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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gold Country Health Center	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45770 Based on observation, interview, and record review the facility failed to provide a homelike environment for one of 15 sampled residents (Resident 42), when the chain that is used to turn on Resident 42's overhead light was broken and unreachable. This failure had the potential to result in Resident 42 not experiencing a homelike environment which can negatively impact his psychosocial well-being. Findings: A review of Resident 42's Admission Record, indicated he was admitted in early September 2024 with diagnoses including depression. During a concurrent observation and interview on 9/24/24 at 8:49 a.m., in Resident 42's room, the chain attached to the overhead light to turn it on and off was broken, approximately three inches long. Resident 42 stated the chain had been broken since admission, which prevented him from turning the light on or off and limited him to do simple things on his own. During a concurrent observation and interview on 9/25/24 at 9:24 a.m. with Licensed Nurse 1 (LN 1) in Resident 42's room, LN 1 acknowledged the chain was too short for Resident 42 to reach and turn his light on and off whenever he needed it. During a concurrent observation and interview on 9/25/24 at 9:51 a.m. with the Director of Nursing (DON), the DON confirmed that the chain to Resident 42's overhead light was broken and should have been replaced immediately to help promote independence, prevent accidents, and help Resident 42 feel more at home while at the facility. A review of the facility's policy and procedure titled, Homelike Environment, revised 2/2021, stipulated Comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable, and homelike environment.

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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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 45770 Based on observation, interview and record review the facility failed to ensure a Significant Change in Status Assessment (SCSA, an assessment that indicates a major decline or improvement in the resident's status) was completed for one of 15 sampled residents (Resident 45), when Resident 45 developed a stage four pressure ulcer (PU, deep wound reaching the muscles, ligaments, and bones) to the left sacrum (triangular bone, back portion of the pelvis). This failure decreased the facility's potential to provide appropriate care and services to Resident 45 based on her status. Findings: A review of Resident 45's Admission Record, indicated she was admitted to the facility in August 2024 with diagnoses including morbid obesity and diabetes (chronic disease when the body can't produce insulin to control blood sugar). During an observation on 9/23/24 at 8:50 a.m., Resident 45 was observed with a wound vacuum (a device that uses suction to help wounds heal) attached to her lower back. A review of Resident 45's Change in Condition note, dated 7/5/24, indicated Resident 45 developed a stage four PU to the left sacrum which measured 5.12 centimeters (cm, a unit of measurement). During a concurrent interview and record review on 9/24/24 at 9:56 a.m., with the Treatment Nurse 1 (TN 1), Resident 45's Progress Notes were reviewed. TN 1 confirmed Resident 45 had developed a stage four PU to the left sacrum while at the facility on 7/5/24 as diagnosed by the wound doctor. During a concurrent interview and record review on 9/25/24 at 12:45 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 45's MDS (an assessment tool) assessments since admission were reviewed. MDSC confirmed she did not complete a SCSA because she did not consider a facility acquired stage four PU a significant change in condition. During an interview on 9/25/24 at 2:10 p.m. with the Director of Nursing (DON), DON stated she considerd a stage four PU a significant change in condition and MDSC should have completed a SCSA for Resident 45 to reflect the resident's current status and therefore staff will be able to develop an appropriate care plan for the resident. A review of the facility's policy and procedure (P&P) titled, Resident Assessments, revised 3/2022, stipulated The resident assessment coordinator is responsible for ensuring .team conducts timely and appropriate resident assessments . A review of the facility's P&P titled, Comprehensive Assessments, revised 3/2022, indicated Significant Change in Status Assessment-The SCSA is a comprehensive assessment for a resident that must be completed .determination was made that the resident had a significant change.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS, an assessment tool used for care) accurately reflected the status of one of 15 sampled residents (Resident 45), when Resident 45's pressure ulcer (PU, an injury that breaks down the skin and underlying tissue) was not coded accordingly. This failure had the potential for Resident 45 to receive inadequate wound care management. Findings: A review of Resident 45's Admission Record, indicated Resident 45 was admitted in August 2024 with diagnoses including morbid obesity and diabetes (chronic disease when the body can not produce insulin to control blood sugar). A review of the facility's census, indicated Resident 45 was sent to the hospital on 8/23/24 for an infection and was readmitted back to the facility on [DATE]. A review of Resident 45's MDS Discharge Assessment, dated 8/23/24, indicated she had a stage four PU to the left sacrum (triangular bone at the back of pelvis). A review of Resident 45's Skin Observation Sheet, conducted on 8/29/24 upon readmission to the facility, indicated Treatment Nurse 1 (TN1) noted that Resident 45 still had a stage four PU to the left sacrum. During an interview on 9/25/24 at 1:45 p.m. with TN 1 and TN 2, both TN 1 and TN 2 confirmed Resident 45 still had the same stage four PU at the left sacrum when readmitted back to the facility on [DATE]. A review of Resident 45's MDS Quarterly Assessment, dated 9/4/24 completed after readmission, indicated Resident 45's left sacrum wound was coded as a deep tissue injury and unstageable. During an interview on 9/25/24 at 12:45 p.m., with the MDS Coordinator (MDSC), MDSC stated she reviewed TN 1's skin assessment for Resident 45's wound to the left sacrum as a stage four PU but decided to code it as deep tissue injury and unstageable wound because she considered these skin conditions worse than the stage four PU. During an interview on 9/25/24 at 2:10 p.m. with the Director of Nursing (DON), DON stated MDSC should have coded Resident 45's left sacrum wound as a stage four PU according to the TN 1's skin assessment on readmission so Resident 45 would receive appropriate wound care management that will help in healing her wound and preventing it from getting worse. A review of the facility's policy and procedure titled, Resident Assessments, revised 3/2022, stipulated, The resident assessment coordinator is responsible for ensuring .team conducts timely and appropriate resident assessments .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 45770 Based on observation, interview, and record review the facility failed to develop a comprehensive person-centered care plan for one of 15 sampled residents (Resident 208), when Resident 208's care plan did not address the use of a leg immobilizer. This failure had the potential for Resident 208's order to be missed and not implemented. Findings: A review of Resident 208's Admission Record, indicated she was admitted in September 2024 with diagnoses including pathological fracture of the right distal femur (lower end of right thigh bone). During an observation on 9/23/24 at 1 p.m., Resident 208 was observed seated in the wheelchair wearing a right leg immobilizer. During a concurrent interview and record review on 9/25/24 at 11:30 a.m. with Licensed Nurse 1 (LN 1), Resident 208's care plan was reviewed. LN 1 stated she could not find a care plan that addressed Resident 208's use of a leg immobilizer. During an interview on 9/25/24 at 2:10 p.m. with the Director of Nursing (DON), DON acknowledged that a care plan was not developed for Resident 208's use of a leg immobilizer. DON stated staff should have developed and completed the care plan as soon as the order was received to prevent delays in its implementation. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical .and functional needs is developed .for each resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45770 Based on observation, interview, and record review the facility failed to provide services which meet professional standards of quality for one of 15 sampled residents (Resident 208), when Resident 208 was allowed to use a right knee/leg immobilizer without a physician's order. This failure increased Resident 208's potential to use a knee/leg immobilizer without a physician order. Findings: A review of Resident 208's Admission Record, indicated she was admitted in September 2024 with diagnoses including pathological fracture of the right distal femur (lower end of right thigh bone). During an observation on 9/23/24 at 1 p.m., Resident 208 was observed seated in the wheelchair wearing a right knee/leg immobilizer. During a concurrent observation and interview on 9/23/24 at 4:18 p.m. with Treatment Nurse 1 (TN 1), TN 1 confirmed Resident 208 had been using the right knee/leg immobilizer since her admission. During a concurrent interview and record review on 9/25/24 at 11:30 a.m., with Licensed Nurse 1 (LN 1), Resident 208's Order Summary Report was reviewed. LN 1 stated Resident 208 was wearing the knee/leg immobilizer daily in and out of bed, but she could not find a written order for its use. During a concurrent interview and record review on 9/25/24 at 2:10 p.m. with the Director of Nursing (DON), DON confirmed after reviewing Resident 208's Order Summary Report that there was no order for a knee/leg immobilizer. DON stated she expected her staff to record physician orders in the resident's chart immediately to prevent inaccuracy in the delivery of care to residents. A review of the facility's policy and procedure titled, Physician Orders, revised 11/2014, indicated, Physician Orders must be signed and dated .When recording treatment orders, specify the treatment, frequency and duration of the treatment .

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45770 Based on observation, interview, and record review the facility failed to ensure an ancillary service was provided to one of 15 sampled residents (Resident 42), when Resident 42 was not assisted to use his hearing aids (HAs) daily as ordered. This failure increased Resident 42's inability to hear clearly and communicate properly. Findings: A review of Resident 42's Admission Record, indicated Resident 42 was admitted to the facility in September 2024 with diagnoses including weakness of upper extremities and cerebral infarction (stroke, blood flow to the brain is blocked). During a concurrent observation and interview on 9/23/24 at 3:12 p.m. with Resident 42, a morning routine instruction was posted near Resident 42's bed which included assisting Resident 42 put on his HAs daily. Resident 42 was observed not wearing his HAs. Resident 42 stated staff did not help him and he was not able to put the HAs on his own due to weakness. A review of Resident 42's Order Summary Report, dated 9/21/24, indicated Resident 42 was to wear HAs in the morning and take them off at night. During an observation on 9/24/24 at 8:49 a.m., Resident 42 was lying in bed with HAs not on. HAs were on top of the nightstand and were not within Resident 42's reach. During a concurrent observation and interview on 9/24/24 at 2:37 p.m. with Licensed Nurse 2 (LN 2), LN 2 confirmed Resident 42 was not wearing his HAs as ordered. During a concurrent observation and interview on 9/24/24 at 2:49 p.m. with the Director of Nursing (DON) inside Resident 42's room, DON confirmed Resident 42 was not wearing his HAs. DON stated Resident 42 should have been assisted by the nurses to put on his HAs as ordered, to help him communicate his needs clearly and be able to interact with other residents appropriately. A review of the facility's policy and procedure titled, Assistive Devices and Equipment, revised 1/2020, indicated, Certain devices and equipment that assist with resident .are provided for residents .The facility provides the resident assistance with assistive devices .including: hearing aids .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 49933 Based on observation, interview, and record review, the facility failed to ensure the menu was being followed for the therapeutic diet (a modification of a regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) for lunch meals on 9/23/24 and 9/24/24 when: 1. Resident 257 with dysphagia (difficulty swallowing) mechanical texture diet (a diet that consist of foods that are moist, mechanically altered, easily mashed) who: a. Received puree zucchini instead of chopped and mashable zucchini on 9/23/24 lunch meal b. Received puree apple bread pudding instead of bread pudding chopped into half inch (1/2) and soak in milk on 9/24/24 lunch meal 2. Resident 21 with CCHO (controlled carbohydrate) diet (a diet to control blood sugar level) received one slice of garlic breadstick instead of one half of garlic breadstick on 9/23/24 lunch meal. 3. Resident 20 with finger food diet (a diet that provides food in appropriate size and shape to be eaten without utensils) who received regular apple bread pudding in one piece instead of the bread pudding cut into four pieces on 9/24/24 lunch meal. These failures had the potential to result in compromising the medical and nutrition status of those three residents. The facility census was 59. Findings: 1. a. During a dining observation of lunch meal service on 9/23/24, beginning at 12:12 p.m., it was noted Resident 257 was on dysphagia mechanical texture diet and received puree zucchini on the meal tray. A concurrent review of a facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Fall Menus, Week 4 Monday, showed that dysphagia mechanical texture diet should receive zucchini as chop 1/2, mashable, no crumbs. During an interview on 9/23/24, at 12:54 p.m., the Registered Dietician (RD) stated dysphagia mechanical soft diet should not get puree zucchini when reviewed the facility spreadsheet and acknowledged it was not correct. b. During meal distribution observation of lunch meal on 9/24/24, starting at 12:10 p.m., it was noted Resident 257 with diet of dysphagia mechanical diet received a puree dessert. A concurrent review of a facility spreadsheet titled, Fall Menus, Week 4 Tuesday, showed that dysphagia mechanical texture diet should receive apple bread pudding, make w/o (without) apples .Chop 1/2' bread pudding, soak and drain for dessert. During an interview on 9/24/24, at 2:47 p.m., with Registered Dietitian (RD), RD stated that the staff needed to follow the menu and spreadsheet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a dining observation of lunch meal service on 9/23/24 beginning at 12:12 p.m., it was noted Resident 21 was on CCHO diet on meal ticket. Resident 21 received one slice of garlic breadstick. A concurrent review of a facility spreadsheet titled, Fall Menus: Week 4 Monday, showed that CCHO diet should have received one half of garlic breadstick. During an interview on 9/23/24, at 12:23 p.m., the RD verified and reviewed the facility spreadsheet and stated Resident 21 should have received half a slice of garlic bread. The RD stated extra bread may affect the blood sugar level. 3. During meal distribution observation for lunch meal on 9/24/24, starting at 12:10 p.m., it was noted that Resident 20 was on finger food, diet and received a regular apple bread pudding in one piece for dessert. A concurrent review of a facility spreadsheet titled, Fall Menus, Week 4 Tuesday, showed that finger food diet should had received apple bread pudding cut into 4's. During an interview on 9/24/24, at 1:00 p.m., with Dietary Supervisor (DS), DS acknowledged and confirmed that Resident 20's apple bread pudding should have been cut into four pieces. During a review of a facility document titled, Dietary Supervisor- Job Duties and Responsibilities, revised June 2020, indicated .Review therapeutic and regular diet plans and menus to assure they are following the physician's order . During a review of a facility document titled, Job Description Cook, revised 9/01/23, indicated, .follow recipes and prepares foods that correspond to menu cycles .prepared by Dietician .handle .prepared food in accordance with department procedures and in compliance with county, state and federal laws and regulations .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49933 Based on observation, interview, and facility document review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when: 1. The microwave in the kitchen was not clean; 2. Several various sizes of metal sheet pans were stacked wet stored at the clean and ready-to-use storage areas; 3. Produce items were not fresh and not discarded; and, 4. One dishwasher was not able to verbalize the procedure for the manual dishwashing with 3-compartment sinks correctly. These failures had potential to cause food-borne illness in a highly susceptible population of 59 out of 59 residents who received food from the kitchen. 1.During a concurrent observation and interview with Dietary Supervisor (DS) on 9/23/24 at 8:48 a.m. at the kitchen's initial tour, the microwave was observed to have dry liquid splashes on the interior top of the microwave. The DS confirmed the microwave was dirty and stated the dry food splashes and dry food debris should be cleaned. During a review of a facility document titled, Section 8- Sanitation, dated 2023, indicated, .11. All .equipment . shall be kept clean . 2. During a concurrent observation and interview with the DS on 9/23/24 at 9:10 a.m. at the kitchen's initial tour, several metal pans were observed wet and stacked together and stored at the clean and ready-to-use areas. Those metal pans included: -Nine of 1/6 sheet metal pans -eight - 1/8 sheet metal pans, and -two - full sheet metal pans were observed to be wet. DS confirmed and stated that dishes, pots and pans needed to be completely dried before being stored to prevent moisture. DS stated added moisture would cause bacterial growth. During a review of a facility document titled, Dishwashing, dated 2023, indicated, .5. Dishes are to be air dried in racks before stacking and storing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a concurrent observation and interview with the DS on 9/23/24 at 10:52 a.m. at the kitchen's initial tour, a bulk of potatoes were stored in an enclosed container with the lid closed. When the lid was opened, a foul odor was noted coming from inside the bin. Four potatoes were not fresh with black and white indents. Two of them were with white fuzzy substances. All the potatoes were mushy when touched. DS confirmed and stated they were mold and the potatoes were rotten and mushy. DS further stated that the potatoes were bad and should be discarded. During a concurrent observation and interview with the DS on 9/23/24 at 10:55 a.m. at the kitchen's initial tour, a bulk of onions were stored in an enclosed container with the lid closed. When the lid was opened, there were gnats (a group of tiny, winged flies, also called blackflies) flying out from the bin. There were four onions with black and white indents and mushy to touch. There were two onions that were mushy and black. The bottom of the container had a mushy liquid substance. The DS confirmed and stated the onions were not fresh and should be discarded. During a review of a facility document titled, Storing Produce, dated 2023, indicated, .1. Check boxes of . vegetables for rotten, spoiled items one rotten .potato in a box can cause the produce to spoil faster. Throw away all spoiled items . During a review of facility's policy and procedure (P&P) titled, Corrective Action when food in the store room reaches above 85 degrees F (Fahrenheit), dated 2023, indicated, .Onions should feel firm and dry. They should be free of gray or black mold . Potatoes .withering or rot, the potato should be thrown out. 4. A concurrent interview and review of manual dishwashing directions on 9/23/24 at 11:11 a.m. with Dietary Aide (DA) and the DS was conducted. DA stated if the dishwashing machine was not working, he would report to the DS and would start to use the 3-compartment sinks for the dishwashing. DA was not sure of sanitizing solution and stated incorrect immersion time of 20 seconds for the dishes. A concurrent review of the directions on the sanitizer solution bottle, it stated 60 secs for immersion time. DS confirmed and stated the directions indicated 60 seconds for immersion time and further acknowledged she also did not know the correct immersion time because the facility switched to a new supply vendor. During a follow up interview on 9/24/24 at 02:47 p.m. with the Registered Dietitian (RD), she stated the dishwasher and the dietary aides in their position should have a knowledge of the manual dishwashing. During a review of a facility document titled, 3-Compartment procedure for manual dishwashing, dated 2023, the steps manual indicated .Clean .wash .rinse .Step 5. Immerse all washed items for 60 seconds (note time) .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 49933 Based on observation and interview, the facility was unable to provide a clean environment for the residents and visitors when three of three garbage dumpsters, located outside the facility, was not closed securely due to deformed dumpster lids. This failure had the potential for an unsafe environment for the residents and visitors due to possible pest infestation and spread of diseases in the facility. Findings: During a concurrent observation and interview with Dietary Supervisor (DS) on 9/23/24 at 8:38 a.m outside, three out of three dumpsters were covered with bent and deformed lids with bags of trash inside the bins. There were gaps between the deformed lids and the bins because the lids lacked integrity to securely cover the bins. DS confirmed the condition of the dumpster lids and agreed that the facility needed to order new trash bins. The DS further acknowledged that the lids needed to be closed tightly to prevent pest issues. During a review of facility policy and procedure titled, Miscellaneous Areas, last revised 2023, indicated, 1. All food waste must be placed in sealed leak proof, non absorbent, tightly closed containers .the trash collection area is a potential feeding ground for vermin and rodents and must be kept clean . According to the Food and Drug Administration (FDA) Food Code 2022, Section 5-501.15 Outside Receptacle, referenced 7/23/24, (A) Receptacles and waste handling units for refuse .used with materials containing food residue and used outside the food establishment shall be designed and constructed to have tight-fitting lids, doors, or covers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 45770 Based on observation, interview, and record review the facility failed to follow infection prevention and control practices for two of 15 sampled residents (Resident 24 and Resident 15) when: 1. Licensed Nurse 4 (LN 4) did not wear the required Personal Protective Equipment (PPE; equipment worn to protect the body from hazards in the workplace) while providing care to Resident 24 who was on droplet precaution; and, 2. Enhanced Barrier Precautions (EBP; an infection control method) were not implemented for Resident 15 with stage three presurre ulcer (a full thickness skin loss). These failures had the potential to spread infection among residents in the facility. Findings: 1. A review of Resident 24's Admission Record, indicated Resident 24 was admitted in September 2024 with diagnoses including chronic obstructive pulmonary disease (COPD, lung disease that makes it difficult to breathe) and was positive for corona virus disease-19 (COVID-19) 10 days after admission. During an observation on 9/23/24 at 9:10 a.m., a droplet precaution sign was posted on Resident 24's door. LN 4 was observed inside Resident 24's room wearing a surgical mask and speaking near Resident 24's ear while administering medications. During an interview on 9/23/24 at 9:18 a.m. with LN 4, LN 4 confirmed she was just wearing a surgical mask inside Resident 24's room and stated she should have worn the N-95 mask (a respirator mask) because Resident 24 had COVID 19 infection. During an interview on 9/25/24 at 2:10 p.m. with the Director of Nursing (DON), DON stated she expected her staff to accurately follow the proper infection prevention and control practices before entering a room on any precautions to prevent the spread of infection in the facility and placing others at risk. A review of the facility's policy and procedure (P&P) titled, Policies and Practices-Infection Control, revised 10/2018, indicated, This facility's infection control policies and practices are intended .to help prevent . disease and infections . All personnel will be trained on infection control policies and practices .and use pertinent procedures and equipment related to infection control . A review of the facility's P&P titled, Personal Protective Equipment, revised 10/2018, indicated, Personal Protective Equipment . appropriate to specific task .The type of PPE required for a task is based on: the type of transmission-based precaution . 48694 (continued on next page)

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 09/26/2024
NAME OF PROVIDER OR SUPPLIER Gold Country Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4301 Golden Center Drive Placerville, CA 95667	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 15's Admission Record, indicated Resident 15 was admitted in May 2024 with diagnoses including complete paraplegia (inability to move lower body from waist down), weakness, and presurre ulcer on the sacral region (lower back between hip bones). A review of Resident 15's Minimum Data Set (MDS; an assessment tool), dated 8/30/24, indicated presence of a stage three pressure ulcer on the sacral region. During a concurrent observation and interview on 9/24/24 at 11:28 a.m. with LN 3, Resident 15's room was observed. There was no sign on the door indicating EBP. LN 3 checked the personal protective supplies in the lower drawer of Resident 15's dresser as per facility practice and no supplies were available. LN 3 agreed EBP sign and PPE supplies were missing. During an interview on 9/26/24 at 10:30 a.m. with DON, DON stated staff should have placed EBP sign on the door and supplies in bottom drawer of Resident 15's dresser. DON stated missing EBP sign and protective supplies increased the risk of spreading infection to Resident 15, other residents, and staff. During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated 2024, indicated, EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds include those with pressure ulcers . Signs may be posted on the door or wall outside or inside the resident room indicating the type of precautions and PPE required. The facility may choose to have PPE available inside of the resident rooms in a designated drawer or bin or in another area readily accessible for use when needed .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. Building B. Wing	09/26/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48694 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of 15 sampled residents (Resident 18). This failure decreased Resident 18's potential to get assistance from staff in a timely manner when needed. Findings: A review of Resident 18's Admission Record, indicated Resident 18 was admitted to the facility in February 2023 with diagnoses including dementia (impaired ability to remember, think, or make decisions) and need for assistance with personal care. During a concurrent observation and interview on 9/23/24 at 9:23 a.m. with Certified Nursing Assistant 1 (CNA 1), Resident 18 was observed sitting in a chair next to her bed. Resident 18's call light was clipped to the head side of mattress in bed and behind Resident 18. CNA 1 confirmed Resident 18's call light was out of reach. CNA 1 stated the call light was supposed to be in front of Resident 18 and within her reach. During an interview on 9/26/24 at 10:40 a.m. with Director of Nursing (DON), DON stated the call light placed out of reach for Resident 18 might have caused missing needed care and fall. DON further stated staff must place call lights within reach of all residents. A review of the facility's policy and procedure titled, Answering Call Light, dated 2022, indicated, .Ensure that the call light is accessible to the resident .