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 12/11/2024
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for one of three residents, (Resident 1), when Resident 1 was admitted on [DATE] with history of abnormalities of gait and mobility, assessed with severe cognitive impairment and the need for assistance with mobility, and experienced falls on 11/7/24, 11/8/24, 11/11/24, 11/14/24 and 11/15/24 and did not provide supervision and effective interventions to prevent falls in accordance with policies and procedures and professional standards of practice. These failures failure resulted in Resident 1 obtaining an acute, mildly displaced left intertrochanteric and subtrochanteric fractures (type of break in the bones near the hip) following the 11/15/24 fall and causing Resident 1 to undergo open reduction and external fixation (ORIF- surgical procedure that treats broken bones by inserting implants), avoidable pain and suffering, hospitalization from [DATE]-[DATE] and ongoing physical therapy (PT) to regain strength and balance. Findings : During a review of Resident 1's Admission Record (AR- 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] with diagnosis for syncope (fainting), repeated falls, orthostatic hypotension (low blood pressure that occurs when standing or sitting), Parkinson ' s disease (disorder that causes nerve cells in the brain to weaken or die), abnormalities of gait (walking) & mobility , bradycardia (slow heart beat), dizziness, muscle weakness, gout (causes joint pain and swelling due to uric acid build up), mood disorder, shortness of breath, hyperuricemia (condition of too much uric acid in the blood), hypertension (high blood pressure), cerebral aneurysm (a bulge in a blood vessel in the brain), arthritis (painful inflammation and stiffness of the joints). 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 11/11/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 4 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 had severe cognitive impairment. (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: 056301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s document titled, Incident by Incident Type- Falls, dated 12/4/24, the document indicated, Resident 1 had documented falls on 11/7/24, 11/8/24, 11/11/24, 11/14/24 and 11/15/24. During a record review of Resident 1 ' s, Fall Care Plan, dated 11/7/24, the CP indicated, .At risk for fall or injury due to impaired balance, weakness, orthostatic hypotension . During a record review of Resident 1 ' s, Fall Risk Evaluation, dated 11/8/24, the record indicated, Resident 1 had a documented fall risk score of 31 (a score 10 or higher indicates high risk for falls). During a record review of Resident 1 ' s Interdisciplinary Team (IDT- team that consists of various staff that are involved with resident ' s care) Post Fall Meeting, dated 11/8/24, the record indicated, . Resident had two unwitnessed falls that occurred on 11/8/2024 at approximately 2134 (9:34 p.m.) and 0440 (4:40 a.m.) . IDT recommendations fall mat to right side of bed- room change closer to nursing station for visibility- placed of fall program 11/8 . During a record review of Resident 1 ' s, Behavior Care Plan (CP), dated 11/8/24, the CP indicated, . behavior symptoms, non-compliance continuously removing brief, impulsive behavior continuously attempting to self-transfer, crawling out of bed and preferring to lay on floor . During a record review of Resident 1 ' s, Functional abilities section-GG, dated 11/11/24, the record indicated, Resident 1 required moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) to maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) for toileting, dressing, lying/sitting on side of bed, sit to stand and transfers wheelchair/bed. During a record review of Resident 1 ' s, IDT Post Fall Meeting, dated 11/14/24, the record indicated, . Resident had a witnessed fall that occurred 11/14/24 . continue with 30-minute checks, staff to assist resident with toileting after meals and at bedtime. Continue on fall program . During a review of Resident 1 ' s, Fall Care Plan, dated 11/14/24, the record indicated, . witnessed fall on 11/14/24 . interventions, 1 on 1 (staff member assigned to care for resident at all times) staff observation . During a record review of Resident 1 ' s, Post Fall Risk Evaluation, dated 11/14/24, the record indicated Resident 1 ' s fall risk score was 26 (Score 10 or higher indicated the resident is at high risk of fall). During a record review of Resident 1 ' s Clinical Alert, dated 11/15/24, the record indicated, CNA come at 7:30 a.m. went to the nurse got report what patient was on 1 on 1 CNA went to the doorway and saw the patient getting up and witness the patient fall . During a record review of Resident 1 ' s, Nurses Note, dated 11/15/24, the note indicated, . Resident was attempting to sit on her wheelchair when she slipped and fall hitting her head on the wall as per the CNA that witnessed the fall. Resident helped off the floor to the bed. An assessment was done with no visible cut to the head . Resident later transferred to the hospital . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During a record review of Resident 1 ' s, Post Fall Risk Evaluation, dated 11/15/24, the record indicated Resident 1 ' s fall risk score was 17 (Score 10 or higher indicated the resident is at high risk of fall). During a record review of Resident 1 ' s, Emergency department Results, dated 11/15/24, the record indicated, . there is an acute, mildly displaced left intertrochanteric and subtrochanteric fractures . During a review of Resident 1 ' s, Emergency Department Note, dated 11/15/24, the note indicated, . brought in by ambulance (BIBA) from [facility name] for fall. Patient got up to use the restroom using her walker and tripped fell to left side striking left side of head. Patient main complaint is left leg pain . During a review of Resident 1 ' s, Operative Report, dated 11/16/24, the report indicated, . procedure performed open treatment of left intertrochanteric femur fracture with cephalomedullary nailing (form of fixation that restores length, alignment and rotation of the femur) . During a review of Resident 1 ' s, Orthopedic Trauma Progress Note, dated 11/17/24, the note indicated, . post operation day 1 status post left hip ORIF. Plan weight bearing as tolerated to left lower extremity, physical therapy and occupational therapy evaluation and treatment . During an interview on 12/4/24 at 1:04 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated the facility process was for residents who had two or more falls within a 24-hour period, would have been placed on one -to-one care until further notice. CNA 1 stated the purpose of the one-to-one care was to prevent falls and to keep the residents safe. CNA 1 stated when a resident was assigned a one-on-one care, it indicated a staff member was expected to be with the resident at all times. During an interview on 12/4/24 at 1:15 p.m. with licensed vocational nurse (LVN) 1, LVN 1 stated it was the facility process to assign one to one care for residents who had two or more falls in a 24-hour period. LVN 1 stated the one-on-one care was implemented to prevent further falls and for resident safety. During a concurrent interview and record review on 12/4/24 at 2:03 p.m. with the director of nursing (DON), Resident 1 ' s, Fall Care Plan, dated 11/14/24 was reviewed. The Fall Care Plan indicated, . Witnessed fall on 11/14/24 . interventions, 1 on 1 staff observation . The DON stated on 11/14/24, Resident 1 was assigned a one-to-one care that began on the afternoon shift from 2 p.m. to 10:30 p.m. The DON stated on the night shift of 11/14/24-11-15/24 from 10:30 p.m. to 7:30 p.m., there was no staff assigned for one-on-one care for Resident 1 until 7:30 a.m. on 11/15/24. The DON stated Resident 1 had a fall on 11/15/24 during shift change at 7:30 a.m. when the night shift staff left and the morning staff began their shift. The DON stated Resident 1 was confused, non-compliant with care and had behaviors that included attempting to get out of bed without assistance. The DON stated Resident 1 had a total of five falls in the facility since admission. The DON stated the facility process was for residents to be put on one-to-one care when the resident had two or more falls in 24-hour period. The DON stated, a staff sould have been assigned 1:1 care to monitor Resident 1 and prevent an avoidable fall on 11/15/2024. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 12/5/24 at 12:40 p.m. with LVN 4, LVN 4 stated on 11/14/24, Resident 1 was supposed to have a staff member assigned to a one on one care. LVN 4 stated, Resident 1 did not have a staff member assigned prior to Resident 1 ' s fall on 11/15/24. LVN 4 stated the facility process was for a resident who had two or more falls in a 24-hour period, be assigned a staff member for one-to-one care. LVN 2 stated according to the facility policy, Resident 1 should have had a staff member assigned for one on one due to multiple falls and had behaviors that included attempting to self transfer and noncompliance with asking for assistance. LVN 4 stated Resident 1, should have had a staff member present during an avoidable fall that occurred on 11/15/24. During a telephone interview on 12/10/24 at 10:45 a.m. with family member (FM 1), FM 1 stated Resident 1 was able to complete all task while at home including walking and transferring prior to admitting to the facility. FM 1 stated it was not normal for Resident 1 to have had five falls in the facility as Resident 1 was only in the facility for short term rehabilitation. During an interview on 12/11/24 at 10:55 a.m. with registered nurse (RN) 1, RN 1 stated the facility process was for residents with or more falls in 24 hours to have been placed on one-to-one care. RN 1 stated that the process was to inform the DON of all falls and the DON determined when a resident was placed on one-to-one care, 30-minute monitoring or 15-minute monitoring. RN 1 stated apart from the DON, the charge nurse and nurse assigned to resident could have assigned a one-on-one care as needed for the Resident 1's safety. During an interview on 12/11/24 at 11:11 a.m. with LVN 3, LVN 3 stated the facility process for falls was for residents who experience two or more falls in 24 hours be placed on one-on-one care. LVN 3 stated the process was to inform the DON of all falls and the DON would decide who and when would be placed on one-to-one care. LVN 3 stated the one-to-one care could have benefited residents by preventing falls and ensuring safety. During an interview on 12/11/24 at 11:34 a.m. with the administrator (ADM), the ADM stated there was a new fall program implemented for the facility that included revision of the policy. The ADM stated it was the facility expectation for all staff to follow the new implementations related to falls. During a telephone interview on 12/18/24 at 9:01 a.m. with CNA 2, CNA 2 stated that on the morning of 11/15/24, she was called to the facility for a 1 on 1 care for Resident 1. CNA 2 stated she had arrived to the facility between 7:30 a.m. and 8:00 a.m., when CNA 2 arrived she reported to LVN 4 for report and update on Resident 1. CNA 2 stated the morning shift had begun at 6:00 a.m. that morning and when she arrived there was no one assigned to Resident 1. CNA 2 stated after receiving report from LVN 4, she entered Resident 1 ' s room and observed Resident 1 standing and then falling to the floor. CNA 2 stated Resident 1 had behaviors of transferring without assistance, noncompliance and attempting to walk without supervision. CNA 2 stated, Resident 1 ' s fall would have been avoidable if there was a staff member present for 1 on 1 care as assigned. During a review of the facility ' s policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 11/2024, the P&P indicated, . Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . The facility recognizes frequent falling to be 2 falls in 30 days. If a resident falls 2 or more times within 24 hours they will be placed one on one supervision for 72 hours and will be reevaluated by IDT for further interventions, if needed .

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	056301	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Modesto Care Center	1900 Coffee Road Modesto, CA 95355

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review the facility failed to ensure residents were free of significant medication error for one of four sampled residents (Resident 1), when Resident 1 was administered the Insulin (a hormone that helps regulate blood sugar level) without a physician order and diagnosis. This failure had the potential to result in Resident 1 experiencing a hypoglycemic event (occurs when the body ' s sugar levels drop too low) causing trembling or shaking, weakness, sweating or chills, dizziness or lightheadedness, confusion or trouble concentrating, irritability, tingling or numbness of the lips, tongue or cheeks and had the potential to result in death. Findings: During a review of Resident 1's Admission Record (AR- 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] with diagnosis for syncope (fainting), repeated falls, orthostatic hypotension (low blood pressure that occurs when standing or sitting), Parkinson ' s disease (disorder that causes nerve cells in the brain to weaken or die), abnormalities of gait (walking) & mobility, bradycardia (slow heart beat), dizziness, muscle weakness, gout (causes joint pain and swelling due to uric acid build up), mood disorder, shortness of breath, hyperuricemia (condition of too much uric acid in the blood), hypertension (high blood pressure), cerebral aneurysm (a bulge filled with blood in the brain), arthritis (painful inflammation and stiffness of the joints). 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 11/11/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 4 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 had severe cognitive impairment. During an interview on 12/4/24 at 1:44 p.m. with licensed vocational nurse (LVN) 1, LVN 1 stated it was important to accurately document physician orders to avoid administration of the wrong medication to the wrong resident. LVN 1 stated Resident 1 had a potential for harm when the medication for insulin was administered. (continued on next page)

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	056301	A. Building B. Wing	12/11/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/4/24 at 2:03 p.m. with the director of nursing (DON), Resident 1 ' s, Physician Order (PO), dated 11/10/24, and Medication Administration Record (MAR), dated 11/2024 were reviewed. The PO indicated, . Insulin Lispro injection solution . inject 5 unit (unit of measure) subcutaneously (beneath the skin) before meals for hyperglycemia (high blood sugar) . The MAR indicated, Resident was administered insulin lispro (type of insulin) on 11/10/24. The DON stated Resident was administered insulin medication on 11/10/24 as a result of a medication error. The DON stated on 11/11/24, LVN 3 received a PO for another resident in the facility for insulin. The DON stated LVN 3 incorrectly documented the PO on Resident 1 ' s electronic medical record (EMR). The DON stated LVN 3 identified the medication error the next morning on 11/11/24 and contacted the physician. The DON stated Resident 1 was placed on 72 hour monitoring for signs and symptoms of low blood sugar and any side effects resulting from the medication error. The DON stated Resident 1 ' s blood sugar was monitored every four hours for one day. During a record review of Resident 1 ' s, PO, dated 11/10/24, the PO indicated, . Insulin Lispro injection solution . inject 5 unit (unit of measure) subcutaneously (beneath the skin) before meals for hyperglycemia (high blood sugar) . During a record review of Resident 1 ' s, Medication Administration Record (MAR), dated 11/2024, the record indicated, Resident was administered medication (insulin lispro) on 11/10/24. During a review of Resident 1 ' s, MAR-fasting blood sugar, dated 11/24, the MAR indicated, . fasting blood sugar (FSBS) every four hours for one day . The MAR indicated Resident 1 ' s blood sugar was checked from 11/11/24-11/12/24. During concurrent telephone interview and record review on 12/5/24 at 12:40 p.m. with LVN 3, LVN 3 stated she had documented the incorrect PO on Resident 1 ' s EMR. LVN 3 stated she had identified the medication error when she arrived the next morning on 11/11/24. LVN 3 stated she contacted the physician to report the medication error and physician gave new order for blood sugar check every four hours for one day. LVN 3 stated Resident 1 did not have a history of diabetes and was not receiving blood sugar checks prior to medication error. LVN 3 stated when Resident 1 was administered the medication (insulin lispro) in error, there was a possibility of hypoglycemia (low blood sugar) and death. During an interview on 12/11/24 at 10:55 a.m. with registered nurse (RN) 1, RN 1 stated it was important to ensure the right medication was administered to the right resident. RN 1 stated when Resident 1 was administered the incorrect medication (insulin lispro) there was a risk for hypoglycemia. During an interview on 12/11/24 at 11:11 a.m. with LVN 4, LVN 4 stated the expectation was to ensure the right medication was administered to the right resident. LVN 4 stated, when Resident 1 received incorrect medication (insulin lispro), there was potential for hypoglycemia or death. During a review of the facility ' s policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, . Medications are administered in a safe and timely manner, and as prescribed . medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the director of nursing services . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled, Adverse Consequences and Medication Errors, dated 4/2014, the P&P indicated, . The interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate . Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported . An adverse drug reaction (ADR), a form of adverse consequences, is defined as a secondary and usually undesirable effect of a drug and is different from the therapeutic and helpful effects of the drug . A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services . Examples of medications errors include . unauthorized drug - a drug is administered without a physician's order .