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	12/10/2025

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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Based on observation, interview, and record review, the facility failed to ensure treatment and care in accordance with professional standards of nursing were provided for one of three sampled residents (Resident 1), when the facility did not develop care plan interventions, monitor, and notify the physician regarding Resident 1's known history of THC (tetrahydrocannabinol, the ingredient in cannabis [marijuana] that can alter mood, perception, and reduce pain) substance abuse.This failure had the potential to result in Resident 1's unmet medical needs, delayed treatment, and injury.Findings: A review of Resident 1's admission record indicated Resident 1 was admitted in summer 2025 with diagnoses which included right knee fracture, major depressive disorder, anxiety, and difficulty walking. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment), dated 6/27/25, the MDS indicated Resident 1 had a BIMS (Brief Interview for Mental Status-used to screen and identify cognitive condition) score of 15, which indicated Resident 1 had no memory impairment. During a review of Resident 1's History and Physical (H&P), dated June 2025, the H&P indicated Resident 1 had a social history of THC use. During a review of Resident 1's Social Services Notes (SSN), dated 11/14/25, the SSN indicated, SS [Social Services] found THC edible in her [Resident 1's] top drawer. There was no documented evidence of a care plan addressing substance use or physician notification. During a review of Resident 1's SSN, dated 9/26/25, the SSN indicated, SS was informed by nursing staff that [Resident 1] might have a vapor pen.a THC vaporizer was found. There was no documented evidence that a related care plan was developed and implemented or that a physician was notified of findings. During a concurrent observation and interview on 11/19/25 at 11:30 a.m. in Resident 1's room, no behavioral health interventions or monitoring were observed in Resident 1's room. Resident 1 confirmed a history of THC substance abuse and stated there was no individualized substance abuse care plan provided upon admission or after the finding of THC in her room in September and November 2025. Resident 1 stated tearfully, If they had talked to me, I think it [care plan] would have helped. During an interview on 11/19/25 at 12:40 a.m. with Licensed Nurse (LN) 1, LN 1 stated that physician notification and a substance abuse care plan would have been expected for safety and to determine the need for reversal [medications to reverse adverse effects of an overdose]. During a concurrent interview and record review on 11/19 at 12:15 with LN 2, Resident 1's Electronic Medical Record (EMR) was reviewed. The EMR indicated there was no substance abuse care plan or monitoring documented for Resident 1. LN 2 confirmed she was aware of Resident 1's substance abuse and that Resident 1 had a THC product in her room on two occasions. LN 2 confirmed there was no documentation of a substance abuse care plan and that there was no physician notified of Resident 1's change of condition. LN 2 further stated she expected Resident 1 to have had a care plan to safely monitor Resident 1's care. LN 2 further stated she expected the physician to have been notified of any change of condition including incidents involving possible substance abuse. During an interview on 11/19/25 at 1:20 p.m. with Certified Nursing Assistant (CNA), the CNA stated if THC was found in a resident's room, the nurse would have been notified by the CNA and safety charting would have been expected for the safety of the residents. During an interview on 11/19/25 at 1:35 p.m. with the Social Service Director (SSD), the SSD confirmed that no care plan was developed, and the physician was not notified after THC was found on two occasions for Resident 1. The SSD stated she would have expected the care plan to be updated and the physician to be notified to provide Resident 1 with proper care. During a concurrent interview and record review on 11/19/25 at 1:45 p.m. with the Social Services Assistant (SSA), the SSN dated 9/26/25 was reviewed. The SSA confirmed there was no care plan for substance abuse for Resident 1 and a physician was not notified after finding THC in September and November 2025. The SSA stated he expected the physician to be notified and Resident 1's substance abuse to be care planned so the facility could safely provide the same to the resident. During an interview on 11/19/25 at 3 p.m. with the DON, the DON stated that substance abuse history should have been identified through diagnoses and H&P, and that care planning and physician notification were expected for any change in condition, including suspected substance abuse, to provide the best care for residents. During a review of the facility's policy and procedure (P&P) titled, Care Planning/Interdisciplinary Team Care Planning Conference, dated 2024, the P&P indicated, The IDT shall complete a comprehensive care plan withing seven (7) days of completion of the resident's assessment (MDS).Care planning may include review of clinical issues.coordination of care. During a review of the facility's P&P titled, Change of Condition, dated 2024, the P&P indicated, It is the policy of the facility to notify the physicians and family and IDT when the