

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555736	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/02/2025
NAME OF PROVIDER OR SUPPLIER Golden Sonora Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to immediately notify the responsible party or family member about a resident's death for 1 of 1 resident (Resident 1). This deficient practice violated Resident 1's responsible party (RP), the right to be informed of the resident's change in condition or death. A review of Resident 1's admission RECORD, indicated Resident 1's contact list had 7 different contact persons and Family Member (FM) 1 was the responsible party (RP) for Resident 1. During an interview on [DATE], at 12:53 PM, with Family Member (FM) 1, FM 1 stated she was at the facility the night before and when she came back the next morning, she found Resident 1's room empty and was told that Resident 1 passed away. FM 1 stated that she reviewed Resident 1's medical records, which indicated that the reporting party was notified. FM 1 stated that the facility did not call her, and other family members were reportedly informed but after speaking with them, they confirmed that they had not been notified either. FM 1 stated she was the RP for Resident 1, and everything went through her before the facility reached out to other family members. FM 1 stated Social Services (SS) did not contact her as well. FM 1 stated the hospice agency (provides end-of-life care for terminally ill patients, focusing on comfort and quality of life rather than cure) contacted her after she showed up at the facility and the hospice agency already knew that she was not notified by the facility. FM 1 stated the facility said numerous family members was present at the time of the death, but it was not true. During an interview on [DATE], at 1:46 PM, with License Nurse (LN) 1, LN 1 stated when a resident passed away, as a nurse she needed to assess the resident and notify the hospice nurse. LN 1 stated either the facility, or the hospice would call the family. LN 1 stated the nurses also notified the doctor. LN 1 stated it was important to call the family because they need to know. LN 1 stated the nurses contacted the RP or the emergency contact #1, then would go down the list of contact persons if they could not reach the RP. During a concurrent interview and record review, on [DATE], at 2:01 PM, with the Director of Nursing (DON), the DON stated that when a resident on hospice passed away, she expected her nurses to do an initial assessment, and make appropriate notifications to hospice, to the MD, and to the family of the resident. At 2:03 PM, the Assistant Director of Nursing (ADON) joined the concurrent interview and record review with the DON. The ADON stated that the facility would notify the hospice agency and contact the family for any change of condition (COC) of the resident. The ADON further stated that the nurses would also inform the facility's medical director who oversaw the care. The ADON stated she expected nurses to contact the hospice agency first when a resident passed away. The ADON stated the nurse would talk to the hospice nurse and determine who would contact the family then they would coordinate together. The DON stated it was important to contact the family of the resident that passed away so that they were aware and not be surprised when they made a visit. Resident 1's progress notes, dated [DATE], at 8:30 PM, was reviewed with the DON and the ADON. Resident 1's progress note indicated that the family was at the facility the night before she passed. The ADON confirmed that the family was not at bedside when Resident 1 passed away at around 3 AM on [DATE]. The DON stated that the hospice was contacted by the nurse, and the hospice agency said they would contact the family and would send a hospice nurse to the facility. The ADON stated if a resident was not on hospice, the facility would contact the family for death notification, the nurse would call the RP or the emergency contact #1 or and they would keep calling everybody on the list if the RP could not be reached. The ADON stated the nurse noted that the hospice would notify the family. The ADON stated the nurses should have notified the family even if the hospice agency said they would call the family. During an interview on [DATE], at 2:46 PM, with the Social Service Assistant (SSA), the SSA stated when a resident on hospice passed away, the nurses notified the family of the resident. The SSA stated the nurses were supposed to call the family and the hospice agency. The SSA stated the family of Resident 1 should have been notified and it was important to notify the family, and they should be the first to know or be notified. During an interview on [DATE], at 3:18 PM, with LN 2, LN 2 stated that she would contact the family when a resident passed away, regardless of whether the resident was on hospice care or not. LN 2 stated the nurses also notify the medical director. LN 2 stated that it was important to contact the RP, or the family if the resident was actively dying, has died, or if there was any change in condition. LN 2 stated that the family must be notified because they expected that they would be informed of any changes in condition, regardless of severity, especially if the resident passed away. LN 2 stated even if the hospice agency said they would contact the family, she would still need to contact the family because she would not be sure if the hospice</p>