

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/25/2024
NAME OF PROVIDER OR SUPPLIER Golden Modesto Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Coffee Road Modesto, CA 95355	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713</p> <p>Based on observation interview and record review, the facility failed to ensure residents were free from abuse and neglect for one of three sampled residents (Resident 2) when Resident 2 did not receive assistance to go to the restroom and was told by CNA 1 to soil herself while in bed.</p> <p>This failure resulted in Resident 2 feeling humiliated and neglected by CNA 1 when Resident 2 held her urine until her stomach was in pain and urinated on herself.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 10/25/24 at 11:00 a.m. with Resident 1, in Resident 1 ' s room, Resident 1 was observed communicating using a notepad. Resident 1 stated that on the night of 10/14/24, Resident 2 asked certified nursing assistant (CNA) 1 for assistance to the restroom. Resident 1 stated CNA 1 told Resident 2, to wet her brief in bed because CNA 1 did not have time to take her to the restroom. Resident 1 stated Resident 2 was a nice person and heard Resident 2 tell CNA 1 that she was sorry, she would try harder and be a better resident. Resident 1 stated she felt angry and helpless because of the incident.</p> <p>During a review of Resident 1's Admission Record (a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated Resident 1 was admitted to the facility on [DATE].</p> <p>During a review of Resident 1's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 9/5/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact.</p> <p>During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of dementia (mental disorder with loss of reasoning, thinking and remembering), muscle weakness, abnormalities of gait (walking) and mobility, urinary calculi (hard masses that form in the urinary tract), falls .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's BIMS score was 8 out of 15 which indicated Resident 2 had moderate cognitive impairment.</p> <p>During an observation on 10/25/24 at 11:02 a.m. with Resident 2 in Resident 2 ' s room, Resident 2 was observed assisted to the restroom by CNA 2.</p> <p>During an interview on 10/25/24 at 11:17 a.m. with Resident 2, Resident 2 stated she recalled that during the night she had requested to go to the restroom. Resident 2 stated she was told by the staff member to wet her bed because the staff member was not going to assist her to the restroom. Resident 2 stated she held the urge to urinate because she could not soil herself and laid in bed until her stomach hurt and was forced to urinate on her bed. Resident 2 stated she felt demeaned, humiliated and felt like she was wrong for wanting assistance to the restroom. Resident 2 stated she told the staff member that she was sorry, I know I could do better.</p> <p>During an interview on 10/25/24 at 11:22 a.m. with CNA 2, CNA 2 stated Resident 2 was continent of bowel and bladder and would use the restroom as needed. CNA 2 stated Resident 2 would stand, pivot and transfer to the restroom and to bed without any issues and requiring one-person moderate assistance. CNA 2 stated it was the facility expectation that assigned staff would assist residents when they requested to go to the restroom. CNA 2 stated it was not acceptable for a staff member to refuse to assist Resident 2 to the restroom.</p> <p>During a review of Resident 2 ' s, Activities of Daily Living (ADL) care plan (CP), dated 10/8/24, the CP indicated, . requires assistance with ADLs . call light within reach and answered promptly . transfers partial to moderate assist .</p> <p>During an interview on 10/25/24 at 11:39 a.m. with CNA 3, CNA 3 stated it was the facility ' s expectation for CNAs to assist residents with care, especially residents such as Resident 2 who used the restroom. CNA 3 stated it was important to maintain the resident ' s ability to transfer and use the restroom to keep residents from declining in physical function. CNA 3 stated, when CNA 1 refused to assist Resident 2 to the restroom, it was a form of neglect.</p> <p>During an interview on 10/25/24 at 11:47 a.m. with CNA 4, CNA 4 stated it was the facility expectation that staff assist all residents in the facility. CNA 4 stated staff could not refuse to assist a continent resident, such as Resident 2, to the restroom because it was the residents right. CNA 4 stated it was considered neglect, when CNA 1 refused to assist Resident 2 to the restroom. CNA 4 stated Resident 2 was put at risk for falls, and episodes of incontinence when she was not assisted.</p> <p>During an interview on 10/25/24 at 12:05 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was the facility expectation for staff to assist residents to the restroom if they are continent. LVN 1 stated it was not acceptable for any staff members to refuse to assist residents to the restroom and ask them to soil themselves. LVN 1 stated it as considered neglect when CNA 1 refused to assist Resident 2 to the restroom. LVN 1 stated Resident 2 was at risk for urinary tract infection, pain and falls when not assisted to the restroom.</p> <p>During an interview on 10/25/24 at 12:27 p.m. with the Director of Staff Development (DSD), the DSD stated it was the facility ' s expectation for staff to assist all residents with their needs. The DSD stated it was considered neglect and abuse when CNA 1 did not assist Resident 2 to the restroom.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/25/24 at 1:06 p.m. with the administrator (ADM), the ADM stated it was the facility ' s expectation that all staff will ensure residents were safe. The ADM stated CNA 1 had been removed from the facility and no longer working pending investigation. The ADM stated the facility was ensuring all residents were safe and free from abuse.</p> <p>During a telephone interview on 10/30/24 at 9:57 a.m. with CNA 1, CNA 1 stated she was no longer employed by the facility following incident on 10/14/24. CNA 1 stated she could not recall any incident involving residents the night of 10/14/24 and did not recall refusing to take any resident to the restroom. CNA 1 stated during her employment in the facility she was in serviced and trained on abuse and neglect.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Abuse, neglect, exploitation and misappropriation prevention program dated 2/2021, the P&P indicated, . Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but.is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms . Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to, facility staff, other residents .</p> <p>During a review of the facility ' s P&P titled, Resident Rights, dated 2/2021, the P&P indicated, . Employees shall treat all residents with kindness, respect, and dignity . free from abuse, neglect, misappropriation of property, and exploitation .</p>		