

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  07/31/2025
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)
F 0689  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards that were within the facility's control, when the facility did not provide supervision to prevent one of three residents sampled for elopement (to leave a health care facility without permission or authorization), from leaving the facility without staff awareness and wandered in their wheelchair toward a busy street. Staff had not noticed Resident 1 missing until a staff member saw him on the street in his wheelchair on her way to work. This failure had the potential to result in physical harm, getting ran over by a car, and exposure to the elements (weather) for all residents who wander and/or have the potential to elope. This could have serious negative impacts on their safety, physical and emotional well-being. During a review of the facility policy and procedure titled, Wandering/Elopement, dated 4/17/24, indicated, It is the policy of this facility to protect residents from wandering away from the facility and to begin an immediate search if resident is found missing. A review of Resident 1's medical record indicated that Resident 1 was admitted on [DATE] with diagnoses that included, Neurocognitive Disorder with Lewy Bodies (progressive brain disorder that leads to decline in thinking, reasoning, and independent function), Chronic Obstructive Pulmonary Disease (COPD, a group of lung diseases that block airflow and make it difficult to breathe), and Diabetes Mellitus (DM). A review of Resident 1's Minimum Data Set (MDS, Tool for evaluating and implementing a standardized assessment) Brief Interview for Mental Status (BIMS, Section C assessing cognitive function) score dated 05/07/2025, indicated Resident 1 rated 6/15, which equates to severe cognitive impairment. Resident 1 was not their own representative (RP), and did not make their own medical decisions, but is able to verbalize needs and preferences. During an interview on 7/3/25 at 09:30 am, with Kitchen Staff (KS) in their office, KS stated, I am aware of the incident where Resident 1 escaped. I found them halfway up the steep ramp close to a busy street in their wheelchair. I was headed to work; it was early and hard to see them. I returned them to unit 1 and was informed no staff was aware that they were gone. The charge nurse looked mortified because they had no idea Resident 1 was not in the building. During an interview on 7/3/25 at 11:00 am, with Licensed Nurse (LN) 4 at Nursing Station 1, LN 4 stated, I heard of the incident regarding Resident 1's elopement. Resident 1 was found by kitchen staff on the driveway ramp headed to the street. During a record review of the current resident assessment, Wandering Risk Scale (tool to determine the level of risk for a resident to potentially wander or elope), dated 4/29/25 at 12:58 am, indicated Resident 1 scored 11 which equates to being a High Risk for wandering/elopement. During a record review of Resident 1's, Progress Notes, N-Alert Charting, dated 5/5/25 at 5:45 am, indicated, Resident was found outside of building in wheelchair at top of driveway. Returned by kitchen staff member. No indication of any injury or harm resulting from adventure. Returned to [Station] Stn 1. without further incidents. During a concurrent interview and record review on 7/3/25 at 2:00 pm, with Director of Nursing (DON) and Administrator (Admin) in the facility conference room, Resident 1 Progress Notes and medical chart were reviewed. DON and Admin concurred and confirmed that Resident 1 was a confused resident that required supervision and permission to be outside the facility, regularly demonstrated active exit seeking behaviors, did exit the facility building on 5/5/25, was found in a wheelchair propelling it up the driveway incline to the street, staff was unaware of the resident's exit and location, and that this incident had a potential to have been a seriously dangerous and hazardous incident.</p>		