

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  02/06/2026
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 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on interview and record review the facility failed to ensure annual performance reviews were completed for Certified Nursing Assistants (CNAs) for one of three sampled staff (CNA 1). This failure had the potential for the facility to be unaware of staffing performance concerns for CNA 1, with the potential for all resident care to be negatively affected. During a review of CNA 1's current employee file, employee file indicated, most recent performance review was completed 5/17/2021. File indicated, CNA 1 was hired on 5/1/2018. During an interview on 2/6/26, at 9:22 a.m., with Director of Staff Development (DSD), DSD stated, the most recent performance review we have documented for CNA 1 is dated 5/17/2021. DSD stated, performance reviews are supposed to be done annually for all CNAs. DSD stated, the purpose of the annual performance review is to ensure the staff member is doing their job. During a review of the facility's policy and procedure (P&amp;P) titled, Competency Evaluation dated 2024, the P&amp;P indicated, It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job. Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training programs, and/or job performance evaluations.</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
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