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	02/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident from abuse for one of four sampled residents (Resident 1) when Resident 1 was found crying and saying, Get him away from me, as Resident 2 was witnessed by staff inappropriately touching Resident 1 while touching his genitals.This failure has resulted inResident 1 not being free from abuse by Resident 2, andResident 1's right to be free from abuse not being protected.Findings:Review of Resident 1's admission Record, indicated that Resident 1 was admitted [DATE] with diagnosis including cerebral palsy (a group of permanent movement and posture disorders caused by damage to or abnormal development of the brain) and contracture right elbow (shortening or ligaments of muscle around a joint as a result the elbow can't bend or straighten).Review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/14/26 indicated Resident 1 had severe cognitive (memory) impairment.Review of Resident 2's admission Record, indicated that Resident 2 was admitted on [DATE] with diagnosis including unspecified dementia (a progressive state of decline in mental abilities). Review of Resident 2's MDS dated [DATE], indicated that Resident 2 had intact cognition.Review of IDT (Interdisciplinary Team-a team of health care professionals that form a care plan for residents) notes dated 2/9/26 indicated, today around 2:30 pm a Certified Nurse's Assistant (CNA) 2, CNA 2 came forward.She was in attendance with CNA 1 for the recheck on both patients. Upon entering the room, they found Resident 2 sitting at the end of Resident 1's bed with his pants down. His back was to the door, but they could see his left hand stretched out to Resident 1's bed. Upon looking they discovered bed 2's (Resident 2) hand was underneath bed 1's (Resident 1) gown and his other hand was on his own genitalia area. Resident 2 immediately started to stand to pull his pants up his pants.During an interview on 2/11/26 at 2:32 p.m., CNA 1 stated he went into Resident 1's room after doing evening care on Sunday (2/8/26) and discovered Resident 2 was sitting on Resident 1's bed with his briefs pulled down. Resident 2 had his right hand on his genitals and left hand on Resident 1's hip. When CNA 1 pulled Resident 1's covers off him, he (CNA 1) could see Resident 1's penis was exposed out of his brief. After the alleged abuse incident, Resident 1 stated, Get him away from me, and was tearful.During an interview on 2/11/26 at 4:16 p.m. with CNA 2, CNA 2 stated she was asked to come into room Resident 1's room with CNA 1. CNA 2 stated she saw Resident 2 on edge of Resident 1's bed and that Resident 2 did not have brief or underwear on. CNA 2 saw his (Resident 2) brief on the floor. And Resident 2 was trying to pull on pants. CNA 2 stated, Resident 2's right hand was under Resident 1's gown and that Resident 1's penis was exposed. CNA 2 saw Resident 2 move his hand away from Resident 1. CNA 2 stated, Resident 1 was lying in bed in a fetal position curled up and crying.During an interview on 2/11/26 at 4:50 p.m. with the Assistant Director of Nursing (ADON), stated she would consider this incident sexual abuse. The ADON further stated that every resident has the right to be free from abuse in the facility.During a review of the facility's policy and procedure (P&P) titled, Abuse, (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
	056391	A. Building B. Wing	02/11/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Neglect, Exploitation, and Misappropriation, revision 10/12/23, the P&P indicated, Abuse of any type will not be tolerated in this facility at any time . Each resident has the right to be free from abuse . residents must not be subjected to abuse by anyone including, other residents.

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	02/11/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an allegation of abuse was reported timely and immediately within the required time frame for one of four sampled residents (Resident 1) when an allegation of abuse was not reported per federal regulation.This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure residents' safety.Findings:Review of Resident 1's admission Record, indicated that Resident 1 was admitted [DATE] with diagnosis including cerebral palsy (a group of permanent movement and posture disorders caused by damage to or abnormal development of the brain) and contracture right elbow (shortening or ligaments of muscle around a joint as a result the elbow can't bend or straighten).Review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool, dated 1/14/26 indicated Resident 1 had severe cognitive (memory) impairment.Review of Resident 2's admission Record, indicated that Resident 2 was admitted on [DATE] with diagnosis including unspecified dementia (a progressive state of decline in mental abilities). Resident 2's MDS dated [DATE], indicated that Resident 2 had intact cognition.Review of IDT (Interdisciplinary Team-a team of health care professionals that form a care plan for residents) notes dated 2/9/26 indicated, today around 2:30 pm a Certified Nurse's Assistant (CNA) 2, CNA 2 came forward.She was in attendance with CNA 1 for the recheck on both patients. Upon entering the room, they found Resident 2 sitting at the end of Resident 1's bed with his pants down. His back was to the door, but they could see his left hand stretched out to Resident 1's bed. Upon looking they discovered bed 2's (Resident 2) hand was underneath bed 1's (Resident 1) gown and his other hand was on his own genitalia area. Resident 2 immediately started to stand to pull his pants up his pants.During an interview on 2/11/26 at 2:32 p.m., CNA 1 stated he went into Resident 1's room after doing evening care on Sunday (2/8/26) and discovered Resident 2 was sitting on Resident 1's bed with his briefs pulled down. Resident 2 had his right hand on his genitals and left hand on Resident 1's hip. When CNA 1 pulled Resident 1's covers off him, he (CNA 1) could see Resident 1's penis was exposed out of his brief. After the alleged abuse incident, Resident 1 stated, Get him away from me, and was tearful. CNA 1 stated he reported this to the Nurse Supervisor on duty that evening.During an interview on 2/11/26 at 5:20 pm, with the Administrator (ADM), the ADM confirmed that the allegation of abuse occurred on 2/8/26 and that the report was made to California Department of Public Health (CDPH) on 2/9/26 at 4:12 p.m. The ADM further stated her expectation was that initial incident report of abuse allegation be sent to CDPH and reported to other enforcement agencies within two hours of the abuse allegation.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation, and Misappropriation, revision 10/12/23, the P&P indicated, all mandated reporters are required to report incidents of abuse or alleged violations of abuse . Not later than two hours after the allegation is made: .3) Department of Public Health-a written report to the local office of Licensing and Certification.