 had been provided the PPD skin test on 8/11/24 and stated, the nurse didn't remove the PPD order from the system and that's why LN B provided the PPD. After it was originally refused, the nurse should have removed the order and entered a note. 2. A review of the Resident [NAME] of Rights, dated 12/1/12, indicated, residents had the right to be free from excessive medication. A review of the Medication Review Report, dated 7/30/25, indicated, Resident 1 received Buspirone HCL (Buspar, a medication that was used to treat anxiety) 15 milligrams (mg, unit of measure), give 1 tablet by mouth three times a day for anxiety manifested by continuous calling out after needs have been met. The Medication Review Report, indicated, Resident 1 received oxycodone HCL (a strong opioid pain medication that had the potential to cause sedation and drowsiness. When using oxycodone and Buspirone together, potential risks and side effects included an increased risk of profound sedation [depressed consciousness], drowsiness, and impaired judgement) 10mg, give one tablet by mouth three times a day for pain and may also give every 4 hours as needed for pain that was scored 4-10 out of 10 on the pain scale. During an interview on 7/24/25 at 10:10 am, Resident 1's RP stated, I'm concerned about her [Resident 1's] anxiety, they started her on a lower level once a day, then they increased to twice a day, then we moved it to three times a day. I just told them, it's helped a lot, there are still minor break outs [related to Resident 1's yelling out], so I asked to up the dosage. During an interview on 7/30/25 at 8:44 am, facility's physician (MD) stated, Resident 1's RP is concerned about the pain, he was pushing for stronger pain medications, we accommodated his request and her pain control really isn't bad. During an interview on 7/30/25 at 9:18 am, LN G stated, Resident 1's RP would by-pass the nurse and go to the DON to complain Resident 1 was in pain and demand more pain meds. I went once to assess Resident 1's pain after the RP said she was in pain, and the RP said, say your pain is a 7, then Resident 1 agreed her pain was a 7. LN G stated, prior to RPs arrival Resident 1 stated she had no pain. LN G stated, sometimes the PRN (as needed dose of oxycodone) was held because nurses felt uncomfortable giving it because she appeared to be sedated or sleepy and the RP would demand that pain meds still be given. LN G stated, there were times when Resident 1 was provided PRN pain medication [oxycodone] due to the RP pushing pain meds and convincing Resident 1 she was in pain, so it's given. During a review of the IDT (Interdisciplinary Team, a group of facility staff such as department heads and staff that provided direct resident care, met to discuss</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to follow their pain management policies and procedures (P&amp;P) for three out of three residents (Residents 1, 2, and 3) when: 1. Resident 1 had high PRN (as needed and must be asked for) pain medication usage for eight months prior to evaluating the need to change the current pain medication regimen. 2. The facility failed to determine if Resident 1's behavior of screaming was caused by pain, anxiety, or related to a diagnosis of dementia. 3a. Non-pharmacological interventions (any health intervention that was used to assist with managing chronic pain and did not involve the use of medication. Examples included but were not limited to distraction, music, re-positioning, stretching, or activities) were not implemented or monitored for effectiveness for Resident 1. 3b. Non-pharmacological interventions were not implemented or monitored for effectiveness for Resident 2. 3c. Non-pharmacological interventions were not implemented or monitored for effectiveness for Resident 3. These failures had the potential to cause resident harm, inconsistent pain control, a decline in health status, and to negatively impact the residents' overall well-being. Findings: 1. A review of the facility's P&amp;P titled, Pain Assessment and Management, revised 10/1/22, indicated, The purposes of this procedure are to help staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&amp;P indicated, the facility would review how often the individual requested and received PRN pain medication and would consider administering regularly scheduled pain medication rather than PRN. The P&amp;P indicated, the facility would monitor the resident to ensure the pain was being adequately controlled. A review of the Client Resident Profile, dated 8/5/24, indicated, Resident 1 was admitted to the facility on [DATE] and Resident 1 was not her own responsible party (RP, decision maker). A review of the Medical Diagnosis, dated 8/5/24, indicated, Resident 1 was admitted to the facility with the diagnoses of pressure ulcer of sacral region, unstageable (a painful wound that was caused by pressure, located at the tail bone area. The wound was unstageable because dead tissue covered the wound making wound depth measurements and visual inspection impossible), depression (a sad mood), and dementia (memory loss). A review of Resident 1's admission Minimum Data Set (MDS, a resident assessment tool), dated 8/15/24, indicated, the facility performed a Brief Interview for Mental Status assessment (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) and scored a 5 out of 15 which indicated severe cognitive (memory, orientation, judgement) impairment. The MDS indicated Resident 1 had received scheduled and PRN pain medication and occasionally had pain. A review of Resident 1's care plan (a document that described resident healthcare needs, goals, and interventions [actions taken by facility staff] required to achieve those goals) titled Pain, dated 8/6/24, indicated, the facility staff would monitor the resident for requests for pain treatment and review pain medication dosing schedules for resident satisfaction. A review of the Order Details, dated 8/5/24, indicated the Physician ordered Gabapentin (an anticonvulsant medication that was used to treat seizure disorders and treated nerve pain) 400 milligrams (mg, a unit of measure) by mouth three times a day for pain that was caused by Resident 1's pressure ulcer. A review of the Order Details, dated 8/5/24, indicated the Physician ordered Oxycodone (a strong narcotic that was used to treat moderate to severe pain) 10 mg by mouth every four hours as needed (PRN) for moderate to severe pain (pain was rated on a scale of 0 through 10 out of ten, 0 meant no pain and 10 meant the worst pain, moderate to severe pain was rated as a 4 through 10). During an interview on 7/29/25 at 3:05 pm, Director of Nursing (DON) stated, the amount the PRN [pain medication] was provided [to Resident 1] was the same as if it had been given on a routine basis. A review of Resident 1's Medication Administration Record (MAR), dated 8/5/24 through 8/31/24, indicated that a request for PRN Oxycodone was made 62 times. A review of Resident 1's MAR, dated 9/1/24 through 9/30/24, indicated that a request for PRN Oxycodone was made 85 times. A review of Resident 1's MAR, dated 10/1/24 through 10/31/24, indicated that a request for PRN Oxycodone was made 73 times. A review of Resident 1's MAR, dated 11/1/24 through 11/30/24, indicated that a request for PRN Oxycodone was made 71 times. A review of Resident 1's MAR, dated 12/1/24 through 12/31/24, indicated that a request for PRN Oxycodone was made 77 times. A review of Resident 1's MAR, dated 1/1/25 through 1/31/25, indicated that a request for PRN Oxycodone was made 73 times. A review of Resident 1's MAR, dated 2/1/25 through 2/28/25, indicated that a request for PRN Oxycodone was made 62 times. A review of Resident 1's MAR, dated 3/1/25 through 3/21/25, indicated that a request for PRN Oxycodone was made 49 times. From 8/5/24</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to follow their policies and procedures (P&amp;P) regarding medication administration documentation for one out of three sampled residents (Resident 1) when Licensed Nurse (LN) B initialed the medication administration record (MAR) for a medication that LN A prepared and administered to Resident 1. This caused inaccurate documentation and had the potential to negatively impact resident safety. Findings: A review of the facility's P&amp;P titled, Administering Medications, revised 4/1/19, indicated, The individual administering the medication initials the residents MAR on the appropriate line after giving each medication and before administering the next dose. A review of the Client Resident Profile, dated 8/5/24, indicated, Resident 1 was admitted to the facility on [DATE] and Resident 1 was not her own responsible party (RP, decision maker). A review of the Medical Diagnosis, dated 8/5/24, indicated, Resident 1 was admitted to the facility with the diagnoses of pressure ulcer of sacral region, unstageable (a wound that was caused by pressure, located at the tail bone area. The wound was unstageable because dead tissue covered the wound making wound depth measurements and visual inspection impossible), depression (a sad mood), and dementia (memory loss). During a concurrent interview and record review on 7/29/25 at 2:10 pm, with LN B, Resident 1's MAR, dated 3/20/25 was reviewed. LN B confirmed, the MAR indicated, LN B had administered oxycodone (a strong pain killer) 10 milligrams (unit of measure), one tablet, by mouth, on 3/20/25, at 6:32 pm, to Resident 1. LN B stated, I checked off the oxycodone [in the MAR], but I didn't give it, LN A did. LN B stated, it is not normal for me to sign off a medication that I did not administer. During an interview on 7/29/25 at 3:05 pm, Director of Nurses (DON) stated, nurses should not sign out medication they did not administer.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to maintain infection control practices when facility staff disinfected the Hoyer lift (mechanical device used to safely transfer residents from one place to another) in the hallway, did not wear gloves, or perform hand hygiene (washing hands or using alcohol-based hand sanitizer) afterwards. This failure had the potential to spread infections to other residents, facility staff, and visitors. Findings: A review of the facility's policies and procedures, (P&amp;P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, revised 9/1/22, indicated, facility staff would clean and disinfect medical equipment in-between resident use. A review of the facility's P&amp;P titled, Personal Protective Equipment (PPE, items worn to prevent the spread of infection such as gowns or gloves), revised 10/1/18, indicated, PPE requirements were specific to job requirements and facility staff would wear the appropriate PPE for specific tasks. A review of the facility's P&amp;P titled, Infection Prevention and Control, revised 12/1/23, indicated, the facility utilized infection control practices to maintain a safe environment. A review of the CaviWipes Safety Data Sheet, dated 6/29/22, indicated, facility staff were required to wear gloves while using CaviWipes (a brand name, cleansing and disinfecting wipes that were used to clean resident care equipment). The safety data sheet indicated repeated exposure could cause dry, cracked skin (this had the potential for bacteria to enter through cracked skin and cause the spread of infection). During an observation on 7/25/25 at 12:54 pm, Certified Nurse Assistant (CNA) C and CNA D were observed wiping down the Hoyer lift without wearing gloves, in the hallway, outside of room [ROOM NUMBER]. When CNA C and CNA D finished, they walked immediately into room [ROOM NUMBER] with the Hoyer lift and were not observed performing hand hygiene. During a concurrent interview and record review on 7/25/25 at 1:00 pm, with CNA C and CNA D, the entirety of the observation made was described. CNA C and CNA D confirmed the observation. CNA C stated, we should wear gloves and acknowledged not performing hand hygiene after cleaning the Hoyer lift and before entering room [ROOM NUMBER]. CNA D produced a plastic container that had a black lid with the name of CaviWipes on the label. CNA D reviewed the instructions on the label and confirmed, the label indicated gloves were to be worn while using the product. During an interview on 7/25/25 at 1:44 pm, the facility's infection preventionist (IP) confirmed the observation made of CNA C and CNA D wiping down the Hoyer lift and stated, they should be cleaning [the Hoyer lift] in the room, not in the hall, and wearing gloves. IP confirmed, hand hygiene should have been performed after wiping down the Hoyer lift.</p>		