

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  12/09/2025
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)
<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>(continued on next page)</p>

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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure medications with physician-ordered parameters were safely administered for one of three sampled residents (Resident 1) when metoprolol (a medication used to control blood pressure) was given to Resident 1 on 11/16/25 and 11/29/25 despite her vital signs (VS-includes heart rate (pulse) and blood pressure) being outside the physician's parameters and not documented on her medication administration record. These failures potentially contributed to Resident 1 experiencing hypotension, requiring emergency evaluation on 11/18/25, and increasing the risk of further health complications. Findings: A review of Resident 1's Medication Administration Record (MAR) dated 11/1/25 through 11/30/25 indicated the following physician's order: .Metoprolol Tartrate Oral Tablet 25 MG. Give 0.5 tablet via J-Tube [a tube placed directly into the jejunum [middle part of the small intestine] used to give food and medicine] every 8 hours for hypertension [high blood pressure]. Hold if SBP &lt;100 [Systolic Blood pressure-top number in a blood pressure reading-less than 100], HR &lt;60 [Heart Rate [pulse] less than 60]. A review of Resident 1's Weights and Vitals Summary for 11/2025 indicated the following: on 11/16/25 Morning shift BP 126/77, no pulse was recorded. Afternoon shift BP 90/66, pulse 90. Evening shift BP and pulse were not recorded. On 11/29/25 Afternoon shift BP was 89/65. A review of Resident 1's MAR, dated 11/2025 indicated Resident 1's metoprolol was administered to her on 11/16/25 on the morning, afternoon, and evening shift and on 11/29/25 on the afternoon shift. Further review of Resident 1's MAR also revealed a BP reading and a pulse were not documented by an LN on the MAR on 11/16/25 for all three shifts. During a concurrent interview and record review with Licensed Nurse (LN) 1, on 12/9/25 at 11:56 AM, LN 1 reviewed Resident 1's Medication Administration Record [MAR] and Weights and Vitals Summary for 11/2025 and verified that on 11/16/25, metoprolol was administered to Resident 1 during the morning, afternoon, and evening shift even though Resident 1's blood pressure and pulse were not documented on the MAR. LN 1 verified during a review of Resident 1's Weights and Vitals Summary that on 11/16/25 Resident 1's BP and pulse were outside of the hold parameters and the metoprolol should not have been administered. A review of Resident 1's Progress Notes dated 11/17/25 indicated Resident 1's physician (MD) documented, . Metoprolol for hypertension. We will continue to maintain the blood pressure log and monitor closely .A review of Resident 1's Progress Notes dated 11/17/25 at 1:25 PM, indicated that LN 4 documented .Pt will be going to a GI (Gastroenterology, digestive system specialist) consult appointment at 2:15 (PM). A review of Resident 1's Progress Notes dated 11/17/25 at 8:56 PM, LN 7 documented, .Resident was sent to [the] ER [Emergency Room] following a GI appointment. called for an update and was told they are going to keep [the] resident [Resident 1] d/t [due to] low HR [heart rate] AND LOW BP. A review of Resident 1's ED [Emergency Department] Physician Notes dated 11/18/25 at 1:43 AM, indicated .(Resident 1) presents for evaluation of low blood pressure. She was at the GI clinic where they found her blood pressure was 75/49. She looked pale and was dizzy so they sent her here (ED) for evaluation. Reason for visit: Weakness or fatigue. Resident 1 was discharged from ED Observation on 11/18/25 at 3: 57 AM with Diagnoses of Hypotension (low BP) and rapid atrial fibrillation (an irregular, fast heartbeat). During a phone interview with LN 5 on 12/31/25 at 10:28 AM, LN 5 stated that she worked with Resident 1 on 11/16/25 at 10:00 PM (evening shift) when Metoprolol was scheduled for administration. LN 5 stated that the Metoprolol should not be administered if the systolic blood pressure was below 100 and/or the heart rate was below 60. LN 5 stated that administering Metoprolol without checking VS could cause the resident to become hypotensive. During a phone interview with LN 6 on 12/31/25 at 11:00 AM, LN 6 stated that he was the nurse caring for Resident 1 on 11/29/25 at 2:00 PM (afternoon shift) when metoprolol was scheduled for administration. LN 6 confirmed that the physician's order to hold metoprolol for systolic BP less than 100 and/or HR less than 60 was correct and verified that the medication should not be administered when those parameters are not met. LN 6 stated that he typically obtains VS prior to administering metoprolol and was aware that Resident 1's BP frequently ran low. LN 6 stated that the metoprolol should have been held on 11/29/25 for the 2:00 PM dose due to a documented BP of 89/65. LN 6 stated that failure to adhere to the metoprolol hold parameters could result in hypotension. A review of the facility policy titled PREPARATION AND GENERAL GUIDELINES dated 10/17, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices. Medications are administered in accordance with written orders of the attending physician.</p>		