STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of 3 of 25 sampled residents (Resident 16, Resident 58, and Resident 83) when: 1. Resident 16's call light was not within reach; 2. Residents 58's call light was attached to the bottom of the bed rail not within reach; and, 3. Resident 83's call light was on a chair not within reach. These failures placed Resident 16, Resident 58, and Resident 83 at risk of falls and unmet needs due to the inability to request assistance from staff. Findings: 1. During a concurrent observation and interview on 2/3/25, at 11:31 AM, with Licensed Nurse (LN) 1 in Resident 16's room, Resident 16 was observed trying to find the call light to call for help. LN 1 confirmed the call light was not in reach. LN 1 stated the call light was found under the pillows and pulled it out and handed it to Resident 16. LN 1 further stated Resident 16 had limited movement and would not have been able to find the call light under the pillows. LN 1 explained the call light not being in reach was a risk to residents who depend on staff for help, getting up, and other needs. During an interview on 2/6/25, at 9:56 AM, with the Director of Nursing (DON), the DON stated it was her expectation residents to have call lights in reach and expected staff to check and make sure it was in reach every time they came into the resident's rooms. The DON further stated the residents should have clips on the call lights so they can be secured to the bed, so the call light stayed in place and within reach. The DON explained the risk to the residents was getting hurt, or not getting their needs met. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 16's care plan revised 9/26/24, indicated, .[Resident 16] has behavior of independently getting out of bed and attempting to stand at bedside .Be sure to answer call light timely .Remind [Resident 16] to use call light for assistance . 2. During a concurrent observation and interview on 2/03/25, at 11:50 AM, with Certified Nurse Assistant (CNA) 1 in Resident 58's room, Resident 58 attempted to access her call light while lying in bed. The call light was attached to the bottom of the bed rail a few inches from the floor. CNA 1 stated Resident 58's call light was out of reach. CNA 1 further stated without access to the call light, Resident 58 was at risk of not being able to call staff for help and unable to make her needs known. During a concurrent observation and interview on 2/03/25, at 11:50 AM, with Licensed Vocational Nurse (LN) 2, LN 2 stated Resident 58's call light was tangled to the bottom of the bed rail and Resident 58 was unable to access the call light. LN 2 further stated that Residents should always have the call light within reach. LN 2 stated the risk for not having the call light within reach was that Resident's care needs could not have been met. 3. During a concurrent observation and interview on 2/03/25, at 12:49 PM, with LN 1 in Resident 83's room, LN 1 stated Resident 83's call light was in a chair, not within reach. LN 1 further stated the call light should have been within reach. LN 1 stated, the risk for not having the call light within reach was Resident 83 could have fallen and not been able to call staff when he needed assistance. During an interview on 2/04/25, at 12:19 PM, with the DON, the DON stated if residents did not have their call lights within reach, they would be at risk of falling or not getting what they needed in a timely manner. A review of the facility policy titled, Call Light Answering, updated August 2023, indicated, .Place the call device within resident's reach before leaving room .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure 7 of 25 sampled residents (Resident 56, Resident 69, Resident 91, Resident 24, Resident 3, Resident 75, and Resident 82) rights related to treatment choices were known and protected when: 1. Resident 69, Resident 24 and Resident 3's POLST (Physician Orders for Life Sustaining Treatment: care directives during life threatening situations), did not have documented evidence that an Advance Directive (legal documentation consistent with a person's medical preference when they were no longer able to make decisions for themselves) was requested/discussed with Resident 69, Resident 24 and Resident 3; 2. Resident 56's and Resident 91's code status order (to provide or not provide life saving measures in the event of an emergency) in the electronic medical record (EMR) did not match the code status listed on the POLST; 3. Resident 75's POLST did not have documented evidence that an Advanced Directive was discussed with Resident 75's Resident Representative who had Power of Attorney (POA - a legal document that allows someone to act on behalf of another person); and, 4. Resident 82's POLST, Section D was incomplete. These failures resulted in Resident 91 receiving CPR when her POLST indicated Do Not Resuscitate (DNR - allow natural death to occur) (Refer to F684), and had the potential for Resident 82, Resident 69, Resident 24, Resident 56, Resident 3, and Resident 75's wishes regarding emergency treatment to not be followed. Findings: 1a. A review of Resident 69's admission RECORD, indicated Resident 69 was admitted to the facility with diagnoses which included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities). A review of Resident 69's clinical document titled, .POLST, dated [DATE], indicated Section D, Information and Signatures, did not have documented evidence of the discussion of Resident 69's Advanced Directives. 1b. A review of Resident 24's admission RECORD, indicated Resident 24 was admitted to the facility with diagnoses which included mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age). A review of Resident 24's clinical document titled, .POLST, dated [DATE], indicated Section D, Information and Signatures, did not have documented evidence of the discussion of Resident 24's Advanced Directives. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1c. A review of Resident 3's admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses which included cancer. A review of Resident 3's clinical document titled, .POLST, dated [DATE], indicated Section D, Information and Signatures, did not have documented evidence of the discussion of Resident 3's Advanced Directives. During an interview on [DATE] at 2:55 PM with the Social Services Director (SSD), the SSD stated she was unaware it was her responsibility to ask about Advance Directives. The SSD stated she thought if there was an Advance Directive then someone would bring it to her. The SSD stated no one told her she should reach out to families and residents about their Advance Directives. During a concurrent interview and record review with the SSD, on [DATE], at 11:29 AM, the SSD acknowledged Resident 69, Resident 24, and Resident 3's POLST, Section D was not filled out. The SSD explained It was important to fill out Section D of the POLST to know whether the resident had an advance directive, and if they have one, the facility needs to ask for a copy and upload it to the residents medical record, it was required.: During an interview on [DATE], at 11:40 a.m., the Director of Nursing (DON), stated social services should ask for a copies of Advance Directives. The DON further stated, if it says advanced directive not available, the facility should contact the family, .code status should match because you don't know what the wishes of the patient are and what can happen. If it doesn't match you could do CPR when they have no CPR order. A review of the facility policy titled, Advance Directive, published 1/2025, indicated, .POLST .This document, signed by an authorized health care professional, is a medial order that records residents' treatment wishes so that emergency personnel know what treatments to provide in the event of a medical emergency. This is not an advance directive .the resident's comprehensive care plan is reviewed and updated routinely in order to incorporate the resident's choices regarding these rights into treatment, care and services . 2a. During a concurrent interview and record review of Resident 56's medical record on [DATE], at 1:57 p.m., Licensed Nurse (LN) 2 stated Resident 56's POLST dated [DATE] indicated a code status of Attempt Resuscitation/CPR (cardiopulmonary resuscitation. It is an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped) and Resident 56's health record revealed a code status of DNR (do not resuscitate. A medical order that instructs health care providers not to perform CPR). LN 2 further stated the risk of not knowing the correct code status was the resident's correct wishes not being followed. 2b. A review of Resident 91's clinical record titled, admission RECORD, indicated Resident 91's diagnoses included atrial fibrillation (a condition where the upper chambers of the heartbeat irregularly and rapidly). A review of Resident 91's physician's orders, dated, [DATE], indicated, .Order Summary: Code Status - FULL CODE (CPR should be performed) . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 91's clinical record titled, POLST, dated [DATE], indicated, .Do Not Resuscitate/DNR . The POLST was signed by Resident 91's Responsible Party (RP), Resident 91's son, and the Physician's Assistant. A review of Resident 91's clinical record titled, Care Plan, (a list of resident specific problems, goals, and interventions), dated, [DATE], indicated, .Focus [Resident 91's name] HAS A POLST - DO NOT ATTEMPT RESUSCITATION/DRN [sic] .Date Initiated: [DATE] .Goal I will have my desires and wishes followed . During an interview with LN 3, on [DATE], at 3:50 PM, LN 3 stated Resident 91's POLST was created on [DATE]. LN 3 explained the POLST was signed by the physician on [DATE]. LN 3 further explained, until [DATE], Resident 91 was a full code, reflecting the discharging hospitals records. LN 3 stated when the POLST was updated we should have updated the EHR to reflect DNR. During an interview with LN 4, on [DATE], at 4:19 PM, LN 4 stated to check a resident's code status you would check the binder that has the POLST and the EHR. LN 4 explained he would check both. During an interview with the Administrator (ADM), on [DATE], at 12:01 PM, the ADM stated the process for determining code status was by the POLST or by what they tell us in their care plan conference (a meeting where a patient's care team reviews and adjusts their care plan. The ADM explained the importance of knowing the residents code status was to respect the residents' wishes. The ADM further explained not following the residents wishes could cause psychosocial harm. The ADM confirmed facility staff performed CPR on Resident 91 when she should have been a DNR on [DATE]. 3. A review of Resident 75's clinical document titled, admission RECORD, indicated Resident 75 was admitted to the facility with diagnoses which included bipolar disorder (a mental health condition characterized by significant and alternating mood swings between periods of extreme highs and lows. Resident 75's admission Record indicated Resident 75's son was her legally recognized representative and her Power of Attorney (POA). Section D of Resident 75's POLST indicated Advanced Directives were discussed with Resident 75, and not Resident 75's son. During an interview with Family Member (FM) 1, on [DATE], at 11:04 AM, FM 1 stated he had POA for Resident 75's medical decisions prior to her admission. FM 1 explained if the facility discussed Resident 75's Advanced directive with her, she would not understand what they were talking about. During an interview with the SSD, on [DATE], at 11:39 AM, the SSD confirmed Resident 75's Advanced Directives were discussed with Resident 75 and should have been discussed with FM 1, as Resident 75 did not have capacity (ability to make decisions for yourself). , 4. A review of Resident 82's clinical record titled, POLST, dated [DATE], revealed Section D, Information and Signatures, was left blank. During a concurrent interview and record review on [DATE] at 3:28 PM with the Social Services Director (SSD), the SSD confirmed Resident 82's POLST Section D had not been filled out. The SSD stated, Section D lets the facility know if Resident 82 has an Advanced Directive and who was spoken to about it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy titled, Advance Directive, revised [DATE], indicated, It is the policy of this facility that residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive .POLST: This document, signed by an authorized health care professional, is a medical order that records residents' treatment wishes so that emergency personnel know what treatments to provide in the event of a medical emergency . A review of the facility policy titled, Advance Directive, published 1/2025, indicated, .POLST .This document, signed by an authorized health care professional, is a medial order that records residents' treatment wishes so that emergency personnel know what treatments to provide in the event of a medical emergency. This is not an advance directive .the resident's comprehensive care plan is reviewed and updated routinely in order to incorporate the resident's choices regarding these rights into treatment, care and services . A review of the facility policy titled, Cardiopulmonary Resuscitation (CPR), updated [DATE], indicated, .CPR is initiated for those residents who .Have requested through advanced directive [a legal document that states your wishes for medical care if you cannot make them yourself] or POLST .to have CPR initiated when cardiac or respiratory arrest occurs .Have not formulated an advance directive nor have a POLST in their medical record .Do not have a valid DNR order .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 - Some	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 observation, interview, and record review, the facility failed to develop and implement care plans (a list of resident specific problems, goals, and interventions) for 3 of 25 sampled residents (Resident 8, Resident 18, Resident 91) when: 1. Resident 8 and Resident 18, who were roommates, were on Enhanced Barrier Precautions (EBP - use of gown and gloves to prevent the spread of Multi-Drug Resistant Organisms (MDRO's illnesses/infections resistant to some antibiotics) but did not have a care plan for MDRO's developed and implemented; and, 2. Resident 91's care plan for Do Not Resuscitate (DNR - allow natural death to occur) was not implemented (Refer F684). These failures placed Resident 8 and Resident 18 at risk for infection and had the potential for other residents residing in the facility to acquire an MDRO, and resulted in facility staff initiating a Full Code (CPR cardiopulmonary resuscitation is emergency treatment when someone's breathing or heartbeat has stopped) on Resident 91 against her wishes. Findings: 1a. A review of Resident 8's clinical document titled, admission RECORD, indicated Resident 8 was admitted to the facility with diagnoses which included a urinary tract infection (an infection in any part of the urinary system). A review of Resident 8's clinical document from an outside facility titled, Urine Culture, dated [DATE], indicated, .Escherichia coli .Extended Spectrum Beta Lactamase producer .[a type of bacteria resistant to certain antibiotics], an active MDRO infection. A review of Resident 8's clinical document regarding MDRO's indicated, .Focus [Resident 8] is on Enhanced Barrier Precautions .to reduce transmission of MDROs .Date Initiated: [DATE] .Goal [Resident 8] will be free from acute infections through review date .Date Initiated: [DATE] .Interventions Enhanced barrier precautions (EBP) wear gowns and gloves when providing high contact resident care activities .Date Initiated: [DATE] . Observe enhanced barrier precautions for infection control .Date Initiated: [DATE] .Orange dot next to name tag to identify residents on Enhanced Barrier Precautions .Date Initiated: [DATE] . b. A review of Resident 18's clinical document titled, admission RECORD, indicated Resident 18 was admitted to the facility with diagnoses which included a history of urinary tract infections. A review of Resident 18's clinical document from an outside facility titled, Urine Culture, dated [DATE], indicated, .Escherichia coli .Extended Spectrum Beta Lactamase producer ., an active MDRO infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 - Some	A review of Resident 18's clinical document regarding MDRO's indicated, .Focus [Resident 18] is on Enhanced Barrier Precautions .to reduce transmission of MDROs .Date Initiated: [DATE] .Goal [Resident 18] will be free from acute infections through review date .Date Initiated: [DATE] .Interventions Enhanced barrier precautions (EBP) wear gowns and gloves when providing high contact resident care activities .Date Initiated: [DATE] .Observe enhanced barrier precautions for infection control .Date Initiated: [DATE] .Orange dot next to name tag to identify residents on Enhanced Barrier Precautions .Date Initiated: [DATE] . During a concurrent observation and interview, on [DATE], at 10:41 AM, the Infection Preventionist (IP) was observed carrying an EBP sign, and personal protective equipment (PPE) to hang on Resident 8 and Resident 18's door in A Hall. The IP explained Resident 18 and Resident 8 should have signage on the outside of their door indicating both residents were on EBP since they both had MDRO's. The IP stated the importance of EBP was to stop the spread of MDRO's. The IP explained it was important because the facility population was at risk of acquiring MDRO's and they do not want to spread them in the facility. During a follow up interview with the IP, on [DATE], at 10:10 AM, the IP acknowledged Resident 8 and Resident 18's EBP care plans were not developed until [DATE]. The IP explained the importance of care plans was so that everyone was aware of and following the residents plan of care. A review of the facility policy titled, Enhanced Barrier Precautions, revised [DATE], indicated, .Enhanced Barrier Precautions (EBP) are initiated to reduce transmission of multidrug resistant organisms (MDRO's) employing targeted gown and glove use during high contact resident care activities. Initiated for residents known to be colonized [when microorganisms are present on the body without causing disease] or infected with MDRO . 2. A review of Resident 91's clinical record titled, admission RECORD, indicated Resident 91's diagnoses included atrial fibrillation (a condition where the upper chambers of the heartbeat irregularly and rapidly). A review of Resident 91's clinical record titled, POLST [Physician Orders for Life Sustaining Treatment: care directives during life threatening situations], dated [DATE], indicated, .Do Not Resuscitate/DNR (Allow Natural Death) . The POLST was signed by Resident 91's Responsible Party (RP), Resident 91's son, and the Physician's Assistant. A review of Resident 91's clinical record titled, Care Plan, dated, [DATE], indicated, .Focus [Resident 91's name] HAS A POLST - DO NOT ATTEMPT RESUSCITATION/DRN [sic] .Date Initiated: [DATE] .Goal I will have my desires and wishes followed . During an interview with the Administrator (ADM), on [DATE], at 12:01 PM, the ADM stated the importance of knowing the residents code status was to respect the residents wishes. The ADM further explained not following the residents wishes could cause psychosocial harm. The ADM confirmed CPR was administered to Resident 91 on [DATE] against her wishes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 - Some	A review of the facility policy titled, Cardiopulmonary Resuscitation (CPR), updated [DATE], indicated, .CPR is initiated for those residents who .Have requested, through advanced directive [a legal document that states your wishes for medical care if you cannot make them yourself] or POLST .to have CPR initiated when cardiac or respiratory arrest occurs .Have not formulated an advance directive nor have a POLST in their medical record .Do not have a valid DNR order . A review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated, . A comprehensive, person-centered care that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan .includes measurable objectives and timeframes reflects currently recognized standards of practice for problem areas and conditions .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of three residents (Resident 91) sampled for a closed record review, received care in accordance with Resident 91's Physician Orders for Life-Sustaining Treatment (POLST; a medical document that outlines a resident's treatment preferences for when they are seriously ill or dying) when, Resident 91's POLST indicated Do Not Resuscitate (DNR; a medical order that instructs healthcare providers not to perform CPR (cardiopulmonary resuscitation; an emergency lifesaving procedure performed when the heart stops beating) and the facility provided CPR to Resident 91 on [DATE]. This failure resulted in Resident 91 receiving CPR against Resident 91's wishes to be DNR, with the potential to cause trauma and psychosocial harm to Resident 91 and Resident 91's family. Findings: A review of Resident 91's clinical record titled, admission RECORD, indicated Resident 91's diagnoses included atrial fibrillation (a condition where the upper chambers of the heart beat irregularly and rapidly) and dementia (a brain disorders that cause a decline in cognitive abilities, such as memory, thinking, reasoning, and judgment). A review of Resident 91's physician's orders, dated [DATE], indicated, .Order Summary: Code Status - FULL CODE (CPR) . A review of Resident 91's clinical record titled, POLST, dated [DATE], indicated, .Do Not Resuscitate/DNR (Allow Natural Death) . Resident 91's POLST was signed by Resident 91's Responsible Party (RP), Resident 91's son, and the Physician's Assistant. A review of Resident 91's code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) care plan (a list of resident specific problems, goals, and interventions), dated [DATE], indicated, .Focus [Resident 91's name] HAS A POLST - DO NOT ATTEMPT RESUSCITATION/DRN [sic] .Date Initiated: [DATE] . A review of Resident 91's clinical record titled, Progress Notes, written by Licensed Nurse (LN) 7, dated [DATE], at 2:51 AM, indicated, .CODE BLUE [usually means that someone is experiencing a life-threatening medical emergency such as a cardiac arrest, when the heart stops, or respiratory arrest, when breathing stops] .[Resident 91] was found by CNA [Certified Nursing Assistant] @0139 [1:39 AM] .Code [status] checked and compression [CPR started] on bed .with back board [used to assist in delivering effective chest compressions] in place and Bag-Valve mask [oxygen delivery system] started .by RNs [registered nurse . EMS [Emergency Medical Services] arrival @0147 [1:47 AM] and taken over CPR .IV [intravenous; insertion of a tube into a vein to deliver fluids and/or medications] insertion 0157 [1:57 AM] (500 ml [milliliters a unit of volume] fluids started) total fluid 1500ml, total epi [epinephrine; an emergency medication administered to increase the chance of restoring a heartbeat] administered [given via] IV (4 [times]) @ (0201 [2:01 AM], 0206 [2:06 AM], 0211 [2:11 AM], 0215 [2:15 AM]) .Time of death [the time when a person's vital signs, like breathing and heart, permanently stop] declared by [Medical Doctor (MD) 2] @0221 [2:21 AM]- CPR terminated [stopped] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE], at 3:50 PM, LN 3 stated Resident 91's POLST was created on [DATE]. LN 3 explained Resident 91's POLST was signed by the physician on [DATE]. LN 3 further explained, until [DATE], Resident 91 was a full code (to provide life saving measures such as CPR), which reflected Resident 91's discharging hospitals records. LN 3 stated when Resident 91's POLST was updated and signed by the Physician's Assistant on [DATE], the facility should have updated Resident 91's electronic health record (EHR; an electronic version of a resident's medical history, that is maintained by the provider over time] to reflect the DNR status as indicated on Resident 91's POLST. During an interview on [DATE], at 4:19 PM, LN 4 stated to check a resident's code status you would check the binder that has the residents POLST forms and the residents EHR. LN 4 explained he would check both the POLST and the EHR. During an interview on [DATE], at 9:13 AM, LN 6 stated a (unidentified) CNA was rounding and found Resident 91 not breathing and called for help [on [DATE]]. LN 6 explained Resident 91's code status was checked in Resident 91's EHR, indicating Resident 91 was a full code. LN 6 further explained they started CPR, got the AED (automated external defibrillator; a portable device that delivers an electric shock to a person when their heart suddenly and unexpectedly stops beating), put the backboard in place, and called 911. LN 6 stated she initiated CPR. LN 6 explained the difference between the EHR and the POLST was confusing because Resident 91's POLST said DNR. LN 6 further explained they found out Resident 91's POLST indicated Resident 91 was DNR while EMS was there and informed them, but they had already provided life saving measures to Resident 91 for a few minutes. LN 6 stated the process for finding out a resident's resuscitation status was to look in the EHR. LN 6 stated the risk to performing CPR on someone who was DNR would be trauma to the resident and the resident's family. LN 6 stated they would want to follow the residents', and the families' wishes. During an interview on [DATE], at 9:23 AM, LN 7 explained they did two to three cycles of CPR on Resident 91, stating they had applied the AED pads at the same time they started compressions. LN 7 stated he was not aware Resident 91 was DNR, stating Resident 91's EHR indicated full code, so CPR was initiated. LN 7 stated the process for determining a resident's code status was by checking the POLST to see what the resident's wishes were, full code or DNR. LN 7 stated he did not check the POLST, only the EHR. LN 7 explained the EHR was usually updated with the most current POLST. LN 7 explained the risk of performing CPR on a resident who was DNR was unnecessary damage and trauma to the resident and the resident's family. During an interview on [DATE], at 12:01 PM, the Administrator (ADM) stated the process for determining code status was by the POLST or by what they tell us in their care plan conference (a meeting where a resident's care team which typically consists of the resident, their family, and medical personnel from the facility, to discuss and update a resident's plan of care). The ADM explained the importance of knowing the residents code status was to respect the residents wishes. The ADM further explained not following the residents' wishes could cause psychosocial harm. A review of the facility policy titled, Cardiopulmonary Resuscitation (CPR), updated [DATE], indicated, .CPR is initiated for those residents who .Have requested, through advanced directive [a legal document that states your wishes for medical care if you cannot make them yourself] or POLST .to have CPR initiated when cardiac or respiratory arrest occurs . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Advance Directive, revised [DATE], indicated, It is the policy of this facility that residents have the right to request, refuse, and/or discontinue treatment .and to formulate an advance directive .POLST: This document, signed by an authorized health care professional, is a medical order that records residents' treatment wishes so that emergency personnel know what treatments to provide in the event of a medical emergency .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure proper hydration (process of providing fluid to the body) for 1 of 25 sampled residents (Resident 16) per facility policy and Resident 16's care plan when Resident 16's water was out of reach. This failure resulted in Resident 16 having dry, cracked lips and had the potential to have complications associated with fluid imbalance (when the body loses or gains too much water/fluids). Findings: During a concurrent observation and interview on 2/3/25, at 11:31 AM, with Licensed Nurse (LN) 1 in Resident 16's room, Resident 16 stated she was thirsty. Resident 16 looked on the bedside table for something to drink but nothing was there. LN 1 stated the risk to Resident 16 not having fluids available to drink at bedside was becoming dehydrated (when the body loses too much fluid). During a concurrent observation and interview on 2/3/25 at 11:42 AM, with Certified Nursing Assistant (CNA) 3 in Resident 16's room, Resident 16 stated the staff got her water but moved her bedside table with the water on it out of reach. Resident 16 stated she was still thirsty. CNA 3 confirmed Resident 16's bedside table and water was not in reach. CNA 3 confirmed Resident 16's lips were chapped (cracked, rough or sore) and peeling (lose parts of its outer layer). CNA 3 stated the risk to the resident was dehydration. During an interview on 2/6/25, at 9:56 AM, with the Director of Nursing, the DON stated fluids should always be in reach and available to the residents, especially if the resident had signs of dehydration like dry lips. A review of the resident's care plan revised 9/26/24, indicated, .[Resident 16] will have no s/sx [signs and symptoms] dehydration .Nursing staff will cue [Resident 16] to have frequent sips of fluid . A review of the facility's policy and procedure titled, Hydration Program, updated 9/2023, indicated, .Water is available at bedside for residents not on altered fluid .The nurses observe for signs and/or symptoms of dehydration .dry cracked lips .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 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 respiratory care was provided in accordance with professional standards of practice for 2 of 19 residents when: 1. Oxygen therapy was provided without a physician order for Resident 192 and an oxygen in use sign was not posted outside of Resident 192's room; and, 2. An oxygen in use sign was not posted outside of the room for Resident 296. These failures had the potential to result in negative impacts on the residents' health and safety including risks for ineffective oxygen therapy, and respiratory distress. Findings: 1. A review of Resident 192's admission Record indicated Resident 192 was admitted to the facility with diagnoses which included chronic obstructive pulmonary disease (COPD: a group of lung diseases that block airflow and make it difficult to breathe). During an observation on 2/03/25, at 11:25 a.m., Resident 192 was observed in her room with the oxygen concentrator on at a flow rate of 1.5 liters per minute (LPM-unit of measurement for oxygen delivery) via nasal cannula (a small flexible tube that contains two open prongs intended to sit just inside the nostrils). When asked, Resident 192 stated she had been using oxygen since she had been at the facility. During a concurrent interview and record review on 2/03/25, at 11:55 a.m., with Licensed Nurse (LN) 2, LN 2 confirmed Resident 192 did not currently have a physician order for oxygen use. LN 2 stated Resident 192 was known to use oxygen so she should have an order for it. LN 2 further stated the resident was at risk for receiving incorrect dosage of oxygen without an order from the physician which could have led to respiratory complications. During a concurrent observation and interview on 2/03/25, at 2:30 p.m., with LN 2 outside of Resident 192's room, LN 2 confirmed there was no oxygen in use sign posted outside Resident 192's room. LN 2 stated Resident 192 was known to use oxygen and there should have been a sign posted outside her room. LN 2 further stated the risk for not having an oxygen in use sign could have made it difficult for staff to keep track of Residents who are using supplemental oxygen in the event of fire. During an interview on 2/04/24, at 12:23 p.m., the Director of Nursing (DON) stated she expected oxygen in use signs to be posted outside of the rooms for any resident who used oxygen. The DON explained the risk for not having an oxygen order was that the resident's oxygen saturation (a measure of how much oxygen is in your blood) could have dropped. 2. During a concurrent observation and interview on 2/3/25, at 1:01 PM, in front of Resident 246's room with Certified Nurse Assistant (CNA) 4, CNA 4 confirmed Resident 246 was on oxygen and there was no sign on the door that indicated oxygen was in use. CNA 4 stated it was important to have the sign because oxygen was a potential fire hazard. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/3/25, at 1:05 PM, with LN 2, LN 2 stated they did not usually put signs on the resident's doorways to alert that oxygen was in use. LN 1 overheard and corrected LN 2 and stated it was policy to place the oxygen in use sign on the doorway entrance. LN 1 further stated the risk to the residents and staff when the sign was not placed was that oxygen was combustible and others may not be aware oxygen was in use. During an interview on 2/6/25, at 12:42 PM, the DON stated the residents who were on oxygen were supposed to have signage on their door to alert staff that oxygen was in use. The DON further stated it was important, so people knew to not smoke or use electronic cigarette devices in the room due to its flammability (capable of catching fire and burning). The DON confirmed the policy was not followed when the signs were not placed outside of the doors. Review of the facility policy titled, Respiratory Care; Oxygen Administration, dated, 12/2017, indicated, . Oxygen is administered per physician order .Oxygen liter flow is set by a Licensed Nurse in accordance with physician's orders .No Smoking signs are posted in accordance with State and Federal regulation .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 of 25 sampled residents (Resident 3) was provided pain management that met professional standards of practice when Resident 3's Lidocaine patch (used to relieve nerve pain) was signed off by licensed nurse (LN) 9 as if it had been applied as ordered by the physician but was not placed until three hours later. This failure resulted in Resident 3's pain being unrelieved, negatively impacting Resident 3's health and well-being. Findings: A review of Resident 3's clinical document titled, admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses which included, MALIGNANT NEOPLASM OF AMPULLA OF [NAME], (a type of cancer) and rheumatoid arthritis (a disease that causes pain, swelling, and stiffness in the joints). During a concurrent observation and interview on 2/3/25, at 10:56 AM, with Resident 3, Resident 3 stated LN 9 had not applied her Lidocaine Patch and she was in pain. Resident 3 stated the Lidocaine patch was supposed to be placed on her back and pointed to where it was supposed to be applied. There was not a Lidocaine Patch observed on Resident 3's back. A review of Resident 3's clinical document titled, Order Summary Report, dated 2/3/25, indicated, .Lidocaine External Patch 5% .Apply to lower extremities topically [on the skin] one time a day related to RHEUMATOID ARTHRITIS ., with a started date of 7/15/24. During an interview on 2/3/25, at 10:58 AM, with LN 9, LN 9 stated Resident 3's Lidocaine Patch was due to be placed at 8 AM. LN 9 further stated she signed off the Lidocaine Patch as being applied but had not applied it to Resident 3 yet. LN 9 explained the importance of applying the pain patch on time was to ensure Resident 3's pain was controlled. During a follow up interview on 2/3/25, at 11:06 AM, with Resident 3, Resident 3 explained she was in pain and her Lidocaine patch was important. A review of Resident 3's clinical document related to, Acute Pain/Chronic Pain r/t [related to] chronic knee pain, and scoliosis (curve in the spine). She is at risk for uncontrolled pain .Goal Resident Will Report Satisfactory Pain Control .Interventions Administer pain medications per order .Determine Resident's satisfactory pain level . During an observation on 2/3/25, at 11:07 AM, LN 9 was observed applying Resident 3's Lidocaine Patch. During an interview on 2/5/25, at 10:34 AM, with the Director of Nurses (DON), the DON stated the importance of administering/applying pain medication was to ensure residents pain was managed. The DON explained medications should not be signed off prior to administration. The DON further explained the risk to signing off pain medication prior to administration/application was not receiving the medication and not managing the residents' pain. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Pain Management, updated 1/2015, indicated, .Residents are evaluated for pain upon admission, routinely, and prn [as needed] .resident is evaluated every shift for signs and symptoms of pain, receiving pain management according to the Preliminary Plan of Care and/or physician order .For residents using PRN pain medication, a 0-10 pain scale is used to document .levels of pain .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 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 observation, interview, and record review, the facility failed to ensure 2 of 25 sampled residents' (Resident 3 and Resident 24) medications were administered as prescribed when: 1. Resident 3's PRN (as needed) pain medication, acetaminophen, was left at the bedside; and, 2. Resident 24's medication Sucralfate (used to prevent stomach ulcers) was not administered before meals as prescribed. These failures resulted in Resident 3's pain going unrelieved, the potential for Resident 3 to accumulate the medication, or for another resident to take the medication, and for Resident 24 to experience abdominal discomfort, negatively impacting Resident 3's and Resident 24's health and well-being. Findings: 1. A review of Resident 3's clinical document titled, admission RECORD, indicated Resident 3 was admitted to the facility with diagnoses which included, MALIGNANT NEOPLASM OF AMPULLA OF [NAME] [cancer], and rheumatoid arthritis (causes pain, swelling, and stiffness in the joints). During a concurrent observation and interview with Resident 3, on 2/3/25, at 12:44 PM, Resident 3 stated her nurse did not watch her took her medications and she still had the pills. Resident 3 showed the Department the medications she still had. A review of Resident 3's clinical document titled, Order Summary Report, dated 2/3/25, indicated a physician's order for, .Tylenol Oral Tablet (Acetaminophen) Give 650 mg [milligrams a unit of measure] every 6 hours as needed for PRN PAIN related to OTHER CHRONIC PAIN .Start Date 03/26/2024 . During a concurrent observation and interview with licensed nurse (LN) 9, on 2/3/25, at 12:48 PM, LN 9 stated she administered Resident 3's acetaminophen at 10:06 AM. LN 9 explained she did not watch Resident 3 take her acetaminophen. LN 9 explained the importance of watching the residents taking their medication was to make sure they took it, did not accumulate it, and to ensure another resident does not take a medication that was not prescribed to them. LN 9 confirmed Resident 3 still had pills and asked Resident 3 why she did not take the medication. Resident 3 stated, You didn't tell me anything about the medication. You just handed it to me and left. During an interview with the Director of Nurses (DON), on 2/3/25, at 1:14 PM, the DON stated medications should not be left at the residents' bedside. The DON stated the importance of ensuring the resident takes the medication was there was a risk another resident might take it. A review of the facility policy titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, effective 10/2017, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .The person who prepares the dose for administration is the person who administers the dose . The resident is always observed after administration to ensure that the dose was completely ingested . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 24's clinic document titled, admission RECORD, indicated Resident 24 was admitted to the facility with diagnoses which included gastro-esophageal reflux disease (a condition where stomach contents flow back up causing irritation and inflammation) and gastrointestinal (GI) hemorrhage (any type of bleeding that starts in the digestive tract). A review of Resident 24's clinical document titled, Order Summary Report, dated 2/3/25, indicated, . Sucralfate Oral Tablet 1 GM (gram a unit of measure) (Sucralfate) Give 1 tablet by mouth before meals for gi bleed ., with a start date of 1/25/25. During a concurrent medication administration observation and interview with LN 8, on 2/5/25, at 8:08 AM, LN 8 was observed administering the medication Sucralfate while Resident 24 was eating cold cereal. LN 8 confirmed the medication was due at 6:30 AM and should have been administered before the meal. During an interview with the Director of Nurses (DON), on 2/6/25, at 1:13 PM, the DON stated it was important to administer medications on time and to follow physician orders. The DON stated if medications were administered late the physician should be notified. A review of the facility policy titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES, effective 10/2017, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meals, which are administered based on mealtimes .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food from the kitchen was prepared and served to meet the needs of 3 out of 13 Residents (Resident 8, Resident 42, and Resident 54) on a fortified (added calories) diet, and 1 of 1 Residents (Resident 65) on a finger food diet, for the lunch meal on 2/5/25, when: 1. Resident 8, Resident 42, and Resident 54, who were on an ordered fortified diet did not receive the added food items to increase calories; and, 2. Resident 65 did not receive his/her ordered diet of finger foods. These failures had the potential to result in residents not receiving adequate nutrients, which could lead to unplanned weight loss, vitamin imbalances, and further compromise their medical status. Findings: 1. During an observation on 2/5/25, at 11:48 AM, the lunch tray line staff prepared the trays for Resident 8, Resident 42, and Resident 54 with regular mashed potatoes instead of the fortified mashed potatoes. During an interview on 2/5/25, at 1:24 PM, the Dietary Manager (DM) stated the importance of following the ordered diets and preferences was to prevent unintended weight loss or worsening medical conditions. The DM further stated the lunch menu on 2/5/25 had fortified mashed potatoes that had extra butter and added half and half (half milk and half heavy cream) for additional calories. The DM further stated the cooks follow the fortified diet recipes, however, could not find a fortified diet policy. A review of an undated facility provided document titled, Fortified Potatoes, Mashed (mix) - ½ Cup [unit of measurement], indicated, .Ingredient: Mix, Mashed Potato, dry, water, boiling, creamer, half and half, bulk, margarine . 2. During an observation on 2/5/25, at 11:48 AM, the tray line staff was observed preparing the lunch tray for Resident 65. Resident 65 was served a regular tray of an open-faced (a piece of bread topped with sliced meat, covered in gravy) pork sandwich with mashed potatoes and gravy, sliced glazed carrots, and lemon cake. During an interview on 2/6/25, at 9:37 AM, the Registered Dietician (RD) confirmed Resident 65's meal card indicated finger foods and the policy for finger foods was not followed. The RD stated finger foods were available in the kitchen for residents. The RD further stated the importance of following the policy was to provide dignity to the resident who needed it to self-feed instead of being fed by staff. Review of a facility provided record titled, NUTRITION NOTE, dated 1/2025, for Resident 65, indicated, . Diet/Texture Order: Regular diet, Regular textures, Thin liquids, finger foods . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure titled, Therapeutic Diets, (Healthcare Services Group, Inc. and its subsidiaries) revised 2/2022, indicated, .Therapeutic diet is defined as a diet ordered by a physician, or delegated registered or licensed dietician, as part of the treatment for a disease or clinical condition .The purpose of a therapeutic diet is to .increase specific nutrients in the diet . Review of the facility's policy and procedure titled, Diet and Nutrition Care Manual, Finger Food Diet, dated 2019, indicated, This diet allows independence in eating for individuals who wish to maintain self-feeding and independence .Foods allowed: Any foods that are easy to pick up and eat using fingers. Bite size pieces, or foods that are easily bitten and chewed such as half or quarter sliced sandwiches, chicken nuggets, French fries .Foods to avoid .Any slippery foods that may be difficult to pick up .mashed potatoes .vegetables or pastas with dressing or sauce .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 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 provide safe food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 89 residents who received facility prepared meals when: 1. The stove, oven, convection oven (ovens that have a fan to circulate heat and bake more evenly), back splash, and sides of oven contained grease, buildup of food particles, and white, black, brown colored encrusted grimy areas; and, 2. Sliced yellow cheese was removed from its original package and was stored in the refrigerator without being labeled; Food stored in the refrigerator was available for use beyond the use by date (UBD). 3. The kitchen was found with following unsanitary conditions: a. A floor sink located between the oven and a commercial food steamer was observed to have rust-colored stains, chipped, peeling white paint, debris, dirt, and unknown type of liquid splatter marks on the metal wall behind it. b. A wall behind a food preparation table was damaged with areas of chipped away paint and exposed dry wall. The wall contained pieces of dried food particles, and brown liquid splatter. c. Clean metal sheet pans stored on a shelf had food particles and grease marks. d. The steam table had black encrusted food residue, white, black, and brown stains of grease and grime, and food particles stuck on it. 4. An industrial meat slicer, and mixer were wrapped in dirty clear plastic, as clean, and were both found to be stained and splattered with food particles. 5. A baked cake was not sealed properly and stored on a shelf that contained dried food particles; and, 6. A baked cake was prepared in a pan with encrusted black, brown, and rust colored residue stuck to it and served to residents. These failures had the potential to put the 89 residents who ate the facility prepared meals at risk for foodborne illnesses. Findings: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During the initial kitchen tour on 2/3/25, at 8:53 AM, with the Dietary Manager (DM), the convection oven, stove, oven, range top, metal back splash and sides of the equipment was observed with moderate grease buildup, crumbs, black and white ashes, and tan and brown colored stained liquid residue on the outside, and inside the ovens. The side of the range had stuck on tan tape with food particles attached. The DM stated the ovens, range, and surrounding areas should be cleaned after each use and weekly. The DM further stated the risk to the residents was cross contamination of bacteria and residents getting sick. During an interview on 2/4/25, at 12:28 PM, with the Registered Dietician (RD), the RD stated his expectation was for the ovens and areas near the ovens to be cleaned, wiped down every night, cleaned weekly, and the lack of cleanliness did not meet his expectations. The RD further stated the importance of cleanliness was to ensure organisms (bacteria) did not grow and prevented cross contamination to the residents. 2. During the initial kitchen tour on 2/3/25, at 9:02 AM, with the DM, a large gallon container of sliced yellow cheese had been removed from its original package and placed in an unlabeled and undated container that was available for use in the refrigerator. During a concurrent observation and interview on 2/3/25, at 9:05 AM, with the DM, a container of pumpkin with a UBD of 1/31/25, and a container of cranberry sauce with a UDB of 1/29/25 was available for use in refrigerator. The DM stated the risk to the residents was illness from expired foods or contamination. During an interview on 2/4/25, at 12:28 PM, the RD stated unlabeled and undated foods available for use did not meet his expectation. The RD also explained foods available for use beyond the UBD was not acceptable. The RD further stated it was important to label and date food for the kitchen staff to know when to use the food by. The risk to the residents was getting sick from foodborne illness. The RD explained the residents were already at risk and were vulnerable to illness. 3. During the initial kitchen tour on 2/3/25, at 9:01, AM the following was observed and confirmed by the DM: a. A floor sink located between the oven and a commercial food steamer was observed to have rust-colored stains, chipped, peeling white paint, debris, dirt, and unknown type of liquid splatter marks on the metal wall behind it. b. A wall behind a food preparation table was damaged with areas of chipped away paint and exposed dry wall. The wall contained pieces of dried food particles, and brown liquid splatter. c. Clean metal sheet pans stored on a shelf had food particles and grease marks. d. The steam table had black encrusted food residue, white, black, and brown stains of grease and grime, and food particles stuck on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/4/25, at 12:28 PM, the RD stated the floor drain looked stained and aged, with dirt and debris, including the wall panels behind it. The RD stated it should be cleaned and wiped down every night. The RD stated the broken dry wall behind the food preparation area should be flat, easily cleaned, and without broken parts. Risk to residents was the pieces of broken wall can hold bacteria. The RD further stated the importance of cleanliness in the kitchen was to ensure organisms did not grow and to prevent cross contamination. The RD explained it was his expectation the steam table be cleaned out after each use. The risk to the residents was cross contamination. 4. During a concurrent observation and interview on 2/4/25, at 9:46AM, with the Certified Dietary - District Manager (CD-DM), the meat slicer was observed to be covered in clear plastic that had food residue and particles on it. The meat slicer was uncovered from the dirty plastic and observed with dried brown liquid substance on it. The industrial mixer was found to have food particles stuck to the top of it and was also wrapped as clean. The CD-DM stated when wrapped with plastic the meat slicer and mixer are considered clean. The CD-DM confirmed the meat slicer, the mixer, and the plastic covering were not clean. The CD-DM stated it was important to keep the equipment clean to prevent bacteria growth, cross-contamination, and foodborne illness to the residents. During an interview on 2/6/25 at 9:26 AM, the RD stated it was his expectation for the meat slicer and mixer to be cleaned per facility guidelines. The RD further stated they should be cleaned after each use. The RD explained the risk to the residents was a biological hazard for cross contamination which could lead to foodborne illness. 5. During a concurrent observation and interview on 2/5/25, at 10 AM, with [NAME] (CK) 2, CK 2 stated she prepared and baked a lemon cake yesterday (2/4/25). CK 2 stated the cake had been sitting on a shelf under the convection oven since it was baked. The cake was baked on a large metal two-inch deep sheet pan, and was covered with another sheet pan of the same size. The cake was not tightly sealed, and gaps were noted between the sheet pans, exposing the cake. During a concurrent observation and interview on 2/5/25 at 10 AM, the DM stated the storage of the cake did not meet expectations and should be tightly wrapped with foil or plastic wrap. The DM further stated since the cake covering left gaps, it was at risk for pests or bugs to get into it. During an interview on 2/6/25, at 9:37 AM, the RD confirmed the cake should have been wrapped tightly in plastic and not left with open gaps. The risk was contamination from pests. 6. During a concurrent observation and interview on 2/5/25, at 10:18 AM, the DM confirmed the lemon cake was baked in a two-inch sheet pan. The sheet pan had encrusted rust and black colored markings stuck on the sides. The DM stated the markings were from the pan being old. During an interview on 2/6/25, at 9:37 AM, the RD stated the cake pan should not be used and did not meet expectations. The RD stated it should be replaced or lined with foil. The RD further stated the risk to the residents could be cross contamination, or a physical hazard if bits from encrusted cake pan were consumed by residents. Review of a facility policy and procedure titled, Equipment, revised 9/2017, indicated, .All equipment will be routinely cleaned and maintained .All staff members will be properly trained in the cleaning and maintenance of all equipment .All food contact equipment will be cleaned and sanitized after each use .All non-food contact equipment will be clean and free of debris . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy and procedure titled, Food: Preparation, revised 2/2023, indicated, .All refrigerated, ready-to-eat TCS prepared foods that are to be held for more than 24 hours at a temperature of 41 F or less, will be labeled and dated with a prepared date (Day 1) and a use by date (Day 7) . Review of a facility policy and procedure titled, Environment, revised 9/2017, indicated, .The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls .will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces . Review of a facility policy and procedure titled, Food Storage: Cold Foods, revised 2/2023, indicated, .All food will be wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . Review of a facility policy and procedure titled, Food: Preparation, revised 2/2023, indicated, .Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination . Review of the United States (US) Food and Drug Administration (FDA) 2022 Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils indicated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Review of the FDA 2022 Food Code section 4-202.11 indicated, .The purpose of the requirements for multiuse food-contact surfaces is to ensure that such surfaces are capable of being easily cleaned and accessible for cleaning. Food contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Review of the FDA 2022 Food Code Section 3-302.11 (A)(4) Covering stored food: .Food is protected from cross contamination by storing the food in packaged, covered containers, or wrappings . Review of the FDA 2022 Food Code section 4-204.12 .Equipment and covers that are used to protect storage, stored or prepared food from contaminants are to have covers that overlap the opening .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain a closed garbage dumpster bin. This failure had the potential to lead to insect and rodent (mice and rats) infestation for the 89 residents who lived at the facility. Findings: During a concurrent observation and interview on 2/3/25, at 9:59 AM, with the Dietary Manager (DM), the lid to one of the garbage dumpster bins located outside behind the building was observed propped open. The DM confirmed the lid was open. The DM stated the garbage dumpster lid should be kept closed and secured to avoid attracting rodents. During an interview on 2/4/25, at 12:58 PM, with the Registered Dietician (RD), the RD stated his expectation was for the garbage dumpster bin to be closed. The RD further stated the risk of it being opened was attracting rodents. A review of the 2022 Food Code, published by the Food and Drug Administration (FDA), dated 1/18/23, in the Section 5-501.15, 111, and 115, indicated, .Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents .Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents . (https://www.fda.gov/media/164194/download)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, and record review, the facility failed to maintain complete and accurate medical records for 2 of 25 sampled residents (Resident 43 and Resident 77) when: 1. Protected Health Information (PHI - any information that can be used to identify a person and is related to their health including any information about a person's physical or mental health, treatment, and payment for healthcare) of another person was found in Resident 43's medical record; and, 2. The facility failed to ensure psychotropic medication (type of drug that affects behavior, mood, thoughts, or perception) informed consent documents included the frequency, dose, and duration for Resident 77. These failures resulted in an inaccurate account of information in Resident 43 and Resident 77's medical records. Findings: 1. During a concurrent interview and record review on 2/3/25, at 8:56 AM, with the Director of Nursing (DON), the DON confirmed laboratory results for another Resident were in Resident 43's medical record. The DON stated this was done by accident. The DON further stated that this could have led to wrong results being reported to the physician of Resident 43. 2. During a record review of the facility's, PSYCHOTROPIC DRUGS DISCLOSURE AND CONSENT, form for Resident 77, dated 1/5/25, the form indicated, trazodone 50 milligram (trazadone, a drug used to treat depression). During a record review of the facility's, PSYCHOTROPIC DRUGS DISCLOSURE AND CONSENT, form for Resident 77, dated 1/6/25, the form indicated, abilify (abilify, a drug used to regulate mood, behaviors, and thoughts). During a record review of the facility's, PSYCHOTROPIC DRUGS DISCLOSURE AND CONSENT, form for Resident 77, dated 1/5/25, the form indicated, divalproex sodium (divalproex sodium, a mood stabilizing drug). During a concurrent interview and record review on 2/4/25, at 2 PM, with the Director of Nursing (DON), the DON confirmed that the PSYCHOTROPIC DRUGS AND DISCLOSURE AND CONSENT, forms for Resident 77 did not include the frequency, dose, or duration for trazodone, abilify, and divalproex sodium. During a concurrent interview and record review on 2/4/25, at 2:10 PM, with the DON, the facility's policy and procedure (P&P) titled, Informed Consent for Psychotropic Drugs, last updated September 2017, was reviewed. The P&P indicated, .the licensed nurse reviews/completes the following with the resident and or responsible party .the drug, dose, frequency .discuss the rational/benefits for the orders .discuss potential risk factors .documented in the progress notes along with individuals reviewed with, and their responses to the information provided . The DON confirmed in Resident 77's medical record that no progress notes were made and the facility's P&P was not followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain its infection prevention and control program, for a census of 89 residents, when: 1. Physical therapy assistant (PTA) 1 was not wearing an N95 respirator (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) in a COVID 19 positive resident room; 2. Certified nurse assistant (CNA) 5 was not wearing a gown when transferring a resident on enhanced barrier precautions (EBP a set of infection control measures that use gowns and gloves to reduce the spread of multidrug-resistant organisms (MDROs microorganisms that are resistant to multiple classes of antibiotics and antifungals)), from her wheelchair to her bed; 3. Two residents (Resident 8 and Resident 18), who were roommates with MDROs, were not placed on EBP; and, 4. A glucometer (used to check blood sugar) was not sanitized between resident's use. These failures had the potential to spread COVID-19, MDROs, and bloodborne illnesses to residents residing in the facility. Findings: 1. During a concurrent observation and interview, on 2/3/25, at 3:13 PM, PTA 1 was observed wearing a surgical mask (a loose-fitting mask disposable face mask) in a COVID 19 positive resident room. PTA 1 confirmed that he was wearing a surgical mask and not the required N95 respirator. PTA 1 explained wearing an N95 respirator was important to prevent himself from being infected with COVID 19 and passing it on to residents residing in the facility and staff. During an interview with the Infection Preventionist (IP), on 2/4/25, at 12:08 PM, the IP stated when entering a room with COVID 19 positive residents, staff were required to wear a gown, gloves, N95 respirator, and a face shield. The IP explained a surgical mask would not be sufficient protection from COVID 19, it would not protect you. A review of the facility policy titled, SARS-CoV2 [severe acute respiratory syndrome coronavirus 2] (COVID-19) SNF [Skilled Nursing Facility], published 1/2025, indicated, .Centers observe source control for all healthcare personnel (HCP) as follows .N-95 respirators that are in use for source control are removed and discarded and a new N-95 respirator donned [put on] following resident care encounters for those with known or suspected SARS-CoV-2 infection . 2. During a concurrent observation and interview, on 2/5/25, at 4:25 PM, CNA 5 was observed transferring a resident, on EBP, from her wheelchair to her bed without wearing a gown. CNA 5 acknowledged she was not wearing a gown, and she should have been wearing a gown due the resident having an indwelling urinary catheter (tube placed into the bladder to drain urine). CNA 5 explained wearing a gown helped prevent the spread of MDROs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the IP, on 2/6/25, at 10:45 AM, the IP explained the whole purpose of wearing a gown and gloves was to reduce the spread of MDROs. The IP further explained when you have a gown on you have a barrier between yourself and the resident. The IP explained not wearing a gown when caring for a resident with an MDRO risks transferring the MDRO from one resident to another. A review of the facility policy titled, Enhanced Barrier Precautions, revised 3/26/24, indicated, .Enhanced Barrier Precautions (EBP) are initiated to reduce transmission of multidrug resistant organisms (MDRO's) employing targeted gown and glove use during high contact resident care activities. Initiated for residents known to be colonized [when microorganisms are present on the body without causing disease] or infected with MDRO or have open wound or indwelling medical devices .EBP are indicated for residents with any of the following .Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . 3a. A review of Resident 8's clinical document titled, admission RECORD, indicated Resident 8 was admitted to the facility with diagnoses which included a urinary tract infection. A review of Resident 8's clinical document from an outside facility titled, Urine Culture, dated 10/25/24, indicated, .Escherichia coli .Extended Spectrum Beta Lactamase producer ., an active MDRO infection. b. A review of Resident 18's clinical document titled, admission RECORD, indicated Resident 18 was admitted to the facility with diagnoses which included a history of urinary tract infections. A review of Resident 18's clinical document from an outside facility titled, Urine Culture, dated 2/8/24, indicated, .Escherichia coli .Extended Spectrum Beta Lactamase producer ., an active MDRO infection. During a concurrent observation and interview, on 2/3/25, at 10:41 AM, the IP was observed carrying an EBP sign, and personal protective equipment (PPE) to hang on Resident 8 and Resident 18's door in A Hall. The IP explained Resident 18 and Resident 8 should have signage on the outside of their door indicating both residents were on EBP since they both had MDRO's. The IP stated the importance of EBP was to stop the spread of MDRO's. The IP explained it was important because the facility population was at risk of acquiring MDRO's and they do not want to spread them in the facility. A review of the facility policy titled, Enhanced Barrier Precautions, revised 3/26/24, indicated, .Enhanced Barrier Precautions (EBP) are initiated to reduce transmission of multidrug resistant organisms (MDRO's) employing targeted gown and glove use during high contact resident care activities. Initiated for residents known to be colonized [when microorganisms are present on the body without causing disease] or infected with MDRO . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent medication pass observation, interview, and record review with licensed nurse (LN) 8, on 2/6/25, at 6:50 AM, LN 8 was observed performing a blood sugar (BS) test with a glucometer (device used to test residents blood sugar level) on a resident residing in the facility. Following the BS test, LN 8 was observed wiping the glucometer with a [brand name] bleach wipe and then wrapping the glucometer in a paper towel without allowing the bleach solution to remain visibly wet (dwell time) on the surface of the glucometer for the required time for sanitization (to reduce or eliminate bacteria on the surface) to occur. LN 8 stated the process for cleaning and sanitizing the glucometer was to wipe the glucometer with the bleach wipe and then wrap it in a paper towel to dry. LN 8 stated she did not know what dwell time/wet time was. LN 8 reviewed the container specifications for the [brand name] bleach wipe, which indicated, .4 minute wet contact time. During an interview with the Director of Nurses (DON), on 2/6/25, at 8:37 AM, the DON stated the process for cleaning and sanitizing the glucometer was to wipe it off with a bleach wipe, and let it dry. During an interview with the IP, on 2/6/25, at 10:02 AM, the IP stated the importance of cleaning and sanitizing the glucometer was to make sure it was clean, so you do not pass on germs to the next person, and to sanitize the glucometer so it was ready to use on the next resident, and you are not contaminating the medication cart. The IP explained if the glucometer was not sanitized after cleaning it residents could be exposed to bacteria and blood that was on the glucometer from another person, which could cause bloodborne illness in other residents. A review of the facility policy titled, Disinfecting Glucometer .Machine, updated 2/2017, indicated, .The Center disinfects the multiuse glucometer .between each resident use .Multi-resident use glucometers are cleaned/disinfect [kill most germs on the surface] with appropriate bleach product .between residents, and when visibly soiled . A review of the bleach wipe document titled, Trusted protection for critical environments., updated 9/2024, indicated, .Effective against .multi-drug resistant bacteria and bloodborne pathogens . A review of the bleach wipe document titled, General Guidelines For Use, updated 4/2024, indicated, .Allow surface to remain visibly wet for four (4) minutes. Use additional wipe(s) if needed to ensure continuous 4 minute wet contact time. Let air dry .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure 1 of 25 sampled residents (Resident 75) was offered the Pneumococcal booster Vaccine (vaccine to prevent pneumonia) even though Resident 75 was eligible to receive the vaccine. This failure resulted in Resident 75 being at higher risk for contracting pneumonia from not receiving the pneumococcal vaccine when eligible. Findings: 1. A review of Resident 75's admission Record indicated Resident 75 was admitted to the facility with diagnoses which included muscle weakness, anemia (when the body does not have enough red blood cells), Type 2 Diabetes Mellitus (the inability to regulate sugar levels in the body) and chronic obstructive pulmonary disease (lung disease). A review of Resident 75's medical record titled, Immunization Record and History, dated 10/25/17, indicated Resident 75 had received the PCV13 vaccination (protects against 13 types of bacteria that can cause pneumonia) on 10/25/17. During a concurrent interview and record review on 2/6/25, at 8:10 AM, with the Infection Preventionist (IP), the IP stated Resident 75 was eligible for the PPSV23 vaccine (protects against 23 types of bacteria that can cause pneumonia) and should have been offered the PPSV23 for increased risk for pneumococcal disease in adults over the age of 65. The IP stated the risk for not offering pneumonia vaccination was that Resident 75 could have acquired pneumonia which could have led to hospitalization. During an interview on 2/06/25, at 9:06 AM, with the Director of Nursing (DON), the DON stated Resident 75 should have been offered the PPSV23. The DON further stated the risk for not offering pneumonia vaccination was that the Resident could have gotten pneumonia. A review of the Centers for Disease Control and Prevention (CDC) document titled, Vaccines & Immunizations, reviewed 10/30/19, indicated, .Pneumococcal polysaccharide vaccine (PPSC23) can prevent pneumococcal disease .These bacteria can cause many types of illness, including pneumonia, which is an infection of the lungs .people with certain medical conditions, adults [AGE] years older .are at the highest risk .PPSV23 protects against 23 types of bacteria that cause pneumococcal disease .PPSV23 is recommended for all adults 65 years or older .People 65 years or older should get a dose pf PPSV23 even if they have already gotten one or more doses of the vaccine before they turned 65 . A review of the CDC document titled, Vaccines & Immunizations, reviewed 10/26/24, indicated, .People at increased risk for pneumococcal disease include .adults 65 years or older .Chronic lung conditions that increase someone's risk include chronic obstructive pulmonary disease .CDC recommends pneumococcal vaccination .Adults age [AGE] years or older have the option to receive 1 dose of PCV 20 or 1 dose of PCV21 (a pneumococcal vaccine) at least 1 year after the last PCV13 dose (a pneumococcal vaccine) .and PPSV23 (a pneumococcal vaccine) at or after the age of [AGE] years old .PPSV23 .give to adults who have received an earlier vaccine called PCV13. This vaccine protects against serious infections caused by 23 types of pneumococcal bacteria .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain kitchen equipment for 89 residents who received food from the kitchen when the steamer (small appliance that cooks food using steam) was leaking water onto the ground. This failure had the potential to injure staff due to a wet floor and compromise food safety for the 89 residents receiving food from the kitchen. Findings: During the initial kitchen tour on 2/3/25, at 9:01 AM, the steamer (which sat next to the stove) was observed leaking water from the bottom onto a maroon kitchen tray and then overflowed onto the ground. There were no signs that cautioned wet floors in the area. During a concurrent observation and interview on 2/5/25, at 10:14 AM, standing water was observed puddling onto an overflowing maroon serving tray on the floor under the steamer and being tracked across the kitchen. Dietary [NAME] (CK) 1 stated they needed to keep emptying the tray or it overflowed. CK 1 stated it has been repaired a few times but continuously leaked. CK 1 confirmed a wet floor caution sign was not in use. During an interview on 2/5/25, at 1:10 PM, with the Dietary Manager (DM), the DM stated the risk of the steamer leaking water was the water could harbor bacteria or create a fall hazard for kitchen staff. The DM confirmed the steamer needed to be repaired again, the floor should be dry, and a wet floor caution sign should be used. Review of the facility's policy and procedure titled, Equipment, revised 2/2017, indicated, .All equipment will be routinely cleaned and maintained in accordance with manufacturer's direction .All staff members will be properly trained in the cleaning and maintenance of all equipment .The Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed .