

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555180	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Gold Country Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 Golden Center Drive Placerville, CA 95667	
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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on observation, interview, and record review, the facility failed to ensure residents were only transferred or discharged for valid, allowable reasons, when the facility discharged two of five sampled residents (Resident 3 and Resident 4) from skilled nursing facility (SNF) 1 to SNF 2 without documented medical justification, even though both facilities provided the same level of care. The required physician documentation supporting improvement or unmet needs was absent or contradictory, and the residents were not given a choice. This failure violated Resident 3 and Resident 4's discharge rights to remain in the facility and placed them at risk for transfer trauma and disruption of care. Findings: A review of SNF 1 and SNF 2's licensing and certification information showed both facilities were licensed as SNFs providing the same level of care and certified for skilled nursing and long-term care services. A review of Resident 3's admission record (AR) showed Resident 3 was admitted in spring 2026 with diagnoses including weakness, back bone fracture, foot ulcer, depression, and diabetes mellitus (DM, disorder with difficulty in blood sugar control which could contribute to poor wound healing). A review of Resident 3's Physician Visit Note (4/2026) showed Resident 3's memory was intact. A review of Resident 3's Notice of Proposed Transfer/Discharge (NTD, 7/13/26) showed the stated reason: The transfer/discharge is appropriate because your health has improved sufficiently so that you no longer require services of this facility. A review of Resident 3's Discharge Summary (DS), dated 7/13/26, showed Resident 3 discharged in stable condition to a nursing facility for long-term care and still had wounds present to feet. The DS contradicted NTD by showing active wounds and ongoing long-term care needs. A review of Resident 3's Notice of Medicare Non-Coverage (NOMNC), dated 7/9/26 showed Medicare services would end on 7/11/26. Resident 3 was discharged on 7/13/26. A review of Resident 3's Physician Discharge Note (PDN), dated 7/13/26 showed no physician documentation supporting that Resident 3 had improved sufficiently to no longer require SNF 1's services. A review of Resident 4's AR showed Resident 4 was admitted in early spring 2026 with DM with foot ulcer, liver cirrhosis (late-stage liver disease with scar tissues blocking normal blood flow), and anxiety. A review of Resident 4's NTD dated 7/13/26 showed two conflicting discharge reasons: (1) needs could not be met at the facility, and (2) health had improved sufficiently so services were no longer required. A review of Resident 4's PDN dated 7/13/26 showed discharge to SNF 2 for long-term care with active diagnoses including wound to primary foot, DM with ulcer (when high blood sugar damages blood vessels causing difficulty in healing), nonalcoholic steatohepatitis with cirrhosis (liver damage), chronic heart failure (a weak heart), and Chronic Obstructive Pulmonary Disease (COPD, long-term lung disease causing difficulty breathing). The PDN contained no documentation identifying specific needs that SNF 1 could not meet and indicated, The facility attempts to meet those needs, or services available at the receiving facility (SNF 2). During a concurrent interview and record review on 7/16/26 at 12:26 p.m., Social Service 1 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 555180	Facility ID: 555180
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observation, interview, and record review, the facility failed to ensure required transfer and discharge notifications were provided for three of three sampled residents (Resident 2, Resident 3, and Resident 4), when the facility notified Resident 3 and Resident 4 of their discharges on 7/13/26, the same day they were discharged, without any documented exception permitting shorter notice; the facility did not notify the Office of the State Long-Term Care Ombudsman (OMB, an independent advocate for residents of long-term care facilities) before the transfer/discharge of Resident 3; and the facility issued no written notice while attempting to discharge Resident 2. These failures removed Resident 3 and Resident 4 from the facility with same-day notice, denying their right to exercise appeal rights, and denied Resident 2 the required notice and opportunity to appeal a facility-initiated discharge and had the potential to affect residents' mental and psychosocial well-being. Findings: A review of Resident 3's admission record (AR) showed Resident 3 was admitted in spring 2026 with diagnoses including weakness, back bone fracture, foot ulcer, depression, and diabetes mellitus (DM, disorder with difficulty in blood sugar control). A review of Resident 3's Physician Visit Note, dated 4/2026, indicated Resident 3's memory was intact. A review of Resident 4's AR indicated Resident 4 was admitted in early spring 2026 with diagnoses including DM with foot ulcer, liver cirrhosis (late-stage liver disease with scar tissues blocking normal blood flow), and anxiety. A review of Resident 3's Notice of Proposed Transfer/Discharge (NTD), dated 7/13/26 indicated the facility notified Resident 3 on 7/13/26 and discharged Resident 3 on 7/13/26. No exception to the 30-day notice requirement was documented. A review of Resident 3's Nurse Progress Note (NPN), dated 7/13/26 at 1:36 p.m., indicated Resident 3 was discharged to another skilled nursing facility (SNF 2), departing at 1:10 p.m. A review of Resident 3's NTD and NPN both dated 7/13/26 indicated Resident 3 was notified and discharged on 7/13/26. There was no evidence the facility notified the Ombudsman Program (OMB) before Resident 3's discharge. A review of Resident 4's NTD, dated 7/13/26, indicated Resident 4 was notified and discharged on the same day, with no documented exception. A review of both residents' Discharge Summaries (DS), dated 7/13/26, indicated both were discharged to SNF 2 for long-term care. During a telephone interview on 7/16/26 at 1:01 p.m., Resident 4's Family Member 1 (FM 1) stated Resident 4 felt like he did not have any other choice and felt pushed out. Staff told him his days were running out. If he transferred to another facility his days would extend, and if not, he would have to pay a shared cost. He expressed he did not want to go. During a telephone interview on 7/16/26 at 1:28 p.m., Resident 4 stated, It was [SS 1 Social Services] who had me sign the paper, but I did not get an orientation of what I was signing, and I signed something and I did not feel like it was explained. Resident 4 stated a copy was supposed to be returned to him but was not provided, and stated, I didn't know they were supposed to give me a grace period. During a telephone interview on 7/16/26 at 3:09 p.m., Resident 3 stated the notice he received was two days before discharge. During an interview on 7/16/26 at 3:26 p.m. with the Director of Nursing (DON), the DON stated residents were notified 72 [hours] prior for all insurance discharges and were given the NOMNC (Notice of Medicare Non-Coverage, a notification of the date Medicare coverage will end and how to appeal the coverage decision) form to sign. The DON's description of the transfer and discharge process did not include a 30-day written notice. The DON described the transfer/discharge steps but did not include OMB notification. During an interview on 7/16/26 at 4:39 p.m. with the Administrator (ADM), the ADM stated, I've never given a 30-day notice to any residents in 30 years. Never needed to. During an interview on 7/16/26 at 4:43 p.m. with the DON, the DON stated, The only (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time you get a 30-day is if the facility is asking you to leave, and stated a 30-day notice had never been given. During a review on 8/6/26 of email from the OMB program, dated 7/27/26 at 11:08 a.m., the email indicated the OMB received Resident 3's NTD on 7/14/26, one day after the discharge. The OMB reported no NTD was received for Resident 4. A review of Resident 2's AR indicated Resident 2 was admitted in late spring 2025 with diagnoses including degenerative disease of the nervous system (disease that can cause difficulty walking and talking), anxiety, and depression. A review of Resident 2's Physician's Progress Notes (PPN, 4/26) showed Resident 2 had no memory impairment. A review of Resident 2's clinical record showed no written notice of transfer/discharge. During a concurrent interview and record review on 8/6/26 of email from the OMB program dated 7/27/26 the email indicated no notice was received for Resident 2, and the OMB first learned of Resident 2's discharge situation when the OMB met with Resident 2 at the facility on 7/21/26, at which time Resident 2 reported being urged to be discharged by the facility. Resident 2 indicated she did not want to leave the facility and did not want to make a lateral transfer. During an interview on 7/16/26 at 10:30 a.m., Resident 2 stated, Monday or Friday, I started hearing I was moving. I didn't even know. It wasn't even discussed until Tuesday. We had a meeting. I was not provided with 30-day notice. Resident 2 stated she was told she had until the 31st of this month to go. Resident 2 indicated she did not speak with the OMB, and stated she was told they are moving away from being long term skilled nursing here. During an interview on 7/16/26 at 3:50 p.m., the Assistant Director of Nursing (ADON) stated Resident 2 was notified during a care conference the day before (7/15/26) but could not provide a copy of any written notice. A review of the facility's policy and procedure (P&P) titled, Discharge Summary and Plan, revised 3/25, the P&P indicated, A member of the IDT reviews the final discharge plan with the resident and family at least twenty-four (24) hours before the discharge is to take place. A review of the facility's P&P titled, Transfer or Discharge, revised 3/25, indicated, Once admitted to the facility, residents have the right to remain in the facility. Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record. Residents have the right to appeal a transfer or discharge through the state agency that handles appeals. The facility will assist the resident in filing the appeal, if such assistance is requested.		