

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 04/02/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure treatment and care was provided in accordance with professional standards of practice for two of four sampled residents (Resident 1 and Resident 2) when: 1. Resident 1's ammonia levels test results (blood test that measures waste buildup caused by liver or kidney failure) on 3/23/26, 3/26/26 and 3/29/26 were not reported to the MD (medical doctor), and; 2. Resident 2's basic metabolic panel (BMP - laboratory test to check on fluid balance, kidney function and blood sugar levels) laboratory results on 3/23/26 and 3/30/26 were not reported to the MD. These failures had the potential for the facility to not recognize Resident 1 and Resident 2's potential change in conditions which could have resulted in delays in their care and worsening conditions. Findings: 1. A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses that included hepatic encephalopathy (a brain dysfunction condition caused by advanced liver disease when toxins like ammonia builds up and affects brain function), liver cirrhosis (permanent scarring of the liver caused by long term damage which hinders blood flow and the ability to filter toxins), and chronic kidney disease (condition when the kidneys are permanently damaged and not filtering blood properly). A review of Resident 1's medical record titled, Order Listing Report, indicated, lab work: check ammonia levels. Notify doctor if labs are about 65 [reference range - 9 to 35] every day shift. was ordered on 3/21/26. A review of Resident 1's medical record, the ammonia level laboratory results were as follows: a. 3/21/26 = 57 b. 3/22/26 = 51 c. 3/23/26 = 66 d. 3/24/26 = 57 e. 3/26/26 = 71f. 3/27/26 = 52 g. 3/29/26 = 93h. 3/30/26 at 1500 (3 p.m.) = 93i. 3/30/26 at 1951 (7:51 p.m.) = 44 j. 4/1/26 = 42A review of Resident 1's medical record titled, Progress Notes, indicated the following dates with ammonia level results above 65, were as follows: a. 3/23/26 -No documentation found for Resident 1's ammonia levels were received and reported to MD.b. 3/26/26 - .Ammonia. Serum level. Drawn this morning. Value 71. no documentation of the result reported to MD. c. 3/29/26 - no documentation found for Resident 1's ammonia levels were received and reported to MD.d. 3/30/26 - .[Resident 1's preferred name] informed this writer regarding his concern about his ammonia level yesterday was 93.Requested to sent out to ER [emergency room] if the result of the ammonia level today (blood drawn 1.5 H [1 hour and 30 minutes] ago) is still high. RN on duty informed [MD] obtained an order to send him out to .ER. During a concurrent interview and record review on 4/1/26, at 2:31 p.m., with Licensed Nurse (LN) 1, Resident 1's medical record was reviewed. LN 1 confirmed Resident 1 had an order for his ammonia levels to be checked daily and to have notified the MD if the result was above 65, dated 3/21/26. LN 1 stated Resident 1 had an order for medication called Lactulose (medication for constipation and to reduce ammonia levels in the blood) to manage his ammonia levels. LN 1 further stated this medication was the reason for the frequent ammonia levels to be checked so the MD could have adjusted the medication dose based on the results. LN 1 stated it was important to have provided Resident 1 with the care that he needed because he relied on the facility for his overall health. LN 1 further stated Resident 1's health could have gone downhill and could get depressed if he was not getting the care he needed. During an interview on 4/1/26, at 3:25 p.m., with LN 2, LN 2 stated when the resident had a laboratory blood draw order, the nurse would have sent the results to the MD for (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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>review to determine what was needed to be ordered for the resident. During an interview on 4/2/26, at 10:14 a.m., with LN 3, LN 3 stated if a resident had laboratory blood draw orders and the results were already received, the nurse would have notified by messaging or faxing the results to the MD. LN 3 further stated the nurse would have called the MD right away if the laboratory results were critical or urgent. LN 3 stated the nurse would have documented under the resident's progress notes if the nurse followed up and to have also indicated any MD orders. During a concurrent interview and record review on 4/2/26, at 11:55 a.m., with the Unit Manager (UM), Resident 1's medical record was reviewed. The UM confirmed Resident 1's ammonia daily laboratory order indicated a result of 65 and above should have been reported to the MD. The UM stated Resident 1 had ammonia level results above 65 on the following dates without any documentation that the results were reported to the MD on 3/23/26, 3/26/26 and 3/29/26. The UM further stated the nurses who received laboratory results should have documented in Resident 1's chart that the MD was notified, laboratory results were sent and whether MD ordered anything based on the results. The UM stated it was important to have reported Resident 1's ammonia laboratory results because his Lactulose medication could have been adjusted or he could have been sent out to the hospital if needed. The UM further stated it was important for the nurse to have documented to determine if the results were reported to the MD. The UM further stated Resident 1's ammonia levels could have been unnecessarily high and would also have been hard to track due to the lack of documentation. 2. A review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility in 2025 with diagnoses that included dementia (a progressive state of decline in mental abilities) and cognitive communication deficit (difficulty with speaking, listening or understanding). A review of Resident 2's medical record under MD orders indicated, .bmp [basic metabolic panel] in the morning every Mon [Monday] for hyponatremia [a condition when the level of sodium/salt in the blood is low]. ordered on 3/23/26. A review of Resident 2's medical record indicated Resident 2 had BMP laboratory results completed on 3/23/26 and 3/30/26. A review of Resident 2's medical record titled, Progress Notes, indicated there was no documentation found for Resident 2's BMP results received, faxed or reported to the MD for the results dated 3/23/26 and 3/30/26. During a concurrent interview and record review on 4/2/26, at 11:55 a.m., with the UM, Resident 2's medical record was reviewed. The UM confirmed Resident 2 had a BMP order in place to be done every Monday for hyponatremia. The UM verified Resident 2 had BMP laboratory results dated [DATE] and 3/30/26 and confirmed no documentation was found in Resident 2's chart that these results were reported or faxed to the MD. The UM stated the nurses who received Resident 2's laboratory results should have at least documented if the results were faxed to the MD. During an interview on 4/2/26, at 3:03 p.m., with the Assistant Director of Nursing (ADON), the ADON stated staff were expected to have documented on a resident's chart upon receipt of laboratory results, whether MD was notified, and have faxed the results to the MD's office. The ADON further stated it was important for the residents to get their laboratory orders completed as ordered and to have reported the results to the MD timely because it could potentially cause a delay in the resident's care.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on interview, and record review, the facility failed to obtain laboratory testing for one of four sampled residents (Resident 1) when Resident 1's order for daily ammonia level tests (blood test that measures waste buildup caused by liver or kidney failure) was not completed on 3/25/26, 3/28/26 and 3/31/26. This failure had the potential for Resident 1's ammonia levels to further increase which could potentially lead to confusion, extreme fatigue and severe health issues affecting his brain function. Findings:A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 with diagnoses that included hepatic encephalopathy (a brain dysfunction condition caused by advanced liver disease when toxins like ammonia builds up and affects brain function), liver cirrhosis (permanent scarring of the liver caused by long term damage which hinders blood flow and the ability to filter toxins), and chronic kidney disease (condition when the kidneys are permanently damaged and not filtering blood properly).A review of Resident 1's medical record titled, Order Listing Report, indicated, .lab work: check ammonia levels. Notify doctor if labs are about 65 every day shift. was ordered on 3/21/26.During a joint interview on 4/1/26, at 1:30 p.m., with Resident 1 and Resident 1's Family Member (FM), Resident 1 stated he was upset because he had an order for his ammonia levels to be checked daily and the facility had not been able to get them done. Resident 1 further stated his last ammonia blood draw was done on Monday (3/30/26) when he went to the hospital and the facility had not drawn his blood since then. Resident 1 stated his ammonia level got high at 93 and went down to 44 when he went to the hospital on 3/30/26. Resident 1's FM stated she was concerned about Resident 1's ammonia levels not being checked daily and that he had to go to the hospital on Monday just to get it checked.During a concurrent interview and record review on 4/1/26, at 2:31 p.m., with Licensed Nurse (LN) 1, Resident 1's medical record was reviewed. LN 1 confirmed Resident 1 had an order in place for ammonia levels to be checked daily since 3/21/26. LN 1 stated the blood draws were done by the facility's nurses and the blood samples were then taken to the hospital laboratory to be processed. LN 1 further stated if Resident 1's ammonia levels were not being checked, it could have caused serious complications of his organs shutting down, toxicity to the brain, and worst case would have been death.During an interview on 4/1/26, at 3:25 p.m., with LN 2, LN 2 stated the laboratory blood draws were usually done in the morning time and the resident would be monitored for 72 hours until the results were received. LN 2 further stated the nurse should have followed up with the laboratory for results to be sent to the MD (medical doctor) to be reviewed.A review of Resident 1's medical record for Resident 1's ammonia laboratory results from the timeframe 3/21/26 to 4/1/26, indicated there were no results for 3/25/26, 3/28/26 and 3/31/26.During a concurrent interview and record review on 4/1/26, at 4:09 p.m., with the Unit Manager (UM), Resident 1's ammonia level results were reviewed. The UM confirmed Resident 1 did not have ammonia level results on 3/25/26, 3/28/26 and 3/31/26. The UM stated the importance of following Resident 1's laboratory orders were due to the need to check his ammonia levels daily because the levels could have changed at any time. The UM further stated the risk of not getting Resident 1's ammonia levels checked would have been extremely high levels which could have caused him to have been lethargic (a decrease in consciousness) and unresponsive.During a follow-up interview on 4/2/26, at 1:17 p.m., with Resident 1, Resident 1 stated he went out of the facility for an appointment at the hospital on 3/31/26 and had returned before lunch time. Resident 1 further stated the facility had time to get his blood drawn that day, but they were not able to do so.During a concurrent interview and record review on 4/2/26, at 11:55 a.m., with the UM, Resident 1's medical record was reviewed. The UM stated all laboratory orders were drawn by the facility nurses during the morning shift. The UM further stated if the morning shift nurse was unsuccessful with the blood draw, it would have been passed on to the evening shift for as long as the sample was drawn before midnight. The UM stated it was important to have blood specimens drawn timely, because the laboratory would have set timeframes to have processed the results. The UM further stated delays in drawing blood could have caused levels to be (continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>unknown, either to be high or unstable. The UM stated the residents would be placed on alert charting following the blood draw and the nurse was supposed to have documented and to have followed-up with the laboratory for the results. The UM further stated if the nurse was not able to draw the resident's blood sample or have not obtained the results, the nurse should have notified management to get it addressed and to have documented in the resident's chart. The UM confirmed Resident 1's order for daily ammonia levels to be checked was not followed based on the missing results for dates 3/25/26, 3/28/26 and 3/31/26. During an interview on 4/2/26, at 3:03 p.m., with the Assistant Director of Nursing (ADON), the ADON stated a resident's blood draw could have been drawn every shift by the nurses. The ADON further stated it was her expectation from the nurses to have notified the UM, ADON, Director of Nursing (DON) and the resident's MD if they were not able to complete the blood draw. The ADON stated it was important for the nurses to have kept track of any resident with laboratory orders with documentation that the blood was drawn and to have followed-up with the laboratory for the results. The ADON further stated it was important to have followed the MD's laboratory orders because there could have been critical results that could potentially be missed that needed immediate attention. The ADON stated the risk of missing a resident's laboratory orders could have meant the facility was not meeting the care needed by the resident. During a phone interview on 4/3/26, at 2:15 a.m., with the [LABORATORY STAFF NAME], the [LABORATORY STAFF NAME] stated the facility's staff would come and drop off blood draw specimens to the laboratory to be processed. The [LABORATORY STAFF NAME] further stated ammonia blood draws should have been delivered to the laboratory within 20 minutes of being drawn and was considered a STAT order (order needs to be carried out immediately). The [LABORATORY STAFF NAME] further stated the laboratory kept logs of specimen drop-offs and reviewed the log for Resident 1's ammonia blood specimens the laboratory received from the facility. The [LABORATORY STAFF NAME] confirmed Resident 1's ammonia blood draw specimens were not received by the laboratory on dates 3/25/26, 3/28/26 and 3/31/26. The [LABORATORY STAFF NAME] stated if the laboratory received a blood sample that was not viable (laboratory sample that was properly collected for accurate results), the facility would have been notified to obtain a new sample to be processed.</p>		