

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/25/2025
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.			
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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on interview, and record review, the facility failed to ensure one out of 24 sampled resident (Resident 17) was provided with an ongoing activity program that meets psychosocial needs (a combination of mental health, emotional, spiritual, or behavioral needs that are important to a person) when Resident 17's frequency of ongoing activity program visit was followed. These failures had the potential for Resident 17 to not achieve her highest mental, emotional, spiritual, and psychosocial well-being. Findings: A review of Resident 17's clinical record indicated Resident 17 was admitted February of 2018 and had diagnoses that included dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), skin cancer, and muscle weakness. A review of Resident 17's Minimum Data Set (MDS- an assessment tool used to guide care) Cognitive Patterns, dated 9/16/25, indicated Resident 17 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 2 out of 15 which indicated Resident 17 had a severely impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 17's annual MDS Preferences for Customary Routine and Activities, dated 3/16/25, indicated it was very important for Resident 17 to listen to music she likes and to do her favorite activities, and it was somewhat important for Resident 17 to have books, newspapers, and magazines to read. A review of Resident 17's active physician's order, dated 5/7/19, indicated, May participate in activity plan as not in conflict with treatment plan. A review of Resident 17's care plan, initiated 7/26/19, indicated, The resident [Resident 17] chooses not to attend activities. Mostly bed bound [someone unable to leave their bed due to inability to walk, even with assistance], 1:1 room visits. A review of Resident 17's care plan goal, initiated 4/5/21, indicated, Activities will visit 3 times a week through the review date. A review of Resident 17's care plan intervention, revised 1/6/25, indicated, Activity department will supply materials, audio, visual, entertainment as needed by resident, per preferences. During an observation on 9/22/25 at 9:57 a.m., in Resident 17's room, Resident 17 was observed awake and was lying on her bed. Resident 17's television was off, there was no radio or any music devices, and there were no books, newspapers, or magazines in her room. During another observation on 9/23/25 at 9:52 a.m., in Resident 17's room, Resident 17 was observed lying on her bed, eyes closed, and breathing was unlabored (something natural, flowing, or relaxed, and doesn't require effort). Resident 17's television was again off, there was no radio or any music devices, and there were no books, newspapers, or magazines in her room. During a third observation on 9/23/25 at 2:55 p.m., in Resident 17's room, Resident 17 was again observed lying on her bed, eyes closed, and breathing was unlabored. Resident 17's television was still off, there was no radio or any music devices, and there were no books, newspapers, or magazines in her room. During a fourth observation on 9/24/25 at 9:17 a.m., in Resident 17's room, Resident 17 was again observed lying on her bed, eyes closed, and breathing was unlabored. Resident 17's television was again off, there was no radio or any music devices, and there were no books, newspapers, or magazines in her room. A review of Resident 17's progress notes titled, ACTIVITY NOTE, for the months of June, July, August, and September 2025, indicated the following:-Resident 17 was only visited by an activity staff for activity one (1) time (6/13/25) for the month of June 2025. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055640	Facility ID: 055640 If continuation sheet Page 1 of 20

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident 17 was visited by an activity staff for activity three (3) times (7/3/25, 7/7/25, and 7/21/25) for the month of July 2025.-Resident 17 was visited by an activity staff for activity four (4) times (8/14/25, 8/20/25, 8/27/25, and 8/31/25) for the month of August 2025.-Resident 17 was visited by an activity staff for activity one (1) time per week (9/2/25, 9/13/25, and 9/15/25) for the month of September 2025 as of 9/24/25.During a concurrent interview and record review on 9/24/25 at 10:37 a.m. with the Activities Director (AD), Resident 17's activity records were reviewed. The AD confirmed that Resident 17's frequency of ongoing activity program visit was followed. The AD also confirmed that there were no documented refusals of Resident 17 with activities. The AD stated she would expect staff to try and follow the planned activity frequency and preferences of Resident 17 because there would be a risk of decline in the quality of life and activities of Resident 17 if the plan was not followed.During an interview on 9/24/25 at 2:07 p.m. with the Director of Staff Development (DSD), the DSD stated she expects that residents' ongoing activity program frequency to be followed because bed bound residents might feel isolated and there would be a risk for well-being issues. During an interview on 9/24/25 at 2:33 p.m. with the Director of Nursing (DON), the DON stated she expects that residents are provided with an ongoing activity program, and the frequency, resident preferences, and care plan should be followed because of the risk of isolation and well-being concerns.A review of the facility's policy and procedure (P&P) titled, Activity Programs, Revised 6/2018, indicated, 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. 4. Activities are considered any endeavor, other than routine AD Ls, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health .7. Our activity programs consist of individual, small group and large group activities that are designed to meet the needs and interests of each resident .9. All activities are documented in the resident's medical record .		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to ensure the menu was followed for therapeutic diets (a modification of a regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) during the lunch meals on 9/22/25 and 9/23/25 when:1. Two residents (Resident 19 and 77) with CCHO (controlled carbohydrate) diets (a therapeutic diet to manage diabetic disease and/or to stabilize blood sugar level) received one slice of garlic bread instead of one half (1/2) slice.2. 22 residents (Resident 3, 5, 16, 22, 28, 32, 37, 38, 40, 47, 50, 62, 63, 65, 66, 67, 70, 74, 77, 81, and 96) with fortified diets (a dietary pattern that includes foods that have been enriched with additional nutrients, such as calories and protein) did not get the fortified foods.3. Two residents (Resident 26 and 44) with puree (a very smooth, crushed or blended food usually for people with swallowing and/or chewing difficulties) diet received mashed potatoes and did not get the pureed red beans and rice as the menu indicated.4. Two residents (Resident 10 and 40) had diets with half (1/2) portion size got served with small portion size. These deficient practices had the potential to result in compromising the medical and nutritional status of 26 residents for a census of 80 who consumed meals from the facility kitchen. Findings: During dining observation on 9/22/25 at 12:04 p.m. and 12:16 p.m. in the dining room: 1. Resident 19 and Resident 77 were noted with CCHO diet received one slice of garlic bread with their lunch meals. A concurrent review of the spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Fall Menus, Week 4 Monday, indicated CCHO diet should receive 1/2 slice of garlic bread. During an interview and concurrent review of spreadsheet on 9/23/25 at 1:20 p.m. with Registered Dietitian (RD), RD stated residents with CCHO diet should receive 1/2 slice of garlic bread. During the lunch meal distribution on 9/23/25 beginning at 11:57 a.m., the following was noted: 2. 22 residents (Resident 3, 5, 16, 22, 28, 32, 37, 38, 40, 47, 50, 62, 63, 65, 66, 67, 70, 74, 77, 81, and 96) with fortified diets did not receive 1/2 ounce (oz., a unit of measurement) extra melted margarine on the red beans and rice and extra two teaspoons (tsp) salad dressing as fortified food. A review of facility document titled, Week 4, Fortified Breakfast, Fortified lunch, Fortified Dinner, Fall 2025, indicated fortified diets should get extra 1/2 oz melted margarine on the red beans and rice, and extra two tsp of salad dressing for lunch meal. During an interview on 9/23/25 at 1:22 p.m. with RD, RD stated residents should get the fortified food as stated on the fortified menu. RD stated the fortified diet was therapeutic diet to provide extra calories for the residents at risk for weight loss. RD stated if residents did not get the fortified food, residents would not get the calories that they need.3. During the lunch meal distribution on 9/23/25 beginning at 11:57 a.m., two residents (Resident 26 and 44) with puree diet orders did not get pureed red beans and rice. During an observation on 9/23/25, began at 11:27 a.m. of the lunch meal distribution, it was noted Resident 26 and 44 received pureed mashed potatoes instead of pureed red beans and rice. A concurrent review of the facility document titled, Fall Menus, Week 4, Tuesday dated 9/23/25, indicated pureed diet should include pureed rice and beans in the lunch meal. During an interview on 9/23/25 at 1:29 p.m. with RD, RD confirmed [NAME] (CK)1 did not prepare the puree red beans and rice for the puree diet meal on lunch. 4. During the lunch meal distribution on 9/23/25 beginning at 11:57 a.m., two residents (Resident 10 and 40) had diet orders of 1/2 portion size for their meals but got served with small portion size. A review of the spreadsheet Fall Menus, Week 4 Tuesday, dated 9/23/25, it did not have 1/2 portion size included on the spreadsheet. During an interview on 9/23/25 at 11:45 a.m. with Dietary Supervisor (DS) 1, DS 1 stated 1/2 portion size was the same amount as small portion size. During an interview on 9/23/25 at 1:22 p.m. with RD, RD confirms 1/2 portion meals should get 1/2 of the regular portion. RD stated if regular portion was three oz. of meat, 1/2 portion would equate to 1.5 oz. of meat. RD stated verbal in-services have been done regarding 1/2 portion sizes, but there have not been formal in-services and there was no policy and procedure for (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the staff to reference. During a follow-up interview on 9/24/25 at 3:23 p.m. with RD, RD acknowledged the findings mentioned above during the dining observation on 9/22/25 and meal distribution observation 9/23/25. RD confirmed and stated the expectation was the dietary staff needed to follow the spreadsheet and fortified food menu.A review of facility policy and procedure (P&P) titled, JOB DESCRIPTION-Food and Nutrition Service Director, dated 2023, indicated .ability to follow prepared menus and portion control guides.DUTIES AND RESPONSIBILITIES: 1. Schedule and supervise the FNS Staff providing in-service training. 3. Is responsible for the food preparation and service of all food and ensures approved menus and accompanying recipes are followed.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food service safety when: 1. The ice machine was not clean; and 2. The arrangement of the food stored in the freezer was not in a food safety manner; and 3. Items found in the clean and ready-to-use storage areas: A few metal sheet pans were stored and stacked wet; and The metal sheet pans, food processor and metal strainers were found with brown substances; and 4. Three dietary staff did not wear hair restraint and beard restraint appropriately; and 5. Three dietary staff did not practice hand hygiene between soiled and clean dishes during the dishwashing process; and 6. The metal coating of the can opener blade was worn off. These failures had the potential to result in food contamination which could cause illness for 80 residents who received food prepared from the facility kitchen. Finding: 1. During an concurrent observation and interview on 9/22/25 at 11:06 a.m. with Dietary Supervisor (DS) 1, DS 1 stated the facility uses an outside vendor for the ice machine deep cleaning (cleaning and sanitizing the machinery parts on the top section of the ice machine and the ice storage bin on the bottom section of the machine with chemical solutions designed to remove lime scale and mineral deposits and to remove algae and slime, then sanitize with chemical agent) every six months. DS 1 stated DS 1 or Registered Dietitian (RD) cleaned and sanitized the ice machine monthly, and the last clean and sanitize was completed on 8/21/25. DS 1 stated the process for cleaning the ice machine included removing the ice before cleaning and sanitizing the ice storage bin. DS 1 stated the top machinery would be cleaned and sanitized too. She stated once the front panel of the top machinery opened, she would disassemble the curtain (a part that controls water flow, prevents splashing, and helps with the ice-making process) and the trough (a shallow, basin-like pan that holds water inside an ice-making machine) and got cleaned and sanitized. Then the clean solution added to the trough and run the clean cycle and add the sanitizer solution (a food-safe chemical mixture used after cleaning an ice machine to kill bacteria, algae, mold, and other microorganisms on food-contact surfaces) to run the sanitizing cycle. DS 1 opened the top machinery part of the ice machine. Upon the removal of the trough, there were black substances observed at the bottom of the evaporator (the crucial surface where water freezes into ice by being rapidly chilled by circulating refrigerant) and could be removed when wiping with a paper towel. A concurrent interview with DS 1, DS 1 confirmed the black substance observed and stated the bottom of the evaporator was scrubbed every time when monthly cleaning. DS 1 stated the areas with black substances that could not be reached or cleaned. During an interview on 9/24/25 at 3:23 p.m. with the RD, the RD stated the ice machine had to be kept clean. RD stated the ice machine gets deep cleaning monthly by dietary. RD stated they used an outside vendor every six months for cleaning the fan and the coils of the machine. RD explained the process for cleaning the ice machine was to first to take out all the ice and then disassembled the removable components of the top machinery of the ice machine, included: the curtain, water trough, probes and then used the cleaner to clean and sanitizer to sanitize the ice making panels and the rims, the bottom of the evaporator, and the walls below the evaporator, and the ice storage bin, the door of the ice bin. Then run the cleaner with the cleaning cycle and then run the sanitizer for the sanitizing cycle. RD stated the inside of the top machinery of the ice machine needed to be scrubbed and cleaned well to get rid of the dirty stuff. RD confirmed DS 1 cleaned the ice machine last cleaning on 8/21/25 and missed the area found with black substance. A review of the facility policy and procedure (P&P) titled, Ice Machine Cleaning Procedures, dated 2023, indicated, . The internal components cleaned monthly. 2. During an observation on 9/22/25 at 10:29 a.m., the reach-in freezer had four shelves with labels on the inside wall from top to bottom: top shelf labeled sausage, second shelf labeled beef, third shelf labeled chicken, and bottom shelf labeled pork. On the top shelf labeled sausage, there was a pack of diced cooked ham stored next to a box of ready-to-eat mac and cheese cups. On the second shelf (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	labeled beef, there was a bag of raw beef patties next to the black bean burger patties. On the third level shelf labeled chicken, there was a pack of raw beef stored next to the boxes of diced chicken meats. On the bottom shelf labeled pork, there was a box of raw ground beef, a box of ready-to-eat garlic bread and a box of cooked beef, and a box of hash browns. A concurrent interview with DS 1, DS 1 stated she was not aware of the hierarchy (proper ranking by internal cooking temperature of food) of food storage and agreed the garlic bread and hash browns were ready-to-eat food and should be stored at the top level and the raw meat should be at the bottom. A concurrent interview with DS 2, DS 2 confirmed and stated the freezer storage should follow the proper food storage per the P&P. During an interview on 9/24/25 at 3:23 p.m. with RD, RD was not aware of the policy and procedure (P&P) for food storage arrangement. RD was made aware of the policy for Storage of Food and Supplies. RD stated it was best practice to follow food storage guidelines. A review of the facility P&P titled, Storage of Food and Supplies, dated 2023, indicated, POLICY: Food and supplies will be stored properly and in a safe manner. A review of the facility P&P titled, Refrigerated Storage and Storage of Frozen Food, indicated, 1. Store raw meat, poultry, and fish separately from cooked and ready-to-eat food to prevent cross contamination. 4. Store cooked or ready-to-eat food above raw meat, poultry, and fish. this will prevent raw-product juices from dripping onto the prepared food and causing food borne illness. 5. Store raw meat, poultry, and fish in the order from top to bottom. This order is based on the required minimum internal cooking temperature of each food .a. Whole fish, b. Whole cuts of beef and pork, c. Ground meat and fish. d. Whole and ground poultry. 3. During the observations on 9/22/25 at 9:22 a.m. and 9:25 a.m., the following items found issues and stored in the clean and ready-to-use storage areas: one full sheet metal pan with brown substances one of 1/6 sheet metal pan with brown substances one full sheet metal strainer with brown substances one full sheet metal pan was wet three of 1/6 sheet metal pans were wet the bowl of the food processor had brown substances During an interview on 9/22/25 at 9:25 a.m. with DS 1, DS 1 stated the brown substances on the pans and equipment were food particles and confirmed the pans listed above were wet. DS 1 stated the pans, dishes and equipment should be clean and air-dried before being stored in the storage area. DS 1 stated the person who puts away the dishes/pans and equipment should check for cleanliness and dryness before storing them away. During an interview on 9/24/25 at 3:23 p.m. with the RD, RD stated the pans, dishes and equipment should be clean without food particles and completely air-dried before store away to prevent bacteria growth. A review of the facility P&P titled, Dishwashing, dated 2023, indicated, . 1. Gross food particles shall be removed by careful scraping and pre-rinsing in running water, 5. Dishes are to be air dried in racks before stacking and storing. A review of the facility P&P titled, Sanitation, dated 2023, indicated, .All utensils.equipment shall be kept clean. 4. During an observation on 9/22/25 at 11:02 a.m., [NAME] (CK) 1 wore a disposable (medical) face mask without a beard restraint with facial hair on the neck area and the side burns were not covered and he was working at the cooking station. A concurrent interview with DS 1, she confirmed CK 1 had facial hair and needed to wear a beard restraint to cover the exposed hair. During an observation on 9/22/25 at 11:20 a.m., Dietary Aide (DA) 4 had exposed side burns and beard without a beard restraint while prepping the food trays on the meal carts. A concurrent interview with DS 1, she confirmed DA 4 had exposed side burns and a beard and stated DA 4 needed to wear a beard restraint. During an observation on 9/23/25 at 11:14 a.m., CK 2 had a beard without beard restraint, and he wore a hat without hair restraint and his hair on the back and sides of the hair was exposed. A concurrent interview with DS 1, DS 1 confirmed and stated CK 2 should wear a beard restraint for the beard, and a hair net should be on to contain all the hair before putting on a hat. During an interview on 9/24/25 at 3:23 p.m. with the RD, RD stated the dietary staff needed to follow the policy and procedure and cover their hair and beards completely with hair and beard restraint. A review of the facility P&P titled, Dress Code, dated 2023, indicated, .PROPER DRESS: .6. Hat for hair, if hair is short which completely covers the hair, 7. Hair net for hair, if hair is long (over the ears or longer), 8. beards and mustaches (any facial hair) must wear beard restraint. A review of the facility (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P&P titled, Personnel Management, dated 2023, indicated, .FNS employees. are required to follow the dress code. 5. During an observation of the dishwashing process on 9/22/25 at 9:57 a.m., it was noted DA 2 touched dirty trays from a meal cart with her bare hands and dumped the leftover food in the trash can; then used the same bare hands and touched the clean dishes without washing hands. At 9:58 a.m., DA 2 touched the dirty dishes on the dirty side of the dishwashing machine and then touched the clean dishes without washing hands. At 11:01 a.m., DA 2 used bare hands to push the dirty dishes in the dishwashing machine and then touched the clean dishes without washing hands. During another observation on 9/23/25 at 9:20 a.m., it was noted DA 1 and DA 3 used their bare hands touching dirty and clean dishes interchangeably without washing hands. DA 3 then touched the dirty dishes and used a towel on her waistline to dry her hands and then touched clean dishes. During an interview on 9/24/25 at 3:23 p.m. with RD, RD stated handwashing had to be performed between soiled and clean tasks during the dishwashing process to prevent cross contamination. RD stated it was an infection control concern. A review of the facility P&P titled, Sanitation, dated 2023, indicated, . 18. A minimum of two employees will be used when dishes are machine washed. One will handle soiled area, and one will handle the clean side. If an employee does need to go from soiled to dirty end, a strict hand washing routine must be followed. A review of the facility P&P titled, Handwashing, dated 2023, indicated, All employees will be instructed in the proper procedure of hand washing. A review of departmental in-services titled, Dietary In-Service, Topic: Handwashing and Dress Code, were completed by DS 1 and RD on 7/23/25 and 9/7/25 respectively. DA 1, DA 2, and DA 3 were not on the attendance sheets. The in-service handout showed, Handwashing Procedure. When to wash hands. bacteria and viruses can travel easily from one person to another or from people to food and food contact surfaces. it is important to wash hands frequently and after any task that may potentially contaminate your hands. wash your hands: .before handling clean equipment and serving utensils. when changing tasks. after handling soiled dishes, equipment, or utensils. Bottom line - if you touch anything else that may contaminate your hands, wash them. 6. During a concurrent observation and interview on 9/22/25 at 9:57 a.m. with DS 1, it was noted the blade tip of the can opener was chipped and discolored. DS 1 stated the metal coating was chipping away and needed to be replaced. During an interview on 9/24/25 at 3:23 p.m. with the RD, RD stated the blade on the can opener needed to be replaced. A review of the facility P&P titled, Can Opener and Base, dated 2023, indicated, .proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result from a dull cutting blade. 6. Replace blade on can opener, as needed.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 80 residents when:1. Enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use) was not implemented to Resident 5 and Resident 63;2. A facility staff did not wear required personal protective equipment (PPE) when performing resident care on Resident 56 who was on EBP; and,3. Facility staff entered a contact precaution room (an infection control measure used in healthcare settings to prevent the spread of infectious agents that can be transmitted by direct or indirect contact with a patient or their environment) without using all the required PPE. These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), and potential exposure of residents and staff to germs. Findings: 1a. A review of Resident 5's clinical record indicated Resident 5 was admitted June of 2025 and had diagnoses that included pressure ulcer (also known as bedsores- are areas of skin damage that develop when pressure is applied to the same spot for an extended period) of right heel, and Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection) due to Methicillin-susceptible Staphylococcus aureus (MSSA- a bacteria that can be effectively treated with antibiotics like methicillin). A review of Resident 5's Minimum Data Set (MDS—a federally mandated resident assessment tool) Cognitive Patterns, dated 9/20/25, indicated Resident 5 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 5 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 5's MDS Skin Conditions, dated 9/20/25, indicated Resident 5 has two (2) unstageable pressure ulcers (are full-thickness skin and tissue losses where the extent of damage cannot be determined due to the presence of debris covering the wound bed) that were present upon admission. During a concurrent observation and interview on 9/22/25 at 1:11 p.m. with Certified Nurse Assistant (CNA) 3, in Resident 5's room, CNA 3 was observed changing Resident 5's linens and transferred Resident 5 to his bed while only using gloves. CNA 3 confirmed the observation and stated she only wear gloves because the resident is not on precaution (EBP). During a concurrent observation and interview on 9/22/25 at 1:11 p.m. with Certified Nurse Assistant (CNA) 3, in Resident 5's room, CNA 3 was observed changing Resident 5's linens and transferred Resident 5 to his bed while only using gloves. CNA 3 confirmed the observation and stated she only wear gloves because the resident is not on precaution (EBP). During an interview on 9/23/25 at 9:39 a.m. with the Treatment Nurse (TN), the TN stated Resident 5 was admitted on [DATE] and he has the wound on his foot at that time already. During a concurrent observation and interview on 9/24/25 at 9:43 a.m. with the TN, in Resident 5's room, the TN was observed doing wound care and dressing change on Resident 5's right foot wounds while only using gloves. The Infection Preventionist (IP) then came to help the TN to hold Resident 5's right foot in place for better visualization in taking wound photo and measurement while also just wearing gloves. The TN confirmed the observation. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1b. A review of Resident 63's clinical record indicated Resident 63 was admitted February of 2025 and had diagnoses that included diabetes mellitus (a chronic condition causing too much sugar in the blood which inhibits the body's natural wound-healing capabilities), peripheral vascular disease (PVD- a condition where blood flow to the arms, legs, and feet are restricted due to narrowed or blocked blood vessels), and need for assistance with personal care. A review of Resident 63's MDS Cognitive Patterns, dated 7/18/25, indicated Resident 63 had a BIMS score of 15 out of 15 which indicated Resident 63 had an intact cognition. A review of Resident 63's Skin and Wound Evaluation, dated 7/23/25, indicated Resident 63 has an arterial wound (also known as arterial ulcers- are painful injuries in your skin caused by poor circulation) on his right foot which was acquired in the facility on 3/28/25. During a concurrent observation and interview on 9/22/25 at 10:55 a.m. with CNA 2, in Resident 63's room, CNA 2 was observed assisting Resident 63 with morning care, toileting, changing Resident 63's briefs, assisting with dressing and transferring Resident 63 to his wheelchair while only using gloves. CNA 2 confirmed the observation. During an interview on 9/22/25 at 12:41 p.m. with Licensed Nurse (LN) 4, LN 4 stated Resident 63 has a wound on his right foot which used to be infected that's why Resident 63 was on contact precaution (an infection control measure that involve wearing a gown and gloves to prevent the spread of germs through direct or indirect contact with a patient or their environment) before. LN 4 confirmed Resident 3 was not on EBP. A review of a facility document titled, Resident list on precautions, provided by the IP on 9/22/25, indicated Resident 5 and Resident 63 were not on EBP or any transmission-based precaution. During an interview on 9/22/25 at 4:01 p.m. with the IP, the IP stated their criteria for putting a resident on EBP is if the resident's wound was not progressing within 30 days. The surveyor requested the facility policy stating only residents with non-progressing wounds are needed to be on EBP, but the IP was not able to provide. During an interview on 9/24/25 at 1:57 p.m. with the IP, the IP stated as long as the resident's wound was showing signs of progression and healing from week to week, then the resident does not need to be on EBP. During an interview on 9/24/25 at 2:33 p.m. with the Director of Nursing (DON), the DON stated they follow their policy on implementing EBP. A review of the facility's P&P titled, Enhanced Barrier Precautions, revised 12/2024, indicated, 2. Enhanced barrier precautions apply when: .b. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained .13. Information regarding CDC-targeted MDROs and current recommendations on Enhanced Barrier Precautions are available at: https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html . A review of The Centers for Disease Control and Prevention (CDC- the national public health agency of the United States) online publication titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, Nursing home residents with wounds and indwelling medical devices are at especially high (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization .Enhanced Barrier Precautions .Applies to: .All residents with any of the following: .Wounds and/or indwelling medical devices .regardless of MDRO colonization status .PPE used for these situations: .During high-contact resident care activities: Dressing .Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting .Wound care: any skin opening requiring a dressing .Required PPE .Gloves and gown prior to the high-contact care activity . (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html) 2. A review of Resident 56's clinical record indicated Resident 56 was admitted June of 2025 and had diagnoses that included neuromuscular dysfunction of the bladder (a condition where the nerves or muscles that control bladder function are impaired, leading to abnormal bladder control), and left thigh fracture (a break in the continuity of a bone). A review of Resident 56's Minimum Data Set (MDS—a federally mandated resident assessment tool) Cognitive Patterns, dated 9/9/25, indicated Resident 56 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 56 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 56's MDS Bladder and Bowel conditions, dated 9/9/25, indicated Resident 56 has Indwelling catheter [a flexible tube inserted into the bladder and left in place to drain urine]. During a concurrent observation and interview on 9/22/25 at 12:23 p.m. with Licensed Nurse (LN) 4, in front of Resident 56's room, LN 4 confirmed that Resident 56's room door has a signage which indicated, ENHANCED BARRIER PRECAUTIONS (EBP) .EVERYONE MUST: Perform hand hygiene before entering the room .ANYONE PARTICIPATING IN ANY OF THESE SIX MOMENTS MUST ALSO: [NAME] gown and gloves .Morning & evening care . LN 4 stated Resident 56 was on EBP because of her foley catheter. A review of Resident 56's active physician's order, dated 9/23/25, indicated, EBP due to Indwelling Catheter. A review of Resident 56's care plan, initiated 9/23/25, indicated, The resident [Resident 56] is on enhanced barrier precautions (EBP) r/t [related to] Indwelling Catheter. A review of Resident 56's care plan intervention, initiated 9/23/25, indicated, Direct care staff to utilize gowns and gloves for all personal care. During a concurrent observation and interview on 9/22/25 at 4:07 p.m., with CNA 4, in Resident 56's room, CNA 4 was observed changing Resident 56's shirt and pants while only wearing gloves and not wearing a gown. CNA 4 confirmed that he only wore gloves when he assisted Resident 56 with dressing. CNA 4 stated he was aware that Resident 56 was on EBP, and they usually wear gloves and gown when they're dealing with Resident 56's catheter. CNA 4 further stated, They [facility staff] didn't say anything about wearing gloves and gown when changing her [Resident 56]. During an interview on 9/24/25 at 1:57 p.m. with the IP, the IP stated staff needed to wear gown when performing all the 6 high contact procedures, including dressing, to residents on EBP to prevent the risk of the resident acquiring infection. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/24/25 at 2:33 p.m. with the DON, the DON stated she would expect staff to follow EBP protocol for residents who are on EBP. A review of the facility's P&P titled, Enhanced Barrier Precautions, revised 12/2024, indicated, EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity .8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing; .c. providing hygiene or grooming . 2. Resident 18 was admitted to the facility in July 2021 with multiple diagnosis which included pneumonia (lung infection) caused by methicillin-susceptible Staphylococcus aureus (bacteria found on the skin), type 2 diabetes mellitus (condition where the body either doesn't produce enough insulin or doesn't respond properly to the insulin) with diabetic nephropathy (lost of kidney function) and acute respiratory failure with hypoxia (lungs fail to adequately exchange oxygen, leading to low levels of oxygen in the body). A review of Resident 1's Minimum Data Set (MDS, an assessment tool) signed 9/22/25, indicated Resident 18 had moderate cognitive impairment. During a concurrent observation and interview on 9/22/25 at 9:57 a.m., with LN 3, Resident 18's room had signage posted on the wall next to the front door which indicated, STOP .CONTACT PRECAUTIONS EVERYONE MUST .PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit .Put on gown before room entry. Discard gown before room exit . LN 3 confirmed Resident 18 was on contact precautions because of MSSA (methicillin-susceptible Staphylococcus aureus) infection. LN 3 stated not wearing proper PPE could potentially cause the spread of germs. During an interview on 9/22/25 at 10:47 a.m., with the IP, the IP confirmed Resident 18 was on contact precautions because he had pneumonia with MSSA. IP stated all staff and visitors are expected to put on gown and gloves when entering contact precaution rooms. During a concurrent observation and interview on 9/22/25 at 12:37 p.m., CNA 1 entered Resident 18's room without wearing gown or gloves and delivered his lunch tray on his bedside table. CNA 1 confirmed she was not wearing any PPE and stated, It was my fault.I didn't know I had to wear PPE when entering the room.I had thought differently. A review of Resident 18's care plans initiated on 9/22/25, indicated, EBP (enhanced barrier precautions) Contact Precautions. A review of the facility's P&P titled, Isolation &ndash; Categories of Transmission-Based Precautions, revised 9/22, indicated, Contact Precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces.Staff and visitors will wear gloves (clean, non-sterile) when entering the room .Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure physician orders were followed in accordance with professional standards of care for one out of 24 sampled residents (Resident 3), when Resident 3 did not receive treatments as ordered by the physician. This failure had the potential for Resident 3's wounds to not heal, put them at risk for further skin breakdown and not achieve their highest practicable well-being. Resident 3 was originally admitted to the facility in September 2024 with multiple diagnosis which included type 2 diabetes mellitus (condition where the body either doesn't produce enough insulin or doesn't respond properly to the insulin) with foot ulcer (open sore on the foot) and cellulitis (bacterial infection of the deeper layers of the skin) of right lower limb. A review of Resident 3's Minimum Data Set (MDS, an assessment tool) signed 8/21/25, indicated, Resident 3 was cognitively intact. A review of Resident 3's Order Summary Report, with start date 9/11/25, indicated, Tx [treatment]: Left medial [middle] ankle wound: cleanse with NS [normal saline], pat dry, apply calmoseptine [ointment to treat skin irritations] to peri wound [skin surrounding the wound], apply Medi honey [medical-grade honey in wound care] to wound bed, cover with 4x4, wrap with kerlix [cotton bandage] followed by ACE [elastic bandage] every day shift every Mon [Monday], Thu [Thursday] for Wound management Monitor for s/sx [signs and symptoms] infection. A review of Resident 3's Medication Administration Record (MAR-a legal document used to record medications given to the residents), for the month of September 2025, indicated treatment for left medial ankle wound was not done on 9/18/25 as physician ordered. A review of Resident 3's Order Summary Report, with start date 8/30/25, indicated, Tx: Dry skin to coccyx [triangular bone at the bottom of the spine]- apply A&D ointment [ointment to treat dry and inflamed skin] every day and evening shift for maintain skin integrity Eval [evaluate] for the need to cont [continue]/change Tx. A review of Resident 3's MAR for the month of September 2025, indicated treatment to the coccyx was not done on 9/11/25, 9/12/25, 9/17/25, and 9/19/25 as physician ordered. During a concurrent interview and record review on 9/23/25, at 2:10 p.m., with the Infection Preventionist (IP), Resident 3's Medication Administration Record (MAR, a legal document used to record medications given to the residents) for the month of September 2025 was reviewed. The IP stated the expectation was for nursing staff to follow physician's orders. The IP confirmed the treatment orders were not done as ordered on 9/11/25, 9/12/25, 9/17/25, 9/18/25 and 9/19/25. The IP further stated not following the physician orders could potentially cause further skin breakdown. A review of the facility's document titled, Job Description Medication Nurse, revised 11/20 indicated, The primary function of the Medication Nurse is to insure effective nursing care is provided as prescribed by the physician. perform treatments according to the physician's orders.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure one out of 24 sampled residents (Resident 56) received treatment and care in accordance with professional standards of practice, and facility's policy, procedure (P&P), and care plan when Resident 56's foley catheter (a thin, flexible tube inserted into the bladder to drain urine) care and butterfly strap (a small, adhesive device designed to secure the catheter tubing to the skin, preventing accidental removal and reducing patient discomfort) monitoring was not done consistently. This failure had the potential for Resident 56 to develop infection and possible foley catheter dislodgement (removal) and/or other complications. Findings: A review of Resident 56's clinical record indicated Resident 56 was admitted June of 2025 and had diagnoses that included neuromuscular dysfunction of the bladder (a condition where the nerves or muscles that control bladder function are impaired, leading to abnormal bladder control), and left thigh fracture (a break in the continuity of a bone). A review of Resident 56's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 9/9/25, indicated Resident 56 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 56 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 56's MDS Bladder and Bowel conditions, dated 9/9/25, indicated Resident 56 has Indwelling catheter [a flexible tube inserted into the bladder and left in place to drain urine]. A review of Resident 56's care plan, revised 7/17/25, indicated, The resident [Resident 56] has Indwelling Catheter: [because of] Neurogenic bladder. During an observation on 9/22/25 at 10:57 p.m., in Resident 56's room, Resident 56 was observed connected to a urinary catheter tubing and bag draining a cloudy, deep yellow liquid. The urinary bag was covered with privacy bag and hung on Resident 2's bedside. A review of Resident 56's active physician's order, dated 6/17/25, indicated, Indwelling Bladder Catheter Care Q [every] Shift every shift for Cath [catheter] care. A review of Resident 56's treatment administration records (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident) for July, August, and September 2025 indicated Resident 56's foley catheter care was not done on the following shifts: 7/3/25- day shift 7/17/25- day shift 8/28/25- night shift 9/8/25- evening shift 9/11/25- day shift. A review of Resident 56's active physician's order, dated 6/17/25, indicated, Monitor Indwelling Bladder Catheter Butterfly Strap Q Shift for Placement. A review of Resident 56's TAR for July, August, and September 2025 indicated Resident 56's foley catheter butterfly strap monitoring for placement was not done on the following shifts: 7/3/25- day shift 7/17/25- day shift 8/28/25- night shift 9/8/25- evening shift 9/11/25- day shift. During a concurrent interview and record review on 9/24/25 at 11:53 a.m. with Licensed Nurse (LN) 2, Resident 56's clinical records were reviewed. LN 2 confirmed that Resident 56's foley catheter care and butterfly strap monitoring for placement was not consistently done. LN 2 stated if it was not charted then it was not done. LN 2 stated that Resident 56's foley catheter care should be done consistently because of the risk of infection and the butterfly strap placement should be monitored consistently because of the risk of catheter dislodgement. During an interview on 9/24/25 at 2:07 p.m. with the Director of Staff Development (DSD), the DSD stated nurses must follow the frequency of foley catheter care and butterfly strap placement monitoring per the physician's order to make sure the resident in comfortable, clean, and the foley catheter does not have any build up to prevent infection. During an interview on 9/24/25 at 2:33 p.m. with the Director of Nursing (DON), the DON stated she expects nurses to follow the doctor's order for foley catheter care and butterfly strap placement monitoring which is every shift. The DON further stated that the butterfly strap placement monitoring was to make sure the catheter was in place and to prevent catheter displacement, and the foley catheter care was to prevent infection of the resident. A review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, Revised 8/2022, indicated, The purpose of this procedure is to prevent (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urinary catheter-associated complications, including urinary tract infections .Review the resident's care plan to assess for any special needs of the resident .Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site .The following information should be recorded in the resident's medical record: .The name and title of the individual(s) giving the catheter care .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure safe and proper delivery of respiratory care consistent with the facility's policy and procedures (P&P) for one out of 24 sampled residents (Resident 11) when Resident 11's oxygen saturation (percentage of oxygen carried in the blood) was not consistently monitored. This failure had the potential to result in Resident 11 developing respiratory issues without staff knowledge and for Resident 11 to not achieve her highest practicable well-being. Findings: A review of Resident 11's clinical record indicated Resident 11 was admitted January of 2024 and had diagnoses that included chronic obstructive pulmonary disease (a group of diseases that causes airflow blockage and breathing-related problems), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently). A review of Resident 11's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 7/7/25, indicated Resident 11 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 11 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 11's MDS Special Treatments, Procedures, and Programs, dated 7/7/25, indicated Resident 11 was on oxygen therapy while a resident in the facility. A review of Resident 11's care plan, revised 10/9/24, indicated, The resident [Resident 11] has oxygen therapy r/t [related to] decreased O2 SAT [oxygen saturation]/ Congestion. A review of Resident 11's care plan intervention, initiated 10/8/24, indicated, Check O2 sats. A review of Resident 11's active physician's order, dated 12/3/24, indicated, O2 [oxygen] @ [at] 2 L/min [liters per minute or LPM- unit of measurement for oxygen administration flow rate] via NC [nasal cannula- a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils] maintain O2 SAT < [sic] [greater than] 92% [percent- measurement of one part in every hundred] with Oxygen every shift. During a concurrent observation and interview on 9/23/25 at 12:40 p.m. in Resident 11's room, Resident 11 was seen sitting on her wheelchair, awake, and was on oxygen delivered via NC with the oxygen concentrator (machine) set at 2 LPM. Resident 11 stated she was always on oxygen because she has trouble breathing most of the time and staff usually monitors her oxygen level. A review of Resident 11's treatment administration records (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident) for August and September 2025 as of 9/23/25, indicated Resident 11's O2 saturation was not monitored on the following shifts: 8/4/25- night shift 8/5/25- night shift 8/14/25- night shift 8/15/25- night shift 8/18/25- night shift 8/24/25- night shift 8/26/25- night shift 8/28/25- night shift 9/1/25- night shift 9/6/25- night shift 9/8/25- evening shift 9/15/25- night shift. During a concurrent interview and record review on 9/24/25 at 11:53 a.m. with Licensed Nurse (LN) 2, Resident 11's clinical records were reviewed. LN 2 confirmed that Resident 11's O2 saturation monitoring was not consistently done. LN 2 stated Resident 11 was on oxygen therapy and her O2 saturation should be monitored every shift. LN also stated Resident 11's o2 saturation monitoring every shift should have been done to make sure Resident 11's O2 saturation was above the prescribed order. LN 2 further stated that Resident 11 might develop respiratory issues without the staff knowing if her O2 saturation was not checked every shift, especially during night shifts because the resident would be sleeping. During an interview on 9/24/25 at 2:07 p.m. with the Director of Staff Development (DSD), the DSD stated it was very important for nurses to monitor Resident 11's oxygen saturation, especially at nighttime because Resident 11 could desat [desaturate- a drop in a person's blood oxygen level below a normal range] without the staff being aware. During an interview on 9/24/25 at 2:33 p.m. with the Director of Nursing (DON), the DON stated she expects nurses to follow the physician's order for monitoring a resident's o2 saturation so they could monitor the resident's health accurately. A review of the facility's policy and procedure (P&P) titled, Pulse Oximetry (Assessing Oxygen Saturation), Revised 10/2010, indicated, 1. Review the physician's orders or facility protocol for pulse oximetry. 2. Review the resident's care plan to assess (continued on next page)		

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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 09/25/2025
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for any special needs of the resident .The SaO2 [saturation of oxygen] flow sheet should be placed in the medical record. In addition, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed .		

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 09/25/2025
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.			
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure one out of 24 sampled residents (Resident 56) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 56's pain medication order was not consistently followed. This failure had the potential for Resident 56 to experience unrelieved pain and not attain her highest practicable well-being. Findings: A review of Resident 56's clinical record indicated Resident 56 was admitted June of 2025 and had diagnoses that included left thigh fracture (a break in the continuity of a bone), and cardiomyopathy (a group of heart muscle diseases that weaken or thicken the heart muscle, making it difficult for the heart to pump blood effectively). A review of Resident 56's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 9/9/25, indicated Resident 56 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 9 out of 15 which indicated Resident 56 had a moderately impaired cognition (mental process of acquiring knowledge and understanding). A review of Resident 56's MDS Health Conditions, dated 9/9/25, indicated Resident 56 occasionally experiences pain and had received scheduled and as needed pain medications and non-medication intervention for pain. During an interview on 9/22/25 at 10:57 a.m. with Resident 56, in Resident 56's room, Resident 56 stated she would usually experience pain and would need to ask for pain medication from the nurse. Resident 56 stated she was not sure if she was getting the right pain medication. A review of Resident 56's care plan, revised 9/12/25, indicated, The resident [Resident 56] has potential for alteration in comfort due to: .left femur [thigh bone] fracture, muscle spasms . A review of Resident 56's care plan intervention, initiated 6/23/25, indicated, Offer PRN [as needed] or routine pain meds [medications] per resident preference. A review of Resident 56's physician's order, dated 6/2/25, indicated, Morphine Sulfate [a pain medication] Oral Solution 20 MG/ML [milligram/milliliter- unit of measurement] .Give 0.25 ml by mouth every 2 hours as needed for mild trouble breathing/ Pain 1-3 [numeric pain scale from 1 to 10; 1 being the lowest and 10 being the highest form of pain]. A review of Resident 56's physician's order, dated 6/2/25, indicated, Morphine Sulfate .Oral Solution 20 MG/ML .Give 0.5 ml by mouth every 2 hours as needed for mod [moderate]-severe trouble breathing/ Pain 4-10. A review of Resident 56's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of July and September 2025 indicated Resident 56 received 0.25 ml of morphine sulfate which was indicated for 1-3 levels of pain on the following occasions: 7/1/25 at 9:52 a.m.- pain level was 4 7/28/25 at 8:11 a.m.- pain level was 4 9/8/25 at 6:38 p.m.- pain level was 4 During a concurrent interview and record review on 9/24/25 at 11:53 a.m. with Licensed Nurse (LN) 2, Resident 56's clinical records were reviewed. LN 2 confirmed that Resident 56's pain medication order was not consistently followed. LN 2 also confirmed there was no documentation that Resident 56's responsible party requested the 0.25 ml dose of morphine sulfate on 7/1/25, 7/28/25, and 9/8/25. LN 2 stated Resident 56 should have received the 0.5 ml dose of morphine sulfate on 7/1/25, 7/28/25, and 9/8/25 because there would be a risk for Resident 56's pain to be not effectively managed. During an interview on 9/24/25 at 2:07 p.m. with the Director of Staff Development (DSD), the DSD stated nurses should always administer the correct dose of pain medication per the ordered scale. The DSD further stated the resident would be under-medicated, and the pain would not be controlled if the resident received the lower dose of pain medication. During an interview on 9/24/25 at 2:33 p.m. with the Director of Nursing (DON), the DON stated that the physician's order should have been followed to be able to control the resident's pain. A review of the facility's P&P titled, Pain Assessment and Management, dated 2001, indicated, The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management .The medication regimen is implemented as ordered. Results of the (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions are documented and communicated directly to the provider when appropriate .A review of the facility's P&P titled, Administering Medications, revised 4/2019, indicated, Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review, the facility failed to ensure dental services were provided in accordance with professional standards of care for one out of 24 sampled residents (Resident 7), when facility staff did not assist Resident 7 in obtaining a dental appointment as physician ordered. This failure had the potential for Resident 7 to experience unnecessary pain and an increased risk for infection. Resident 7 was originally admitted to the facility in August 2024 with multiple diagnosis which included bacteremia (bacteria in the blood), depression (mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities) and anemia (low levels of healthy red blood cells). A review of Resident 7's Minimum Data Set (MDS, an assessment tool) signed 6/27/25, indicated, Resident 7 had severe cognitive impairment. A review of Resident 7's Order Summary Report, with start date 7/30/25, indicated, Dental referral for dental pain. During a concurrent interview and record review on 9/24/25, at 3:21 p.m., with the Social Services Director (SSD), Resident 7's Order Summary Report was reviewed. The SSD confirmed she was responsible for ensuring all residents with dental referrals are seen by the dentist. SSD stated all dental referrals for dental pain are scheduled immediately and residents are usually seen the next day. The SSD confirmed Resident 7 had a physician order for a dental referral for dental pain on 7/30/25 and stated Resident 7 was not seen by the dentist after that date. SSD further stated she was not aware of the dental referral and missed scheduling it. A review of the facility's policies and procedures (P&P) titled, DENTAL CARE, undated, indicated, To assure that residents are provided with the provision of dental services. Social services shall assist the resident in obtaining access to appropriate dental services. Social service staff shall assist the resident/responsible party in scheduling dental appointments.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, the facility failed to ensure special dietary requirements were met for two of 80 residents (Resident 22 and 42) during lunch meal observation on 9/22/25. This deficient practice had the potential to result in meal dissatisfaction and decreasing meal intake that may lead to further compromising medical and nutrition status and/or weight loss of residents. Finding:During an observation of the lunch meal in the dining room on 9/22/25 at 11:57 a.m. with a concurrent review of Resident 22's and Resident 42's meal tickets (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) the following was noted:1. Resident 22's meal ticket indicated, .8 ounces (oz., a unit of fluid volume) of vegetable juice. was one of Resident 22's food preferences but did not receive the vegetable juice with his meal.2. Resident 42's meal ticket indicated, no pepper, no non-salt seasoning but Resident 42 received the pepper and non-salt seasoning packets with her meal.During an interview on 9/22/25 at 12:07 p.m. with Resident 22's family member, and she stated Resident 22 usually got vegetable juice but did not get one today.During an interview on 9/22/25 at 12:12 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 confirmed Resident 42's meal ticket indicated no pepper and no non-salt seasoning with her meal. She confirmed the pepper and non-salt seasoning packets should not have been on Resident 42's meal tray.During an interview on 9/23/25 at 1:20 p.m. with Registered Dietitian (RD), RD stated the staff needed to follow the meal ticket to meet and honor residents' preferences.A review of facility policy and procedure (P&P) titled, JOB DESCRIPTION-Food and Nutrition Service Director, dated 2023, indicated .DUTIES AND RESPONSIBILITIES.Check trays to ensure diets are served as ordered.Visit residents to determine food acceptance and preferences.A review of facility P&P titled, Food Preferences, dated 2023, indicated POLICY.Resident's food preferences will be adhered to within reason.		