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	06/24/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient nursing staff to meet resident needs when medications were given over 60 minutes late to seven out of seven sampled residents (Residents 1-7).This failure had the potential to result in subˆtherapeutic serum levels (medication levels dropping below the minimum needed to work), microbial resistance (bacteria becoming resistant to antibiotics), sudden metabolic or physiological instability (vital signs or blood chemistry becoming dangerously unbalanced), and complications with medications that have a narrow therapeutic range (where even small delays can make the dose ineffective or dangerous) leading to longer hospital stays, irreversible organ damage, or death.During a concurrent interview and observation on 6/24/26 at 11:22 am with Licensed Vocational Nurse (LVN) 1, LVN 1 was charting at the nurse's station. LVN 1 stated she had administered medications late because she did not have enough time to give all medications on schedule while also caring for each resident. LVN 1 stated she had worked several shifts where she was assigned more than 30 residents. LVN 1 explained she was responsible for many tasks in addition to giving medications including checking blood sugar levels before breakfast and giving insulin (a hormone that controls sugar in the blood), checking breakfast trays for correct diets, starting gastrostomyˆtube feedings (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach), admitting and discharging residents, preparing residents for medical appointments, assessing residents, calling doctors for new orders, cleaning and redressing wounds as needed, helping Certified Nursing Assistant's when needed, making care plans (guide to support health), following changeˆofˆcondition documentation and protocol, completing all charting, and responding to resident injuries. LVN 1 stated when residents were injured, she had to assess the injury, call the doctor and family, and arrange transfer to the emergency room. LVN 1 said she told management she had too many residents and could not finish all her work on time, but management told her she should be able to and needed to work faster.During a concurrent interview and observation on 6/24/26 at 12:15 pm with LVN 2, LVN 2 was at her medication cart speaking with a resident in a wheelchair about pain medication. LVN 2 told the resident the pain medication was not due yet and offered to call the doctor for an additional order. The resident agreed and rolled away. LVN 2 said she had just finished her morning medication pass, which started at 6:45 am LVN 2 stated at least four of her residents (Residents 4, 5, 6, and 7) received their medications late that morning. LVN 2 said medications were considered late if they were not given within 60 minutes of the scheduled time. LVN 2 stated it was almost impossible to finish medication passes on time due to the number of residents she was assigned. LVN 2 stated she was also responsible for wound care, care for new amputations, blood sugar checks, insulin before meals, checking meal trays for dietary accuracy, teaching spirometer use (a device to measure lung function), and helping CNAs. LVN 2 said it's a lot to do and explained that nurses also needed to interact with residents and could not just walk away when residents wanted to talk. LVN 2 stated residents had complained about other nurses giving them their medications late. LVN 2 stated she asked management to add another nurse to the shift, but management told her staffing was adequate and she should be able to finish her work on time.During a concurrent interview and record review on (continued on next page)

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

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	6/24/26 at 12:25 pm with LVN 2, Medication Administration Records (MARs) for Residents 1-7 dated 6/24/26 were reviewed. The MARs reviewed indicated the following: Resident 1's MAR indicated, one late medication (Hydralazine hydrochloride oral tablet 50 milligrams ordered for midnight and given at 1:07 a.m., 7 minutes late).Resident 2's MAR indicated, one late medication (Hydrocodone-Acetaminophen Tablet 5-325 mg ordered for 12:00 p.m. and given at 1:01 p.m., 1 minute late).Resident 3's MAR indicated, six late medications (insulin lispro pen subcutaneous solution then pen injector sliding scale prescribed for 7:00 a.m. given at 9:04 a.m., 1 hour 4 minutes late; levothyroxine sodium oral tablet 75 micrograms ordered for 7:00 a.m. given at 9:04 a.m., 1 hour and 4 minutes late; vitamin D oral tablet ordered for 8:00 a.m. given at 9:06 p.m., 1 hour and 6 minutes late; sertraline hydrochloride oral tablet 25 milligram ordered for 8:00 a.m. given at 9:06 a.m., 1 hour and 6 minutes late; clopidogrel bisulfate tablet 75 milligram ordered for 8:00 a.m. given at 9:06 a.m., 1 hour and 6 minutes late; aspirin Enteric Coated tablet delayed release 81 milligram ordered for 8:00 a.m. given at 9:04 a.m., 1 hour and 4 minutes late.Resident 4's MAR indicated, 10 late medications (liquid protein supplement due at 8:00 a.m. given at 10:21 a.m., 1 hour and 21 minutes late; amiodarone 200 mg ordered for 8:00 a.m. given at 10:21 a.m., 1 hour and 21 minutes late; docusate 100 mg ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; metoprolol tartrate 25 mg ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; ascorbic acid 1000 mg ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; apixaban 5 mg ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; lactulose 10 g ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; tamsulosin 0.4 mg ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; multivitamin ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late; oxybutynin chloride Extended Release 5 mg ordered for 8:00 a.m. given at 10:22 a.m., 1 hour and 22 minutes late).Resident 5's MAR indicated, 10 late medications (propranolol 20 mg ordered for 7:00 a.m. given at 10:00 a.m., 2 hours late; hydralazine 25 mg ordered for 7:00 a.m. given at 10:00 a.m., 2 hours late; psyllium dietary fiber ordered for 8:00 am given at 10:01 a.m., 1 hour and 1 minute late; docusate 100 mg ordered for 8:00 a.m. given at 10:00 a.m., 1 hour late; omeprazole DR 20 mg ordered for 8:00 a.m. given at 10:01 a.m., 1 hour and 1 minute late; dutasteride 0.5 mg ordered for 8:00 a.m. given at 10:00 a.m., 1 hour late; sucralfate 1 g ordered for 8:00 am given at 10:01 am, 1 hour and 1 minute late; sennosides 8.6 mg ordered for 8:00 a.m. given at 10:01 a.m., 1 hour and 1 minute late; buspirone 7.5 mg ordered for 8:00 a.m. given at 10:00 a.m., 1 hour late; lisinopril 20 mg ordered for 8:00 a.m. given at 10:01 a.m., 1 hour and 1 minute late).Resident 6's MAR indicated, 2 late medications (lorazepam//Haloperidol/diphenhydramine cream ordered for 8:00 a.m. applied at 11:09 a.m., 1 hour and 9 minutes late; lorazepam 0.5 mg ordered for 8:00 a.m. given at 11:09 a.m., 1 hour and 9 minutes late).Resident 7's MAR indicated, 7 late medications (amiodarone 200 mg ordered for 8:00 a.m. given at 10:10 a.m., 1 hour and 10 minutes late; midodrine 5 mg ordered for 8:00 a.m. given at 10:11 a.m., 1 hour and 11 minutes late; insulin aspart 25 units ordered for 8:00 a.m. given at 10:12 a.m., 1 hour and 12 minutes late; carvedilol 12.5 mg ordered for 8:00 a.m. given at 10:12 a.m., 1 hour and 12 minutes late; fludrocortisone 0.1 mg ordered for 8:00 a.m. given at 10:12 a.m., 1 hour and 12 minutes late; apixaban 5 mg ordered for 8:00 a.m. given at 10:12 a.m., 1 hour and 12 minutes late).LVN 2 stated she was not aware of any negative effects from these late medications but agreed some late doses, such as insulin, could cause lifeˆthreatening complications like dangerously high blood sugar.During a concurrent interview and record review on 6/24/26 at 12:44 pm, with the Assistant Director of Nursing (ADON), staffing schedules were reviewed. The ADON stated the facility knew medications were being given late and confirmed that nurses had been complaining about being assigned to too many residents and not having enough time to complete all care. The ADON said the facility did not conduct audits or measurements to ensure adequate staffing. The ADON stated administration would know if there was not enough staffing coverage by late documentation, nurses staying overtime, or medications given late. ADON stated that no staffing adjustments have been made despite nursing complaints and knowledge of late medication administration.During an interview on 6/24/26 at 12:44 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	p.m. with Administrator (ADM) 2, ADM 2 stated a nurse surveyor had visited the facility on 6/11/26 and was already citing the facility for late medication administration. ADM 2 validated medications had been administered late since the visit on 6/11/26.During a concurrent interview and record review on 7/1/26 at 2:43 p.m. with ADM 1 and the Director of Nursing (DON), the Medication Admin Audit Report from 6/12/26 to 6/24/26 and the facility policy titled Administering Medications (April 2019) were reviewed. The DON stated late medication administration was first reported to the facility on 6/11/26. DON stated medication errors occurred when medications were given outside the 60ˆminute window before or after the scheduled time. DON stated only one LVN had been identified as administering medications late at that time and received in-service training and monitoring. DON stated she knew nurses were complaining about being assigned too many residents, but she did not adjust staffing because the facility believed it met and exceeded staffing numbers. DON stated some signs indicating more staff were needed are nurses working overtime, unfinished charting, and late medication administration. DON and ADM 1 stated they had not realized the severity of the problem until reviewing the Medication Admin Audit Report from 6/12/26 to 6/24/26, which indicated 83 residents had medication errors during that time frame. ADM 1 said Medical Records was responsible for running audits but had not been doing so. DON stated she was ultimately responsible for ensuring the nurses were administering medications properly. Both the DON and ADM 1 admitted by not auditing late medications, the facility did not realize how many medications were being administered late and so they did not know they needed to review the instances and determine the cause of the late medications. DON and ADM 1 stated administering medications over one hour late and not running audits, the facility had not been following its medication administration policy.During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 2. The Director of Nursing Services supervises and directs all personnel who administer medications and/or have related functions. 3. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions; and c. Honoring resident choices and preferences, consistent with his or her care plan. 6. Medications errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.During a review of the facility's P&P titled Staffing, Sufficient and Competent Nursing, dated August 2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. assessing, evaluating, planning and implementing resident care plans; and d. responding to resident needs. 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: a. Resident rights; b. Behavioral health; c. Psychosocial care; d. Dementia care; e. Person centered care; f. communication; g. Basic nursing skills; h. Basic restorative services; i. Skin and wound care; j. Medication management; k. Pain management; l. Infection control; m. identification of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	changes in condition; and n. Cultural competency. 7. Inquiries or concerns relative to our facility's staffing should be directed to the director of nursing services (DNS) or his/her designee.