STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056301	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Modesto Care Center	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 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** Based on interview and record review the facility failed to ensure residents were free from significant medication errors according to their policy and procedure titled, Medication Administration for two of three residents (Resident 2, Resident 4) when on 6/11/26 Licensed Vocational Nurse (LVN) 1 did not administer scheduled medication Insulin (used to manage blood sugar by lowering the glucose) for diabetes mellitus (disorder that causes high blood sugar levels and body cannot produce or use insulin) as ordered by the physician. This failure had the potential for delayed medication effects, causing adverse reactions such as high or low blood sugar, dizziness, increased thirst, shakiness and medication ineffectiveness.Findings: During a review of Resident 2's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis for type 2 diabetes mellitus. During a review of Resident 2's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated 5/7/26, the MDS indicated, Resident 2's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 12 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 moderate cognitive impairment. During a review of Resident 4's admission Record, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnosis for protein calorie malnutrition. During a review of Resident 4's Minimum Data Set, dated [DATE], the MDS indicated Resident 4's BIMS score was 15, which indicated Resident 4 was cognitively intact. During an interview on 6/11/26 at 12:00 p.m. with Resident 4, Resident 4 stated she had a complaint regarding her medications being administered late. Resident 4 stated that she did not receive medications on time and instead had to keep calling the staff into her room to alert the nurse that the medications were due. Resident 4 stated she would press the call light on multiple occasions to ensure she received her scheduled medications daily. Resident 4 stated it was important to receive scheduled medications on time because she needed them to manage her health and because the physician felt it would help her. During a review of Resident 4's document titled, Medication Administration Record (MAR), dated 6/2026, the MAR indicated, . Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale. before meals and at bedtime for high blood sugar -Start Date- 06/03/2026. Scheduled at 7:00 a.m., 11:00 a.m. The MAR indicated Resident 4 was scheduled to receive insulin administration before meals daily. The MAR also indicated that on 6/11/26, Resident 4 was scheduled to receive insulin at 11:00 a.m. but was administered insulin at 2:33 p.m. During an interview on 6/11/26 at 12:41 p.m. with Resident 2, Resident 2 stated he had a complaint regarding his medication administration not completed on time. Resident 2 stated he was concerned about the medication administration for insulin used to manage his high blood sugar. Resident 2 stated the insulin medication was supposed to be administered before meals daily. Resident 2 stated that on 6/11/26, LVN 1 had administered the insulin medication past the administration time for breakfast and for lunch. Resident 4 stated he was scheduled to receive (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication this morning before breakfast when his blood sugar was at 298 at 6:53 am, but Resident 2 stated he didn't get his insulin until after 9:00 a.m. Resident 2 stated he was concerned for the management of his diabetes due to not receiving the scheduled insulin at the time it was due. During a review of Resident 2's document titled, Medication Administration Record (MAR), dated 6/2026, the MAR indicated, . Humalog kwikpen Solution pen injector 100 UNIT/ML (Insulin Lispro) Inject 12 unit subcutaneously (under the skin) before meals for diabetes mellitus. start date 6/3/26 . Scheduled at 7:00 a.m., 11:00 a.m. The MAR indicated that on 6/11/26, Resident 2 was scheduled to receive insulin at 7:00 a.m. but was not administered medication until 9:42 a.m. and was also scheduled to receive insulin at 11:00 a.m. but was not administered insulin until 1:44 p.m. During an interview on 6/11/26 at 1:01 p.m. with LVN 2, LVN 2 stated the facility process with medication administration was for the nurses to follow the physician orders for resident medication administration. LVN 2 stated that during medication administration, there was a timeframe that should be followed to ensure medications were administered on time. LVN 2 stated the scheduled medications could have been administered one hour before or one hour after the scheduled time. LVN 2 stated the facility process was to check residents' blood sugar before meals and administer insulin as ordered. LVN 2 stated that any deviation from the physician order would need a physician notification. LVN 2 stated that residents were at risk for unmanaged blood sugars when they were not administered scheduled insulin according to the physician order. During an interview on 6/11/26 at 1:28 p.m. with the director of staff development (DSD), the DSD stated the facility expectation was for all nurses to follow the physician orders and administer medications timely and safely. The DSD stated the facility process was for the nursing staff to ask the administration staff for assistance when they could not complete medication administration timely or when there were other issues preventing the nurses from completing the medication administration. The DSD stated she had not been notified by LVN 1 that medications were administered late or not on time. During an interview on 6/11/26 at 1:37 p.m. with the Registered Nurse Supervisor (RNS), the RNS stated the RNS responsibilities included assessing residents, delegating responsibilities and assisting the nursing staff when needed. The RNS stated she had not been notified by LVN 1 that medications were administered late or not on time. During an interview on 6/11/26 at 1:57 p.m. with LVN 1, LVN 1 stated she was the nurse caring for Resident 2 and Resident 4. LVN 1 stated she began her medication administration for residents at around 7:00 a.m. and recalled being late on administering some of the medications to residents in the morning during breakfast. LVN 2 stated that due to unforeseen circumstances, medications were given late for breakfast, therefore causing the lunch medication to also be late. LVN 1 stated that blood sugar checks appear at 11:00 a.m. with insulin administration as ordered by the physician. LVN 2 stated that she did not administer insulin as ordered to residents before the residents consume their meals. LVN 1 stated this could result in residents to not eat causing blood sugars to become low. LVN 1 stated she waited until after the residents had their meals to administer insulin medication. LVN 1 stated that on 6/11/26, she had started the medication administration at around 12:15 p.m., after the scheduled ordered time for residents to receive insulin medication and blood sugar check. LVN 1 stated when medications were administered late or not on time, the residents were at risk of receiving too much of a dose if it was given too close to the next administration time and could have affected the residents' blood sugar and diabetes management. During an interview on 6/11/26 at 2:17 p.m. with the administrator (ADM), the ADM stated the facility expectation was for the nursing staff to administer medications timely. The ADM stated that nursing staff should have asked the administration staff for assistance when medications were scheduled and there were other unforeseen circumstances occurring. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are determined by resident need and benefit, not staff convenience. Medications are administered within one hour of their prescribed time, unless otherwise specified.For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure therapeutic diets were followed according to physician orders for one of five sampled residents (Resident 1) when on 6/11/26, the facility staff served Resident 1 a meal tray with a regular consistency (diet with no alterations) and Resident 1 had a physician diet order for soft and bite sized textured meals. This failure resulted in Resident 1 experiencing episode of inability to chew his food and had the potential to cause malnutrition, choking, aspiration and death.Findings: During a review of Resident 1's admission Record (AR- a summary of information regarding a resident 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 protein calorie malnutrition. 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 6/17/25, 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. During a concurrent observation and interview on 6/11/26 at 12:37 p.m. with Resident 1, in Resident 1's room, Resident 1 was observed attempting to chew his food served on his meal tray. Resident 1 was observed spitting food out his mouth and stated, I can't chew this. Resident 1 stated the food that was served was hard to chew and swallow since he did not have any teeth. Resident 1 was observed opening his mouth to show the surveyor that he did not have any teeth. During a review of Resident 1's, Meal tray Ticket, dated 6/11/26, the meal tray ticket indicated, . [Resident 1] Consistency: Soft bite and bite sized. During a review of Resident 1's, Nutrition Care Plan, dated 12/28/25, the care plan indicated, [Resident 1] is on a therapeutic and mechanically altered texture diet, thin liquids. Interventions. Provide, serve diet as ordered. During a review of Resident 2's admission Record, the AR indicated, Resident 2 was admitted to the facility on [DATE]. During a review of Resident 1's MDS dated [DATE], the MDS indicated, Resident 1's BIMS score was 14 which indicated Resident 1 was cognitively intact. During an interview on 6/11/26 at 12:41 p.m. with Resident 2, Resident 2 stated he had alerted CNA 1 and LVN 1 regarding Resident 1's lunch meal as he believed Resident 1 was served the incorrect meal tray. Resident 2 stated he felt frustrated because both CNA 1 and LVN 1 were checking the electronic medical record (EMR) and meal tray ticket for confirmation that the meal served was correct. Resident 1 stated CNA 1 and LVN 1 should have been looking at the food on the meal tray and assessing Resident 1's inability to chew. During a concurrent observation and interview on 6/11/26 at 12:44 p.m. with licensed vocational nurse (LVN) 1 in Resident 1's room, Resident 1's meal tray was observed. LVN 1 stated that after review of Resident 1's diet order in the EMR, the meal tray ticket and observation of the meal tray served, Resident 1 was served the incorrect diet. Resident 1 stated he could not chew the food on the meal tray because he did not have any teeth. LVN 1 stated she was not comfortable downgrading Resident 1's food and instead would notify the speech therapists for an evaluation of Resident 1's inability to chew his food. During an interview on 6/11/26 at 12:58 p.m. with certified nursing assistant (CNA) 1, CNA 1 stated she had served Resident 1 his lunch and was caring for Resident 1. CNA 1 stated that Resident 1's roommate (Resident 2) had alerted CNA 1 that Resident 1's food was served incorrectly and needed to be checked. CNA 1 stated she proceeded to check with LVN 2 to ensure the diet was served correctly for Resident 1. CNA 1 stated that LVN 2 compared the meal tray ticket with the physician order in the EMR and ensured CNA 1 that the diet was correct. CNA 1 stated she then proceeded to inform Resident 1 that the diet was served correctly. During a concurrent interview and record review on 6/11/26 at 1:01p.m. with (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2, a photo taken at 12:37 p.m. of Resident 1's lunch meal tray served on 6/11/26 and Resident 1's EMR were reviewed. LVN 2 stated that according to the EMR, Resident 1 had a diet order that indicated his diet should have been served soft and bite sized texture with thin liquids. LVN 2 stated that after reviewing the photo of the meal tray served, the food on the tray appeared like a regular texture and was not consistent with Resident 1's diet order for soft and bite sized texture. LVN 2 stated that Resident 1 was at risk for choking when he was served the incorrect textured food and was unable to chew the food served on his meal tray. During a concurrent interview and record review on 6/11/26 at 1:18 p.m. with the certified dietary manager (CDM), a photo taken at 12:37 p.m. of Resident 1's lunch meal tray served on 6/11/26 and Resident 1's meal tray ticket was reviewed. The CDM stated that the meal served on Resident 1's lunch tray appeared to be the incorrect diet and consistency. The CDM stated that Resident 1 should have received soft and bite sized texture which he did not. The CDM stated the expectation was for the dietary staff to follow the physician ordered diets for all residents and to ensure the meals were served with the correct texture and consistency. The CDM stated the expectation once the meals leave the kitchen, was for the nursing staff to then observe and ensure the meals served were served according to the physician's order. The CDM stated Resident 1 was at risk for aspirating or choking when he was served the incorrect meal texture. During a concurrent interview and record review on 6/11/26 at 1:28 p.m. with the director of staff development (DSD), a photo taken at 12:37 p.m. of Resident 1's lunch meal tray served on 6/11/26 and Resident 1's meal tray ticket was reviewed. The DSD stated that Resident 1's meal was not consistent with the diet order for soft and bite sized texture. The DSD stated that based on the photo and the meal tray ticket, Resident 1 was served the incorrect diet. The DSD stated the facility process was for the nurse to assess Resident 1's difficulty in chewing his food, identifying the incorrect diet texture and calling the physician to downgrade Resident 1's diet. The DSD stated this process would ensure Resident 1 was able to consume his meals until the speech therapists could evaluate Resident 1 for diet changes. The DSD stated the expectation was for the nurses and CNA's to ensure the residents were given the correct diet and texture prior to serving the residents their meals. The DSD stated Resident 1 was at risk for inability to chew his food, aspiration or choking. During a concurrent interview and record review on 6/11/26 at 1:54 p.m. with Registered Dietitian (RD), a photo taken at 12:37 p.m. of Resident 1's lunch meal tray served on 6/11/26 and Resident 1's meal tray ticket was reviewed. The RD stated that based on the meal tray observed and meal tray ticket, Resident 1 was not given a diet consistent with soft and bite sized textured food. The RD stated the expectation was for the dietary staff to follow the physician orders for resident diets. During an interview on 6/11/26 at 2:17 p.m. with the administrator (ADM), the ADM stated the facility expectation was for the facility staff who were serving residents meal trays, to observe each meal tray individually, not only the meal tray ticket and the physician order. The ADM stated the process included the dietary cook, dietary aide, nurses and then the CNA were responsible for ensuring Resident 1's meal was served correctly and consistently with physician order. During a review of the facility's policy and procedure (P&P), titled, Therapeutic Diets, dated 2017, the P&P indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. Diet order should match the terminology used by the food and nutrition services department. A ?therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. If a mechanically altered diet is ordered, the provider will specify the texture modification. The dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets. As appropriate, the attending physician may temporarily suspend a therapeutic diet for special occasions. The attending physician may liberalize the diet at the request of the IDT (if the resident is losing weight or not eating well) or the resident.