STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555736	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40583 Based on interview and record review, the facility failed to ensure all necessary baseline care plans were created within forty-eight hours of admission for 1 of 3 sampled residents (Resident 1) when, Resident 1 ' s conditions and risks identified upon admission were not created and implemented as part of Resident 1 ' s baseline care plans. This failure resulted in Resident 1's care plan for communication, dehydration, skin, and incontinence not being created and initiated during any part of Resident 1's stay at the facility as they were not initiated until after Resident 1 was discharged from the facility. Findings: A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility on [DATE] and discharged on [DATE], with diagnoses including urinary tract infection (UTI; an infection in any part of the system of organs that makes urine), muscle weakness, need for assistance with personal care, aphasia (a language disorder that affects a person's ability to communicate), dysphagia (difficulty swallowing foods or liquids), cerebral aneurysm (a bulge in a weakened artery in the brain), and adult failure to thrive (global decline in older adults characterized by weight loss, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depression, and impaired immune function). Review of Resident 1 ' s Progress Notes, dated 5/29/24 through 6/3/2024, indicated Resident 1 was hospitalized throughout that period. Review of Resident 1 ' s Nursing Note, dated 5/4/25, indicated, .Resident arrived to facility in a wheelchair by transport with caregiver present .Resident is here for rehab services to improve strengthening and mobility . Noted to have left side weakness .Noted to have slurred and unclear speech at times d/t [due to] hx of stroke [damage to the brain from interruption of its blood supply]. Caregiver states resident is able to use whiteboard for communication needs as well. Resident is incontinent of bowel and bladder .Requires two person assist with transfer. Currently on regular mechanical soft diet [consists of soft, easily chewed and swallowed foods] with thin fluids .Fluids encouraged and tolerated. Resident noted to have discoloration to left eyebrow and eye lid . (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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's clinical document containing focus, goals and interventions, referred to as care plans, indicated four care plans, created and initiated on 6/3/24, five days after Resident 1 was discharged from the facility, as follows: i.Focus [Resident 1] is at risk for further communication deficits r/t [related to] his current slurred speech and he is sometimes understood/understands .uses a whiteboard and pen to communicate some of his needs . Date Initiated 06/03/24 . ii .Focus [Resident 1] is at risk for dehydration r/t his recent hospitalization for UTI and his recent constipation .Date initiated 06/03/24 . iii.Focus [Resident 1] is at risk for skin impairment r/t his decreased mobility s/p [status post - after] CVA [cerebrovascular accident - a stroke] .secondary to aneurysm .Goal The resident will have intact skin, free of redness, blisters or discoloration by/through review date .Date initiated: 06/03/24 . iv.Focus [Resident 1] is currently occasionally incontinent .risk for further incontinence r/t decreased mobility . Date initiated: 06/03/24 . During an interview with the Assistant Director of Nursing (ADON), on 2/25/25, at 10:45 AM, the ADON stated a communication care plan should have been developed within the first 48 hours of Resident 1 ' s admission to the facility. The ADON explained the care plans direct what we do. The ADON explained if the resident uses a whiteboard for communication, we need to use it and if the care plan for communication was not developed the staff may not know the resident has issues with communication. The ADON further explained the dehydration, incontinence, and skin care plans should have been developed within the first 48 hours of Resident 1 ' s stay. The ADON stated care plans should be developed and initiated prior to the resident's discharge. A review of the facility policy titled, Care Plans - Baseline, revised 3/22, indicated, .A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information .including .initial goals based on admission orders and discussion with the resident/representative .Physician orders .Dietary orders .Therapy services .Social Services .

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40583 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received care in accordance with professional standards of practice when: 1. Resident 1's blood pressure (BP - the measurement of the pressure in your arteries when your heart contracts and pumps blood out) medication amlodipine was administered without consistent monitoring of Resident 1's BP prior to administration of the medication and there were no parameters listed on the order to indicate when to hold the medication; and, 2. Resident 1's BPs were not taken regularly during his stay at the facility and a BP of 272/114 was not acted upon (normal blood pressure is less than 120/80). These failures resulted in Resident 1's BP becoming increasingly elevated with inconsistent BP monitoring once Resident 1 started receiving the BP medication amlodipine. These failures also resulted in a BP of 272/114 not being acted upon by licensed nurses and the medical doctor. Ultimately Resident 1 was transferred to one hospital, then another hospital for a higher level of care, on the same day, due to Resident 1 having a stroke, negatively impacting his health and well-being. Findings: 1. A review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses including hypertension (high BP) and cerebral aneurysm (a bulge in a weakened artery in the brain). A review of Resident 1's clinical document titled, Medication Administration Record [MAR; clinical document that lists the medications and times the medications are to be administered], dated 5/1/24 through 5/31/24, indicated, .amLODIPine .one time a day . related to ESSENTIAL (PRIMARY) HYPERTENSION .Order Date . 05/14/2024 .D/C [Discontinue date] Date .05/21/24, and, .amLODIPine .two times a day . related to ESSENTIAL (PRIMARY) HYPERTENSION .Order Date .05/21/2024 . Resident 1's MAR had areas where BP and pulse were to be inputted each time Resident 1's Amlodipine was administered. Resident 1's MAR showed missing BP and pulse entries on the following dates and shifts: 5/18/24 AM shift, 5/21/24 PM shift, 5/22/24 AM and PM shift; 5/23/24 AM and PM shift, 5/24/24 AM and PM shift, 5/25/24 AM and PM shift, and 5/27/24 AM and PM shift. During an interview on 2/19/25, at 2:25 PM, Licensed Nurse (LN) 1 stated Medical Doctor (MD) 1 wanted parameters (specific instructions for when to give or not give a medication) for the BP medication amlodipine. LN 1 explained it was important to monitor the BP in case the resident had a low BP, and we needed to hold the BP medication. LN 1 further explained if the parameters were not in the order, it was the nurse's responsibility to make sure the parameters were in the order. LN 1 stated the nurses should know to take a residents BP prior to administering the amlodipine medication to the resident. During an interview on 2/19/25, at 2:29 PM, LN 2 stated it was necessary to take a residents BP prior to administering amlodipine. LN 2 explained it would be concerning if the BP was not taken and the medication was administered to the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25, at 3:36 PM, the Assistant Director of Nursing (ADON) stated the medication amlodipine required BP hold parameters. The ADON stated we do not want to give the medication if the BP is too low. The ADON stated there was a risk the residents BP could drop, and if the BP was too high, maybe the medication was not effective. During an interview on 2/21/25, at 10:20 AM, MD 1 stated with the medication amlodipine he would expect the residents BP to be taken at least once per shift. MD 1 stated the risk of not taking the residents BP was not knowing what the residents BP was and there was a risk the residents BP was too high or too low. 2. A review of Resident 1's clinical document titled, Blood Pressure Summary, for the month of May of 2024, indicated the following: 5/6/24 BP was not taken on PM (evening) shift; 5/6/24 BP was not taken on NOC (night) shift; 5/7/24 BP was not taken on AM (morning), PM, and NOC shifts; 5/8/24 BP was not taken AM, PM, and NOC shifts; 5/9/24 BP was not taken AM, PM, and NOC shifts; 5/13/24 BP was not taken AM, PM, and NOC shifts; 5/14/24 BP was not taken AM, PM, and NOC shifts; 5/15/24 BP was not taken on PM and NOC shift; 5/16/24 BP was not taken on PM and NOC shift; 5/17/24 BP was not taken on AM and NOC shift; 5/18/24 BP was not taken on PM and NOC shift; 5/19/24 BP was not taken on NOC shift; 5/20/24 BP was not taken on PM and NOC shift; 5/21/24 BP was not taken on PM and NOC shift; 5/22/24 BP was not taken on NOC shift; 5/23/24 BP was not taken on AM shift and NOC shift; 5/24/24 BP was not taken on AM shift and NOC shift; 5/25/24 BP was not taken on AM and NOC shift; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/26/24 BP was not taken on NOC shift; 5/27/24 BP was not taken on NOC shift; and 5/28/24 BP was not taken on NOC shift. A review of Resident 1's clinical document titled, Progress Notes, dated 5/15/24, indicated, .Noted to look pale .At times noted to have difficulty with speech .Vitals signs obtained noted have elevated BP [160/110] . MD notified and ordered to monitor BP .staff will continue to monitor . A review of Resident 1's clinical document titled, Progress Notes, dated 5/16/24, at 6:31 AM, by MD 1, indicated, .During the acute visit, the patient presented with an isolated increase in blood pressure, raising concern for a potential stroke There were no immediate symptoms suggestive of stroke such as facial droop, arm weakness, or speech difficulties. However, due to the elevated blood pressure reading, further evaluation and monitoring were initiated to assess the patient's neurological status and rule out any underlying cerebrovascular event . A review of Resident 1's clinical document titled, Blood Pressure Summary, dated 5/24/24, indicated Resident 1's BP at 9:22 PM was 272/114 and was recorded by Certified Nursing Assistant (CNA) 1. During an interview on 2/20/25, at 2:57 PM, CNA 1 stated she was required to check resident's vital signs at the beginning of a shift. CNA 1 explained that most nurses required the CNA to check a resident's vital signs at the beginning of the shift and if the CNA did not check the vital signs the nurse would. CNA 1 stated she did not remember taking a BP of 272/114 for Resident 1. CNA 1 explained if a residents BP was 160 or greater she would speak to the nurse. During an interview on 2/24/25, at 11:39 AM, LN 3 stated if she had been notified by the CNA of Resident 1's BP of 272/114, she would have addressed it. LN 3 explained she had not been notified of Resident 1's BP reading of 272/114 on 5/24/25. LN 3 further explained she would have obtained another set of vital signs, checked the BP on both arms, and then she would have notified the MD if Resident 1's BP was that high. During an interview on 2/21/25, at 10:20 AM, MD 1 stated his expectation for the frequency of taking a resident vital sign's (VS; include BP and heart rate) was every shift, every day. MD 1 explained the importance of monitoring residents VS were that residents were sick. MD 1 further explained he would expect to be notified if a residents BP was too high. MD 1 stated in the case of a resident with an aneurysm, he did not want the residents BP to be too high and would expect the nurse to call him if it was. MD 1 explained a BP of 140/90 was getting high and a blood pressure with a systolic number (the first number of a BP which indicates the pressure your blood is pushing against your artery walls when the heart beats) of 160 was too high. MD 1 further explained if the resident had an aneurysm, it created increased pressure on the aneurysm, and you wanted to have the BP controlled because it creates a situation where you could have a bleed (aneurysm ruptures) and that was the importance to take a resident's VS at least once a shift. MD 1 stated Resident 1's BP of 272/114 (taken on 5/24/24) should have been reported to the Director of Nursing (DON) and he should have been informed as he would have sent Resident 1 to the emergency roiagnom on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the ADON, on 2/19/25, at 3:36 PM, the ADON stated Resident 1's BP of 272/114 should have been reported to someone. The ADON explained it could have been a change in condition, and nursing would have needed to be alerted so it could have been addressed. During a concurrent interview and record review on 2/25/25, at 10:45 AM, Resident 1's medical record was reviewed with the ADON. The ADON stated if Resident 1's progress notes indicated monitor BP it would mean the Medical Doctor wanted us to take Resident 1's BP and notify him of any irregularities. The ADON explained the importance of checking Resident 1's BP was to see if Resident 1 was still having elevated BP. The ADON further explained she would want to be able to notify the physician if there was a change in Resident 1's condition. The ADON acknowledged Resident 1's BP was not taken and monitored as it should have been. A review of Resident 1's clinical document titled, Progress Notes, dated 5/29/24, at 10:16 AM, indicated, . resident reported had 2 strokes yesterday, resident could not say time of event, c/o [complained of] R [right] sided weakness .b/p [blood pressure] 178/88 .resident requesting to be sent out to ER [emergency room] due to him not feeling normal. MD [Medical Doctor] made aware and agreed to send him out to ER for further eval . A review of Resident 1's clinical document titled, Progress Notes, dated, 5/29/24, at 6:08 PM, indicated, .ER nurse stated [Resident 1] was transport [sic] to [higher level of care hospital] at 1700 [5 PM] . A review of Resident 1's clinical document from a facility Resident 1 was transferred to titled, Department of Neurological Surgery Hospital Discharge Summary, dated 1/21/25, indicated, .HPI [history of present illness] . [Resident 1] .when caregiver saw him last (able to communicate with speech and white board). Found to have worsening dysarthria [a speech disorder that makes it hard to speak clearly], weaker and less coordinated with right hand. Initially went to [name of local hospital] where he was severely dysarthric. CTA [CTA computed tomography angiography, a non-invasive imaging procedure that uses X-rays to create pictures of blood vessels] noted large vertebral artery aneurysm continuing into a second large unruptured aneurysm with compression of the brainstem .[Resident 1] was transferred to [another hospital] for higher level of care due to concern for enlarging aneurysm and possible mass effect [the effects of a growing mass on nearby tissue] .Assessment and Plan .Large unruptured .aneurysm x2 .Brainstem compression .New stroke . A review of the facility document titled, Certified Nursing Assistant, revised 10/20, indicated, .Report all changes in the resident's condition to the Charge Nurse/Nurse Supervisor as soon as practical .Measure residents .blood pressure .and document in the official medical record . A review of the facility document titled, Licensed Practical (Vocational) Nurse (LPN)/(LVN), revised 5/22, indicated, .Obtain and document resident vital signs as needed . A review of an online article published by the American College of Cardiology titled, Guidelines on Management of Patients With Unruptured Intracranial Aneurysms, dated 7/7/15, indicated, .The following are 10 points to remember about the American Heart Association/American Stroke Association Guidelines for the Management of Patients With Unruptured Intracranial Aneurysms (UIAs) .Given that hypertension may play a role in growth and rupture of IAs [intracranial aneurysm], patients with UIA [unruptured intracranial aneurysm] should monitor blood pressure and undergo treatment for hypertension . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2015/07/07/15/20/guidelines-for-the-management-of-patients-with-unruptured-intracranial-aneurysms)