

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Golden Empire		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Dorsey Drive Grass Valley, CA 95945	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45315</p> <p>Based on interview and record review, the facility failed to monitor one out of three sampled residents (Resident 2) that were prescribed an antipsychotic medication (altered brain activity) when there was no monitor in place for staff to evaluate the response or effectiveness of Resident 2 ' s prescribed Haloperidol (Haldol, an antipsychotic) use.</p> <p>This failure could result in the unnecessary use of an antipsychotic medication and cause a decline in overall health status.</p> <p>Findings:</p> <p>A review of the facility ' s policy and procedure (P&P) titled, Care of Residents with Dementia and Care of Residents with Dementia Receiving an Antipsychotic Medication, revised 12/29/23, indicated, antipsychotic medications would be closely monitored for effectiveness.</p> <p>A review of Resident 2 ' s undated Admissions Record, indicated, Resident 2 was admitted to the facility on [DATE] with the diagnosis of dementia (memory loss) and severe major depressive disorder (a sad mood) with psychotic features (symptoms that affected the mind that included an inability to recognize what was real or what was not real and affected thought and behavior). Resident 2 was not her own responsible party and was dependent upon family to make all medical and financial decisions.</p> <p>A review of Resident 2 ' s Orders, dated 12/26/23, indicated the facility ' s physician ordered Haldol 0.5 milligrams (mg, unit of measure), one tablet by mouth two times a day for psychotic disorder due to extreme paranoia that caused extreme fear and distress.</p> <p>A review of Resident 2 ' s Orders, dated 1/4/24, indicated the physician increased Resident 2 ' s Haldol dose, from two tablets a day, to three tablets a day.</p> <p>A review of Resident 2 ' s Care Plan (a document that outlined care a resident received), dated 12/26/23, indicated Resident 2 used Haldol for behavior management and that facility staff would monitor Resident 2 for behaviors and symptoms of extreme paranoia that caused fear and distress. The Care Plan, indicated, facility staff would document per facility protocol.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Golden Empire		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Dorsey Drive Grass Valley, CA 95945	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/3/24 at 1:50 pm, with Director of Nursing (DON), Resident 2 ' s Medication Administration Record (MAR), dated 12/27/23 through 4/3/24 was reviewed. DON stated, the facility physician and pharmacist utilized the data collected from the behavior monitor, located in the MAR, to determine the appropriate dose and effectiveness of antipsychotics that were ordered for residents. DON confirmed, Resident 2 had been prescribed Haldol on 12/26/23, confirmed there was no monitor in place that tracked Resident 2 ' s behaviors from 12/26/23 through 4/3/24, and stated there should have been.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Golden Empire		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Dorsey Drive Grass Valley, CA 95945	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45315</p> <p>Based on observation, interview, and record review, the facility failed to report an outbreak of scabies (tiny mites that crawled under the skin, caused itching, a rash, and was easily spread from person-to-person) to the California Department of Public Health (CDPH, worked to protect the public ' s health) when three residents and one staff member tested positive for scabies.</p> <p>This failure had the potential to cause further spread of scabies to other residents.</p> <p>Findings:</p> <p>A review of AFL 23-08 (All Facilities Letter (AFL), information regarding updated rules, provided to facilities, from CDPH), dated 1/18/23, indicated, the purpose of the AFL reminded facilities of the requirement to report outbreaks (more cases of a disease or infection than expected) to CDPH along with the local public health officer (public health, a resource to the community, that assisted facilities during an outbreak of disease or infection).</p> <p>A review of the undated policy titled, Outbreak Reporting, indicated, the facility would Report all suspected and confirmed outbreaks . to CDPH and the local public health officer.</p> <p>A review of the policy titled, Reporting Communicable Diseases, dated, 7/1/14, indicated, the facility ' s infection preventionist (IP, responsible to preventing the spread of infection and education) was responsible for reporting outbreaks to CDPH and the local public health officer.</p> <p>During an interview on 4/3/24 at 10:08 am, licensed nurse (LN) A stated, Resident 1 had a rash that spread all over Resident 1 ' s body and all 20 residents who lived in the facility ' s dementia (a disease the caused memory loss) unit were treated for scabies as a preventative measure.</p> <p>During a concurrent observation and interview on 4/3/24 at 10:22 am, located in the facility ' s dementia unit, a bag like container that contained personal protective equipment (gloves, isolation gown, shoe covers, worn by staff to prevent the spread of infection), hanging on Resident 1 ' s door, was observed. Certified nurse assistant (CNA) B stated, IP notified CNA B that Resident 1 was on isolation (separating someone from others to prevent spread of infection or disease) due to a rash.</p> <p>During a concurrent interview and record review on 4/3/24 at 11:11 am, with IP, the undated Index Case History and Contact Identification, (line listing, a document used to track and monitor outbreaks) was reviewed. IP stated, the Line Listing, indicated, Resident 3 was the first resident to be diagnosed with scabies on 3/11/24. IP stated, in total, there was one staff member and three residents that tested positive for scabies. IP stated two residents were being treated for scabies empirically (diagnosed by means of experience and not by means of test results). IP confirmed, IP did not report the scabies outbreak to CDPH and should have.</p>		