STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Empire	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)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on interview, record and facility policy review, the facility failed to implement their Abuse policy and investigate an injury of unknown origin for one of three residents who were sampled for abuse (Resident 1), when Resident 1 was found to have a bruise on her left hip and the facility could not determine where the bruise came from, in order to rule out abuse. This failure had the potential for residents not to be protected against abuse in the facility, which could negatively impact their quality of life and physical, emotional and psychosocial well-being. Findings: A review of the facility's policy titled, Abuse, Neglect, Exploitation, and Misappropriation of Resident Property; Prevention Of reviewed 4/17/24, indicated, D. Complaints, observations, suspicions, or reporting of incidents, falls, bruises and skin tears (of suspicious or unknown origin) will be investigated to rule out abuse. Occurrences, patterns, and trends will be assessed by administrative staff, licensed staff, and the interdisciplinary team to determine the corrective action based on the results of the investigation. Results will be reported to the Administrator .for further directions and action plans. F. All incidents of suspected or alleged abuse will be investigated by the assigned staff. The assigned staff will be informed of the nature of the incident and continue the investigation process. The investigation and report shall include: a) Date and time the incident took place. b) Circumstances surrounding the incident. c) Where the incident occurred. d) Names of witnesses and their account when applicable. e) Resident's/representative's account of incident. f) Employee's account of incident when applicable. g) Accounts of any other individuals involved. h) Recommendations for corrective action if applicable. i) Outcome of investigation; and j) Follow-up resolution or further action if necessary. 2. Suspicious falls and other incidents of unknown origin will be investigated to rule out abuse. During a record review of Resident 1's admission record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included frontotemporal neurocognitive disorder (group of brain disorders), tremors (involuntary, rhythmic shaking movements), and dementia (a decline in mental ability). A review of Resident 1's most recent Minimum Data Set (MDS, a standardized assessment tool), indicated that Resident 1 had memory, recall and decision making problems. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's clinical record, there was only one document that indicated that the facility had found a bruise on Resident 1. A Progress Notes Communication with Physician dated 3/14/25 at 3:14 pm, reflected that a nurse had reached out to Resident 1's Hospice provider (supports and manages symptoms and quality of life for people with terminal illnesses), to have an order to monitor a bruise on Resident 1's left iliac (hip) crest. Resident 1's clinical record contained no other documentation about how Resident 1's hip had been injured and bruised. During an interview and concurrent review of the facility's Abuse policy with Director of Nursing (DON) on 3/18/25 at 10:20 am, DON confirmed a bruise had been found on Resident 1s left hip and the injury was of unknown origin, as facility had not known how Resident 1 got the bruise. DON stated she was, pretty sure [Resident 1's hip bruise] might be from her brief [adult diaper] being too tight and then she shifts around in bed. DON confirmed there was no investigative report, documentation, reporting, investigation of the circumstances, witness accounts, resident's representative accounts, employee interviews, recommendations for corrective action, outcome of the investigation or follow-up that was done by the facility administration, as their Abuse policy specified. DON stated she could not remember which staff member first discovered Resident 1's bruise, or when it was discovered.

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NAME OF PROVIDER OR SUPPLIER Golden Empire		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Dorsey Drive Grass Valley, CA 95945	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on interview and record review, the facility failed to ensure one of three sampled resident's (Resident 1) care plans were developed when: 1. A care plan was not developed when a bruise of unknown origin was found on Resident 1's left hip. 2. A care plan was not developed when Certified Nursing Assistant (CNA) A trimmed Resident 1's fingernails and caused lacerations (cuts) on two of her fingers with the nail clippers. These failures had the potential to result in Resident 1's needs not being identified, evaluated and reevaluated, and had the potential to contribute to unwanted pain and infection which could negatively impact her quality of life and ability to attain or maintain her highest practicable level of well-being. Findings: A review of the facility's policy titled, Wound Care (Other than Pressure Ulcers) dated 4/17/24, indicated, If a skin condition is identified, i.e. skin tear, bruise, laceration, abrasion, etc. the licensed nurse will: implement or update a care plan. 1. During a review of Resident 1's admission record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included frontotemporal neurocognitive disorder (group of brain disorders), tremors (involuntary, rhythmic shaking movements), and dementia (a decline in mental ability). During a review of Resident 1's clinical record a, Progress Notes Communication with Physician dated 3/14/25 at 3:14 pm, reflected that Resident 1 was found to have a bruise on her left hip that the facility could not determine how happened. A review of Resident 1's care plans on 3/18/25, reflected that no care plan had been developed for Resident 1's bruise to her left hip which identified the problem, goals, or interventions needed to resolve the problem. 2. During a record review of Resident 1's Progress Notes dated 3/13/25 at 7:00 pm, a nurse documented Resident 1 had lacerations on two fingers of her right hand. Progress Note indicated, One to 2nd right [pointer] finger and 4th [ring] finger. ADON [Assistant Director of Nursing] informed me that [CNA A] clipped the resident's fingers while trimming her nails. [CNA A] reported [Resident 1] was bleeding that was stopped with gauze and pressure. Progress Note indicated that Resident 1's lacerations were treated with normal saline, wrapped with gauze that was held in place with netting. During a record review of Resident 1's Care Plans on 3/18/25, there had been no care plan developed for Resident 1's lacerated fingers, which identified the problem, goals or interventions needed to resolve the problem. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent review of Resident 1's care plans with Director of Nursing (DON) on 3/18/25 at 10:20 am, DON confirmed Resident 1 had a bruise on her right iliac crest (hip) and no care plan had been developed and should have been on 3/14/25, when the bruise was discovered. DON confirmed Resident 1 had no care plan for the lacerated fingers injury and one should have been developed on 3/13/25, when the injury occurred.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50363 Based on observation, interview, and record review, the facility failed to ensure quality care was provided for one of three residents (Resident 1), who were sampled for quality of care when: 1. Certified Nursing Assistant (CNA) A trimmed Resident 1's fingernails and cut the skin and caused lacerations (cuts) on two fingers of her right hand with the nail clippers and the facility had not conducted corrective reeducation with CNA A, to prevent this from happening again. 2. Licensed Vocational Nurse (LN) B did not follow the wound care treatment directions for Resident 1's lacerated fingers, in accordance with what the physician ordered. These failures had the potential to cause Resident 1 unnecessary pain, discomfort and infection and have a negative impact on her quality of life and physical, emotional, and psychosocial well-being. Findings: During a record review of facility policy titled, Wound Care (Other than Pressure Ulcers) 4/17/24, indicated The licensed nurse will track effectiveness of treatments and call Medical Director (MD) for a change in treatment orders if the wound is not healing in a timely manner. 1. During a record review of Resident 1's admission record, Resident 1 was admitted to the facility on [DATE] with diagnoses that included frontotemporal neurocognitive disorder (group of brain disorders), tremors (involuntary, rhythmic shaking movements), and dementia (a decline in mental ability). During a record review of Resident 1's most recent Minimum Data Set (MDS, a standardized assessment tool), indicated that Resident 1 was not able to make decisions on her own. During a record review of Resident 1's, Progress Notes dated 3/13/25 at 7:00 pm, a nurse documented that Resident 1 had lacerations to two fingers on her right hand. Progress note indicated, One to 2nd right [pointer] finger, and 4th [ring] finger. ADON [Assistant Director of Nursing] informed me that [CNA A] clipped the resident's fingers while trimming her nails. Progress note indicated CNA A reported bleeding was stopped with gauze and pressure. Nursing documentation reflected that Resident 1's wounds were treated with normal saline, wrapped with kerlix (gauze), and held in place with netting. During a record review of Resident 1's, Physician Orders dated 3/14/25 at 7:00 am, there was an order to, Cleanse laceration right 4th finger/right 2nd finger with normal saline and pat dry, apply Topical Antibiotic Ointment (TAO). Wrap fingers with kerlix [gauze] and hold in place with netting. Observe daily until healed. Every day shift until healed. During a record review of Resident 1's, Treatment Administration Record (TAR), dated March 2025, indicated Resident 1 had not received the treatment to the fingers on her right hand as the physician had ordered, on 3/14/25 and 3/18/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/18/25 at 9:14 am, Resident 1 was observed sleeping in her bed. Resident 1's right hand was in a hand splint. Resident 1's right hand fingers did not have any dressings over the two fingers that were lacerated. During an observation and concurrent interview with LN A on 3/18/25 at 11:31 am, Resident 1 was observed in her room sitting up in her wheelchair. LN A removed the hand splint from Resident 1's right hand and confirmed Resident 1's fingers were not wrapped in dressing, as specified in the physician's order. Resident 1 was observed to have a scab on the tip of the ring finger and no scab on the second (pointer) finger. 2. During an interview with ADON on 3/18/24 at 10:14 am, ADON confirmed that CNA A reported to her that he had cut Resident 1's two fingers when trimming her fingernails, and they were bleeding. ADON confirmed that the facility had not provided reeducation to CNA A, or any other CNAs, on how to safely trim resident fingernails, nor had an investigation been conducted into exactly what had happened. During an interview with Director of Nursing (DON) on 3/18/24 at 10:20 am, DON stated she was not sure if CNA A received any follow-up nail care corrective action or education. DON stated there was no active investigation into how or why Resident 1 incurred injuries during nail care that was provided by CNA A. During a concurrent interview with CNA A on 3/18/24 at 10:41 am, CNA A confirmed he had trimmed Resident 1's fingernails with clippers. CNA A stated Resident 1, jerked away from him and he cut Resident 1's skin and had noted that one finger was bleeding and added, I had no idea she was bleeding from two fingers. During an interview with Director of Staff Development (DSD) on 3/18/25 at 12:00 pm, DSD confirmed CNA A injured Resident 1 when he clipped her fingernails and cut her skin with the clippers. DSD stated she had not provided reeducation to CNA A, or any other CNAs, because incident occurred, Five days ago and today is my first day back. DSD indicated she needed to do some reeducation with the CNA staff. During an interview with LN B on 3/18/25 at 12:17 pm, LN B stated she last assessed Resident 1's finger lacerations, a couple days ago. LN B confirmed Resident 1's right hand lacerated fingers were not wrapped in dressing, as the physician ordered, at that time. LN B confirmed she had not followed Resident 1's physician ordered treatment and stated, because her fingers weren't bleeding and didn't appear infected. LN B stated, [Resident 1' fingers] would heal in a couple of days so wound care orders weren't necessary. LN B confirmed she had not followed the physcian's orders for Resident 1's wound treatments.