

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/22/2025
NAME OF PROVIDER OR SUPPLIER  Golden San Andreas Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  900 Mountain Ranch Road San Andreas, CA 95249	
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)		
<p>F 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51584</b></p> <p>Based on interview and record review, the facility failed to ensure that nursing staff followed established protocols for the initiation and discontinuation of Cardio-Pulmonary Resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating) for one out of three sampled residents (Resident 5) when, nursing staff discontinued CPR prior to the arrival of Emergency Medical Services (EMS - a system that provides emergency medical care) and without a physician's order or confirmation of death.</p> <p>This failure resulted in a lack of adherence to professional standards of practice and the facility's policies regarding life-saving interventions.</p> <p>Findings:</p> <p>During a review of Resident 5's clinical record titled, ADMISSION RECORD, indicated Resident 5's diagnoses included Orthopedic Aftercare (follow-up care and rehabilitation services provided to Resident 5 after surgery) and Hypertension (high blood pressure).</p> <p>A review of Resident 5's Physician Orders for Life Sustaining Treatment, (POLST, a medical order that directed emergency health care professionals what to do during a medical crisis where the patient cannot speak for him/herself) dated [DATE], indicated, .Attempt Resuscitation/CPR .</p> <p>A review of Resident 5's clinical record titled [Facility] Progress Notes, dated [DATE], at 7:47 a.m., indicated the following chain of events:</p> <p>The Certified Nurse Assistant (CNA) 4 notified the Licensed Nurse (LN) 4 that Resident 5 appeared to have no signs of life. LN 4 assessed Resident 5 and documented . verified the absence of apical pulse [a pulse point on your chest at the bottom tip of the heart] and respirations, pupils fixed and dilated at approx [approximately] 0505 [5:05 a.m.] . LN 5 verified POLST of Resident 5 as Full Code (if Resident 5's heart stopped beating and/or Resident 5 stopped breathing, all means would be provided to keep Resident 5 alive) and ordered CNA 4 to call 911 (phone number used to contact the emergency services). CPR was administered by LN 4 and LN 5. At 5:20 a.m., the time of death was declared by LN 4.</p> <p>(continued on next page)</p>		

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 0678</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on [DATE], at 2:23 p.m., LN 5 stated that LN 4 decided to stop CPR and declared that Resident 5 had died before EMS arrived. LN 4 stated she was unable to recall the exact time EMS arrived in the facility. LN 5 acknowledged that CPR should not have been discontinued until EMS assumed care of Resident 5.</p> <p>During a telephone interview on [DATE], at 1:46 p.m., LN 4 stated that she was covering (taking over someone's duty) for Resident 5's primary nurse (LN 5) when CNA 4 told her that Resident 5 was unresponsive. LN 4 stated she assessed Resident 5 and based off her assessment; Resident 5 had already expired (died). LN 4 stated that when LN 5 verbalized that Resident 5 was a Full Code, LN 4 and LN 5 started CPR. LN 4 stated that they stopped doing CPR before EMS arrived because there were no signs of viability (having a reasonable chance of resuming a heartbeat). LN 4 acknowledged that a licensed nurse could not declare Resident 5's time of death and that CPR should have been continued until EMS arrived. LN 4 was unable to recall the exact time EMS arrived in the facility.</p> <p>During an interview on [DATE], at 3:37 p.m., with the Director of Nursing (DON), the DON stated she was unsure if she would have stopped doing the CPR before EMS arrived. The DON confirmed that per the facility's policy, only a physician is authorized to pronounce a resident's time of death, and that licensed nursing staff do not have the authority to do so.</p> <p>During a telephone interview on [DATE], at 1:26 p.m., with Physician Assistant (PA) 1, PA 1 stated that he was notified of Resident 5's death. PA 1 stated, The only thing that they [LN 4 and LN 5] did not do right was to stop CPR and declared Resident 5 had expired.</p> <p>A review of an undated facility's policy and procedure (P&amp;P) titled, Death of a Resident, Documenting, the P&amp;P indicated .1. A resident may be declared dead by a Licensed Physician or Registered Nurse with physician authorization in accordance with state law .</p> <p>A review of an undated facility's P&amp;P titled, Emergency Procedure-Cardiopulmonary Resuscitation, the P&amp;P indicated .8. Continue with CPR/BLS (basic life support - set of life-saving medical procedures performed in the early stages of an emergency) until emergency medical personnel arrive.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>51584</p> <p>Based on interview and record review, the facility failed to ensure that adequate supervision and safety interventions were implemented for one out of three residents (Resident 3) when Resident 2 grabbed Resident 3 ' s right wrist and shirt and attempted to strike her. This incident occurred 3 days after Resident 2 had been involved in a separate incident with another resident (Resident 4).</p> <p>This failure had the potential to negatively affect Resident 3 ' s physical and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 2 ' s clinical record titled ADMISSION RECORD, the record indicated Resident 2's diagnoses included Dementia (a condition that caused a progressive decline in mental abilities), Paranoid Schizophrenia (a serious mental health condition that included symptoms of altered thinking, feeling and behavior), and Alzheimer ' s Disease (a progressive neurodegenerative disease that altered memory, thinking, and behavior).</p> <p>A review of Resident 3 ' s clinical record titled ADMISSION RECORD, the record indicated Resident 3's diagnoses included Dementia, Bipolar Disorder (a mental health condition characterized by extreme shifts in mood, energy, and behavior), and Anxiety Disorder (a mental health condition characterized by excessive and persistent worry, fear, and nervousness that interfered with daily life).</p> <p>A review of Resident 2 ' s care plan, dated 10/05/24, indicated . Attempt to keep pt. [Patient-(Resident 2)] away from female pt. [Resident 3] and not be alone with other female pts [patients] . Attempt to keep pt away from females pts .</p> <p>A review of Resident 2 ' s clinical record titled, IDT [Interdisciplinary Team; a group of healthcare professionals] POST INCIDENT MEETING, dated 10/09/24, at 10 a.m., indicated, .Per charge nurse, the aggressor [Resident 2] was sitting in the hallway of A-wing in a wheelchair and the victim [Resident 3] was sitting next to the aggressor in a wheelchair. At approx. [approximately] 1900 [7 p.m.] the CNA observed the aggressor grabbing the victim ' s right wrist and holding the victim ' s shirt .</p> <p>During an interview on 5/22/25, at 10:03 a.m., with Licensed Nurse (LN) 2, LN 2 stated that he was informed about the incident between Resident 2 and Resident 3. LN 2 stated he was unaware of the previous incident involving Resident 4 or whether a care plan had been initiated for Resident 2 to be kept away from any female residents or not be alone with other female residents. LN 2 confirmed that Resident 2 had a care plan in place but the care plan was not followed because both residents (Resident 1 and Resident 3) were sitting next to each other during the incident. LN 2 stated that the care plan should have been communicated and followed by staff, which could have protected Resident 3.</p> <p>During a telephone interview on 5/23/25, at 4:31 p.m., with Certified Nursing Assistant 3, CNA 3 stated that she witnessed the incident between Resident 2 and Resident 3 but was not aware there was a care plan in place for Resident 2 to be away from other female residents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/22/25, at 12:08 p.m., with the Director of Nursing (DON), the DON stated that staff attempted to follow the care plan, but it was difficult to completely monitor Resident 2 and Resident 3 and other residents. The DON acknowledged that Resident 2 was not placed on a 1 to 1 monitoring (provided one to one nursing or observation care to an individual patient for a period of time) after the first incident.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>52181</p> <p>Based on interview and record review, the facility failed to maintain a complete and accurate medical record for one of three sampled residents (Resident 1) when, Resident 1's Activity of Daily Living (ADL - refer to the basic self-care tasks essential for independent living, like bathing, dressing, eating and toileting) charting tasks for July of 2024 had multiple shifts that lacked Certified Nursing Assistant (CNA) entries.</p> <p>This failure had the potential to provide insufficient information regarding the condition, care, and services provided to Resident 1.</p> <p>Findings:</p> <p>1. A review of Resident 1's clinical document titled Documentation Survey Report v2, a report that lists all the ADL areas that CNAs are to chart on each shift had missing documentation for the following care areas and dates:</p> <p>Behavior:10 PM-6 AM shift for July 2,3,7,8,17,20,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>Bladder Continence:10 PM-6 AM shift for July 2,3,7,8,17,23,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,9,11,13,15,17,18,19</p> <p>Bowel Continence:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>Bowel Movements:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19,29; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>Fall Interventions:10 PM-6 AM shift for July 2,3,7,8,12,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>Fluid Intake:10 PM-6 AM shift for July 2,3,7,8,12,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19,29; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>GG (A section of an assessment tool related to a resident's functional abilities and goals)-1 Step (Curb):10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>GG-12 Steps:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>GG-4 Steps:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>GG-Upper Body Dressing:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Walk 10 Feet:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18, 19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Walk 150 Feet:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18, 19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Walk 50 Feet with Two Turns:10 PM-6 AM shift for July 2,3,7,8,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Walk 10 Feed on Uneven Surfaces:10 PM-6 AM shift for July 2,3,7,8,12,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Wheel 150 Feet:10 PM-6 AM shift for July 2,3,7,8,12,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11, 17,18,19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Wheel 50 Feet with Two Turns:10 PM-6 AM shift for July 2,3,7,8,12,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>GG-Wheelchair/Scooter Use:10 PM-6 AM shift for July 2,3,7,8,12,17,24,26,30,31; 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11, 13, 15, 17, 18, 19</p> <p>Amount Eaten: 2 PM-10 PM shift for July 4,9,11,17,18,19; and 6 AM-2 PM shift for July 4,11,13,15,17,18,19</p> <p>Bath/Shower Monday/Thursday AM (time on the form also indicated 1700 and is assigned to 2 PM-10 PM shift): 2 PM-10 PM shift for July 4,11,15,18,22,25; There was no documentation option for entry by the 6 AM-2 PM shift.</p> <p>Bowel and Bladder Training: 10 PM-6 AM shift for July 1,3,4,7,8,9,18,25,27,28,31; 2 PM-10 PM shift for July 2,3,4,5,7,8,9,10,11,13,14,15,17,18,19,20,21,22,24,25,26,27,27,30,31; and 6 AM-2 PM shift for July 4,5,9,10, 11,13,14,15,17, 18,19,20,21,22,24,25,26,27</p> <p>During a phone interview with CNA 1 on 5/23/25, at 11:55 AM, CNA 1 stated that there were times she would complete the ADL task but was not able to complete the documentation. CNA 1 stated she was aware of the facility's expectation that CNAs would complete their charting by the end of their shift. CNA 1 stated that the risk of not completing the assigned documentation could have placed Resident 1 at risk for not receiving proper care by the following shift or receiving unnecessary care. CNA 1 stated, If I don't chart a resident had a bowel movement when they actually did, then the charge nurse might give the resident a laxative [medication to help someone have a bowel movement] they didn't need.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview with Licensed Nurse 1 (LN) on 5/23/25, at 10:30 AM, LN 1 stated that CNAs were supposed to complete documentation on resident specific CNA tasks every shift. LN 1 further stated that it was part of a charge nurses' responsibility to hold the CNAs accountable and ensure that they had completed their documentation before they left at the end of their shift, but she did not always complete that task.</p> <p>During a concurrent interview and record review on 5/22/25 at 4:15 PM, with the Director of Staff Development (DSD), the DSD confirmed that there were multiple missing CNA documentation entries on Resident 1's document titled Documentation Survey Report v2 for July 2024. The DSD stated that the risk of CNAs not documenting in the Electronic Health Record (EHR) could have placed Resident 1 at risk for miscommunication of care between shifts, placed the CNA and/or facility at risk for not being able to prove that a task or tasks had been completed, and would have made it difficult for other departments to have accurately assessed Resident 1. The DSD further stated that the expectation was for all CNAs to complete all assigned documentation in full before the end of their shift.</p> <p>During a concurrent interview and record review on 5/22/25, at 4:30 PM, the Director of Nurses (DON) verified there were multiple missing entries for multiple CNA tasks in Resident 1's document titled Documentation Survey Report v2, dated 7/24. The DON stated the expectation was that CNAs would document throughout their shift and ensure that all required charting was completed before they left the facility. The DON also stated that she expected the LN would have reviewed all CNA documentation by the end of the shift to ensure it was completed. The DON stated that the risk of nurses not ensuring all documentation was completed by the end of the shift had the potential to place Resident 1 at risk for not receiving the care and services required in a timely and accurate manner.</p> <p>A review of an undated facility provided policy and procedure (P&amp;P) titled Charting and Documentation, the P&amp;P indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .Documentation in the medical records will be objective (no opinionated or speculative), complete and accurate .</p>		