

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

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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 07/07/2026
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop person-centered interventions for a fall care plan for one of three sampled residents (Resident 1), when Resident 1 had a witnessed fall from her wheelchair on 9/7/25, struck her head, and the facility revised the care plan to only include alert charting for 72 hours (a documentation process used to track changes in a resident's health) without including an intervention which would address Resident 1's specific fall risk of pitching forward from the wheelchair prior to Resident 1 sustaining a second fall approximately two hours later on 9/7/25. This deficient practice resulted in Resident 1's care plan not including an individualized intervention to address the resident's specific fall risk and had the potential to result in additional falls. Findings: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility on [DATE] for respite care (short-term facility care provided to give the usual caregiver temporary relief) while receiving hospice services (comfort-focused care for a person with a terminal illness) with multiple diagnoses including depression (low mood or sadness), delusional disorder (a condition that can affect thoughts or beliefs), and anxiety disorder (worry or nervousness). Review of Resident 1's Progress Note dated 9/7/25, at 9:08 p.m., indicated the Licensed Nurse (LN 2) and Certified Nursing Assistant (CNA) had just readjusted Resident 1 in her wheelchair when the CNA started pushing Resident 1 down the hall in a wheelchair. Resident 1's progress note indicated Resident 1 pitched forward and fell face first onto the floor. The progress note further indicated Resident 1 hit the top of her head and sustained a small cut to the bridge of the nose and a bruise to the top of the forehead. Review of Resident 1's actual fall care plans, both dated 9/7/25 and Resident 1's progress notes related to Resident 1's fall, dated 9/7/25, showed staff added an intervention of alert charting for 72 hours after Resident 1's first fall. Resident 1's care plans and progress notes did not show the facility identified the root cause of the first fall or document how alert charting addressed Resident 1's specific risk of pitching forward from the wheelchair prior to the second fall. Review of Resident 1's progress note dated 9/7/25, at 11:06 p.m., indicated Resident 1 again pitched forward and fell face first onto the floor and hit the top of her head. During a concurrent interview and record review on 7/7/26, at 1:31 p.m., Resident 1's fall risk care plan, initiated 9/4/25 and actual fall care plans, both initiated on 9/7/25, was reviewed with Licensed Nurse (LN 1). LN 1 stated that after a resident fell, staff notified the physician, the family, the Director of Nursing, and the Administrator. LN 1 stated staff would then complete 72-hour charting and update the care plan. LN 1 reviewed Resident 1's fall care plan and stated alert charting for 72 hours was the facility's standard process after a fall. LN 1 stated alert charting documents staff monitoring after a fall but does not, by itself, reduce a resident's risk for another fall. During an interview and record review on 7/7/26, at 3:12 p.m., Resident 1's actual fall care plans, dated 9/7/25, were reviewed with the (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Supervisor (RN 1). RN 1 verified the care plan was updated after the first fall on 9/7/25 to include alert charting. RN 1 stated alert charting was already being done because Resident 1 was a new admission for respite care from 9/4/25 through 9/9/25. RN 1 stated she was unsure whether the intervention was effective in preventing the second fall approximately two hours later. During a telephone interview on 7/14/26, at 7:11 p.m., with the Licensed Nurse (LN 2), LN 2 stated Resident 1's first fall on 9/7/25 occurred after both her and the CNA readjusted Resident 1 in her wheelchair because Resident 1 was sloping. LN 2 stated Resident 1 lurched forward while being pushed by the CNA in the hallway and fell out of the wheelchair. LN 2 stated she completed the initial neurological checks (brief, physical, and cognitive evaluations to quickly assess how well a person's brain and nervous system are functioning), updated Resident 1's fall care plan, and implemented an intervention of alert charting for 72 hours following the fall. LN 2 was unable to explain how alert charting addressed Resident 1's specific risk of pitching forward from the wheelchair or how the intervention was intended to reduce the risk of another similar fall. During a concurrent telephone interview and record review on 7/15/26, at 8:49 a.m., Resident 1's fall risk care plan, dated 9/4/25, Resident 1's actual fall care plans, dated 9/7/25, and Resident 1's progress notes, dated 9/7/25, were reviewed with the Director of Staff Development (DSD). The DSD stated care plans were resident-specific and person-centered. The DSD reviewed the intervention added to Resident 1's actual fall care plan following the first fall which listed Alert Charting for 72 hours. The DSD stated alert charting was a general post-fall intervention and did not address Resident 1's individual fall risk. The DSD further stated staff could have added another intervention, such as close monitoring, following the first fall. Review of facility's policy titled, Fall Management and Neurological Check, updated 1/25, indicated, The center implements a fall management plan based on medical history review and resident evaluation. 5. The LN updates care plans reflecting individualized intervention in an attempt to reduce or prevent falls. 7. The resident's care plan is reviewed quarterly and after a fall to determine effectiveness of current intervention and considers the residents goals, choices and preferences .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure timely procurement and administration of physician-ordered medications for one of three sampled residents (Resident 1), when the facility did not timely coordinate with the pharmacy, physician, and hospice (comfort-focused care for a person with a terminal illness) staff after Resident 1's ordered medications were unavailable upon admission. This deficient practice resulted in Resident 1 missing three doses of Seroquel (a medication used for mood or behavior symptoms) and two doses of Sertraline (a medication used for mood symptoms) from 9/4/25 through 9/6/25 and placed the resident at risk for unmanaged mood and behavior symptoms. FINDINGS: Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility on [DATE] for respite care (short-term facility care provided to give the caregiver temporary relief) with multiple diagnoses including depression (low mood or sadness), delusional disorder (a condition that can affect thoughts or beliefs), and anxiety disorder (worry or nervousness). Review of Resident 1's Order Summary Report, indicated Resident 1 had a physician orders for the following: Sertraline HCl Oral Tablet 50 milligrams (mg; a unit of measurement): Give 1 tablet by mouth one time a day for m/b [manifested by] crying lasting >5 [greater than] minutes related to DEPRESSION . with a start date of 9/5/25. Seroquel Oral Tablet 25 mg: Give 0.25 tablet by mouth one time a day for m/b visual hallucinations [seeing things that are not there] related to DELUSIONAL DISORDERS . with a start date of 9/4/25. Review of Resident 1's September 2025 Medication Administration Record (MAR - a document used to record medications administered or not administered) indicated Resident 1 did not receive the following physician-ordered medications: Seroquel Oral Tablet 25 mg on 9/4/25, 9/5/25, and 9/6/25. Sertraline HCl Oral Tablet 50 mg on 9/5/25 and 9/6/25. During a concurrent interview and record review on 7/7/26, at 1:31 p.m., Resident 1's September 2025 MAR, Progress Notes, and Physician Orders were reviewed with Licensed Nurse (LN 1). LN 1 verified Resident 1 did not receive Seroquel Oral Tablet 25 mg on 9/4/25, 9/5/25, and 9/6/25. LN 1 also verified Resident 1 did not receive Sertraline HCl Oral Tablet 50 mg on 9/5/25 and 9/6/25. LN 1 stated she documented the medications as refused but acknowledged the medications were unavailable at the time. LN 1 reviewed Resident 1's progress notes and verified there was no documentation indicating the physician, hospice staff, or pharmacy was notified of the missed doses. LN 1 stated she should have called the physician, hospice staff, or pharmacy. LN 1 further stated staff could have checked the CUBEX (an automated medication dispensing system) for Sertraline availability and obtained physician direction regarding the missed dose. During an interview on 7/7/26, at 11:18 a.m., the Registered Nurse Supervisor (RN 1) stated medications in the facility's CUBEX could be used for residents when needed. RN 1 verified the CUBEX contained Sertraline 25 mg, with eight tablets available, and Risperidone (medication used for mood or behavior symptoms) 0.5 mg, with eight tablets available. RN 1 stated staff were expected to notify the physician when a medication was unavailable. RN 1 further stated an alternate medication could be ordered by the physician while staff waited for delivery from the pharmacy. During an interview and record review on 7/7/26, at 3:12 p.m., Resident 1's September 2025 MAR and Progress Notes was reviewed with RN 1. RN 1 verified Resident 1 missed doses of Seroquel on 9/4/25, 9/5/25, and 9/6/25 and Sertraline on 9/5/25 and 9/6/25. RN 1 verified there was no documentation that staff notified the hospice team, physician, or pharmacy regarding the missed medications. RN 1 stated the expectation for missed medications was for staff to notify the physician and, if the resident was (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving hospice services, to notify the hospice team and pharmacy. RN 1 stated missed behavior medications placed the resident at risk for uncontrolled behaviors. During a telephone interview and record review on 7/8/26, at 9:34 a.m., Resident 1's September 2025 MAR and Progress Notes were reviewed with the Pharmacy Consultant (PC 1). PC 1 verified missed medications doses for Seroquel and Sertraline. PC 1 also verified there was no documentation that staff notified the physician, pharmacist, or hospice staff regarding the missed doses on the days the medications were not administered. PC 1 stated that when a resident is admitted and an ordered medication is not available, staff are expected to call the pharmacy and physician. PC 1 stated missed behavior medications place residents at risk for recurrence of behavior symptoms. PC 1 further stated missed medications should be administered as soon as possible. Review of facility's policy titled, Medication Ordering and Receiving from Pharmacy, effective 1/22, indicated, .Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt . 3. New medications, except for emergency or 'stat' medications, are ordered as follows: a. If needed before the next regular delivery, inform pharmacy of the need for prompt delivery; b. The emergency kit or emergency drug supply as applicable is used when the resident needs a medication prior to pharmacy delivery .Review of facility's policy titled, Hospice - Provision of Care by Outside Providers, updated 9/17, indicated, . 1. Prior to admission of a resident receiving hospice services by an outside provider, service coordination is agreed upon indicating each party's responsibilities. This may include, but is not limited to: medications .and notifying physicians.4. Medications, medical supplies, and services are provided as indicated by the agreement for coordination of services.		