

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/09/2026
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)		
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. Based on interview and record review the facility failed to ensure professional standards of care were met for one of three sampled residents (Resident 1), when the licensed staff did not obtain a physician's order for care and monitoring or develop a specific care plan related to when Resident 1 sustained an abrasion (wound) to his right thigh during a witnessed fall on 4/8/26. These failures placed Resident 1 at risk of infection and unidentified wound deterioration. Findings: A review of Resident 1's admission RECORD, indicated he was admitted to the facility with diagnoses which included hemiplegia and hemiparesis (weakness or inability to move one side of the body). During an interview on 7/9/26 at 1:24 PM with Resident 1, Resident 1 stated approximately two to three months ago, during a transfer with a mechanical lift (an assistive device used to safely transfer immobile residents between a bed and a chair or wheelchair) staff lost control of him and he was dropped to the floor. Resident 1 further stated he could not remember much else about the incident. During a review of Resident 1's clinical document titled, Alert Charting: Fall/Accident/Injury, dated 4/8/26 at 9:13 PM, the document indicated, .Resident was pulling himself up into a [Brand name mechanical standing aide] with assistance when resident stated, 'I can't pull myself up'. Residents wheelchair was moved behind resident when resident began to slip from [standing aide]. Wheelchair had both breaks on and slid back back [sic], when CNA [certified nurse assistant] then had to assist resident to ground. Resident was assessed, an 8 cm [centimeter, unit of measure] x [by] 4 cm [approximately 3 inches by 1.5 inches] abrasion to right posterior [back of] thigh was noted. (documentation had strike out lines through entire note and strike out reason indicated, not required). During an interview on 7/9/26 at 3:38 PM with licensed nurse (LN) 2, LN 2 stated she was called into Resident 1's room on 4/8/26 by CNA 2. LN 2 further stated when she entered the room, she observed Resident 1 on the floor with his legs still in the standing aide. LN 2 stated she assessed Resident 1 and noted a skin tear to the back of his thigh. LN 2 stated she had no further recollection of the incident. During an interview on 7/10/26 at 10:23 AM with CNA 2, CNA 2 stated on 4/8/26, there were two CNAs in the room transferring Resident 1 from the wheelchair to bed. CNA 2 stated he assisted Resident 1 while the other CNA held the mechanical lift aid device. CNA 2 stated he instructed Resident 1 to pull himself up using the bar on the mechanical lift aide. CNA 2 further stated Resident 1 was unable to pull himself up and the mechanical lift moved away from Resident 1. CNA 2 stated Resident 1 had pushed the wheelchair away when he tried to stand and CNA 2 could not place the wheelchair back under Resident 1, and that was when CNA 2 stated he guided Resident 1 to the floor. During an interview on 7/9/26 at 3:07 PM with the Assistant Director of Nurses (ADON), the ADON confirmed there was no physician's order, care plan, or documentation in Resident 1's clinical record to indicate the LN had routinely monitored Resident 1's abrasion for signs of infection or worsening of the wound. The ADON stated a care plan should have been initiated and an order obtained to ensure proper care was provided. The ADON stated it was her expectation that the licensed nurses would monitor (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's abrasion routinely due to the potential for worsening and/or infection. During a review of a facility policy and procedure (P&P) titled, Skin Integrity, the P&P indicated, .For new skin impairment identified, the LN completes the following: Documents the impairment that includes measurements of location, size, color, presence of odor, exudate, and presence of pain associated with the skin impairment. Bruises, skin tears and abrasions are monitored on the Treatment Administration Record (TAR) weekly, until resolved. Notifies the medical provider and, if needed, obtains a treatment order. Implements interventions and documents on the resident's care plan.		