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	07/01/2025

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

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide adequate supervision to prevent a fall for 1 of 5 sampled residents (Resident 1) when, Resident 1 was left unattended in the bathroom.This failure caused Resident 1 to sustain a fall which resulted in a scalp laceration (cut to the head).Findings:A review of Resident 1's admission RECORD, indicated, she was admitted to the facility on [DATE], with diagnoses which included traumatic subdural hemorrhage (a type of bleeding near the brain that can happen after a head injury) with loss of consciousness (loss of awareness of oneself and one's surroundings) and muscle weakness. A review of Resident 1's pre-admission document titled, Transcriptions-Referral . (hospital information provided to the facility prior to admission to determine if they can meet the needs of the resident) indicated, .admission H&P [history and physical] .6/14/2025 .Chief complaint .possible fall with head strike 4 days ago .transferred from an outside hospital for a higher level of care due to subdural hematoma .Four days prior to transfer, she experienced a fall and hit her head . the section titled, PT [physical therapy] Progress Note, dated 6/17/25, at 12:32 PM, indicated, .Safety Awareness Impaired due to cognition . Standard Safety .Bed in low position, Call device within reach .Fall Risk band on .Anticipated discharge to Inpatient rehab .Discharge Change in Functional Status . Strength loss, Mental status .A review of Resident 1's Progress Notes, dated 6/20/25, at 6:45 PM, indicated, .Nursing Progress Note .Resident arrived to facility around 1730 [5:30 PM] .Able to perform full ROM [range of motion] but with weakness and slow movements. Noted to be weaker to left upper extremity [arm] .Bed remains in low position .A review of Resident 1's Progress Notes, dated 6/20/25, at 10 PM, indicated, .Res [resident] found lying on the floor of the bathroom. It appears that the resident attempted to walk or self-transfer and fell. When asked what happened, the resident stated, I don't know.Blood coming from laceration to right side of scalp .EMS [emergency medical services] took res via ambulance to .ER [emergency room] .A review of Resident 1's Care Plan Report, initiated 6/20/25, indicated, .[Resident 1] is at moderate risk for falls r/t [related to] deconditioning [decline in function], gait/balance problems, and impaired communication .assist with toileting .During an interview on 7/1/25, at 3:39 PM, with Certified Nurse Assistant (CNA) 2, CNA 2 stated, on 6/20/25, he transferred Resident 1 from her wheelchair to the toilet and placed the wheelchair next to her on the left side. CNA 2 further stated Resident 1 was alert, but she slurred her words and had left sided weakness. CNA 2 stated he asked Resident 1 if she wanted privacy and she stated she did. CNA 2 stated he left Resident 1 in the bathroom and went across the hall to the nurse's station to write down Resident 1's vital signs. CNA 2 stated he was gone two minutes and when he returned Resident 1 was on the floor near the sink. During a telephone interview on 7/2/25, at 9:17 AM, with Licensed Nurse (LN) 9, LN 9 stated Resident 1 had been admitted to the facility 3-4 hours prior to the fall. LN 9 further stated, on admission, Resident 1 had been alert but could not state where she was and her responses were delayed. LN 9 stated she was in the hallway when she was alerted by CNA 2 that Resident 1 had fallen. LN 9 further stated she entered the bathroom and witnessed Resident 1 on the floor with blood coming from her head. LN 9 stated she applied pressure to the wound while LN 8 called 911. A review of Resident 1's ED [emergency department] Physician Notes, dated 6/21/25, indicated, .History .Patient struck the posterior [back] part of her head on the ground and had significant bleeding .Procedures .Laceration Repair .The wound was reapproximated [the separated parts were brought back together] in one layer utilizing four staples .During a telephone interview on 7/8/25, at 9:53 AM, with the Director of Staff Development (DSD), the DSD stated, when a resident was identified as a fall risk staff needed to stay close even if the resident requested privacy. The DSD further stated staff should always be within reach and stay right outside the bathroom door for resident safety. A review of a facility policy titled, Fall Management and Neurological Check, dated 1/25, indicated, .The center implements a fall management plan based on medical history review and resident evaluation .History and physical exams are reviewed for potential history of falls .