

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 06/20/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40583</p> <p>Based on observation, interview, and record review, the facility failed to ensure privacy and dignity were maintained for one of seven resident's (Resident 2) with a urine collection bag (urinary catheter-a tube that is inserted into the bladder and drains into a collection bag) in a census of 170, when Resident 2's urine collection bag did not have a privacy cover over it.</p> <p>This failure had the potential to negatively impact Resident 2's feelings of dignity and self-worth.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility with diagnoses which included the need for assistance with personal care.</p> <p>A review of Resident 2's Care Plan, initiated on 2/22/24, indicated, [Resident 2] has a [brand name] catheter .The resident will be/remain free from catheter-related trauma through review date .</p> <p>During an observation on 6/18/24, at 12:37 PM, in Resident 2's room, Resident 2's urinary collection bag was noted to be not covered with a privacy bag.</p> <p>During a subsequent observation on 6/19/24, at 3:19 PM, in Resident 2's room, Resident 2's urinary collection bag remained uncovered.</p> <p>During a concurrent observation and interview with certified nursing assistant (CNA) 4, in Resident 2's room, CNA 4 confirmed Resident 2's urine collection bag did not have a privacy cover on it. CNA 4 explained people should not be able to see the urine in the bag.</p> <p>During an interview on 6/20/24, at 11:10 AM, with the Director of Nursing (DON), the DON stated the urine collection bag being uncovered was a dignity issue. The DON explained her expectation was for the bag to be covered to preserve Resident 2's dignity.</p> <p>A review of the facility policy titled, Dignity, revised 2/2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Staff are expected to promote dignity and assist residents; for example . helping the resident to keep urinary bags covered .</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
---	-------	-----------

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 06/20/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>47046</p> <p>Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of needs for 2 of 39 sampled residents (Resident 103 and 169) when:</p> <ol style="list-style-type: none"> 1. Resident 103's call light (a device used to call for assistance) was not within reach; and, 2. Resident 169's call light was not within reach. <p>This failure had the potential to result in Resident 103 and 169 being unable to ask for needed assistance.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 103's Admission Record, indicated Resident 103 was admitted to the facility with multiple diagnoses which included muscle weakness and difficulty in walking. <p>During an observation on 6/18/24, at 8:01 a.m., in Resident 103's room, Resident 103 was observed sitting at the edge of his bed with no call light visible. Resident 103 was seen trying to use the television remote control to call for help.</p> <p>During a concurrent observation and interview on 6/18/24, at 8:07 a.m., with Certified Nursing Assistant (CNA) 1 in Resident 103's room, CNA 1 confirmed Resident 103's call light was on the floor and out of reach. CNA 1 stated when Resident 103's call light was not within reach, Resident 103 would not be able to call for assistance.</p> <p>A review of Resident 103's Care plan initiated on 5/14/23, indicated, .[Resident 103] is at risk due to .gait [walking]/balance problems, HX [history] of falls .Interventions .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .</p> <p>During an interview on 6/20/24, at 8:29 a.m., with the Director of Nursing (DON), the DON stated residents should have access to their call light. The DON also stated when the call light was not within reach of the resident, facility staff would not be able to meet the resident's needs. The DON further stated when the call light was not within reach, facility staff may not be able to prevent falls.</p> <p>43943</p> <ol style="list-style-type: none"> 2. During a review of Resident 169's clinical record titled, Admission Record, indicated Resident 169's diagnoses included stroke (the brain did not receive oxygen for a period of time causing damage), paralysis (unable to move a side part of the body) on the right side of the body, chronic pain, and difficulty walking. <p>During a concurrent observation and interview with CNA 4 on 6/17/24, at 12:30 p.m., in Resident 169's room, Resident 169 was found in his bed with the call light on the floor on the right side of his bed. CNA 4 confirmed the call light was not within reach of Resident 169.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 169's clinical record titled, Section GG, (an assessment that highlights the resident's ability with everyday activities) indicated Resident 169 needed supervision with eating, oral care, personal hygiene, and toileting hygiene, and was dependent on staff for showering, lower body dressing, and putting on and taking off footwear.</p> <p>A review of Resident 169's clinical record titled, Care Plan, dated 5/28/24, indicated, Resident 169 was at risk for falls related to a stroke, required staff oversight, and had poor safety awareness. An intervention included to have Resident 169's call light within reach.</p> <p>A review of Resident 169's clinical record titled, Morse fall Scale V1, (an assessment tool utilized to predict the risk of falls) indicated Resident 169 was at high risk for falls related to being bedbound, weak, and an impaired walking ability.</p> <p>During an interview on 6/17/24, at 12:36 p.m., with CNA 4, CNA 4 stated Resident 169 was on hospice (end of life care), was paralyzed on one side of his body, and had seizures (uncontrolled body movements). CNA 4 stated it was important for Resident 169 to have the call light in place because he was unable to get out of bed without assistance and was dependent on staff for meeting his needs.</p> <p>During an interview on 6/17/24, at 12:40 p.m., with Licensed Nurse (LN) 1, LN 1 stated Resident 169 was dependent on staff to meet his needs and was not able to pick the call light off of the ground. LN 1 stated Resident 169 was at risk for accidents.</p> <p>During a concurrent interview and record review on 6/20/24, at 9 a.m., with the DON, the undated Policy and Procedure (P&P) titled, Answering the Call Light, was reviewed. The P&P indicated, .When the resident is in bed .be sure the call light is within easy reach of the resident . The DON stated the residents' call light should have been in reach. The DON further stated Resident 169 was a high risk for falls and was dependent on staff to meet his needs. The DON explained staff should have made more frequent rounds and ensured the call light was within reach after care was provided. The DON acknowledged the P&P was not followed.</p> <p>A review of the facility's policy and procedure (P&P) titled, Answering the Call Light, revised February 2020, indicated, .The purpose .is to ensure timely responses to the resident's requests and needs .upon admission and periodically as needed, explain and demonstrate use of the light to the resident .Ask the resident to return the demonstration .When the resident is in bed .be sure the call light is within easy reach of the resident .</p>

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 06/20/2024
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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>47046</p> <p>Based on interview, and record review, the facility failed to ensure 1 of 39 sampled residents (Resident 150) right to self-determination was respected when Resident 1 requested to get a shower instead of a bed bath and staff did not honor his wishes.</p> <p>This failure had the potential to negatively impact Resident 150's psychosocial well-being.</p> <p>Findings:</p> <p>A review of Resident 150's ADMISSION RECORD, indicated that Resident 150 was admitted with diagnoses which included abnormalities of gait (walking) and mobility and the need for assistance with personal care.</p> <p>During an interview on 6/20/24, at 12:47 p.m., with Resident 150, Resident 150 stated he was not given his shower last week on his shower days. Resident 150 stated that he was told by a Certified Nursing Assistant (CNA) that they did not have time to give Resident 150 a shower.</p> <p>During a concurrent interview and record review on 6/20/24, at 7:09 a.m., with the Director of Nursing (DON), Resident 150's clinical records were reviewed. Resident 150's Minimum Data Set (MDS, an assessment and care screening tool) dated 4/26/24, indicated Resident 150 needed partial to moderate assistance for a shower/bath, confirmed by the DON. Resident 150's ADLs (activities of daily living) task was also reviewed. The DON was not able to provide any documentation that Resident 150 was given a shower or bed bath on his shower days.</p> <p>During a concurrent interview and record review on 6/20/24, at 11:05 a.m., with CNA 2, Resident 150's ADLs task was reviewed. CNA 2 was not able to find if a shower or bed bath was provided to Resident 150 the week prior. CNA 2 stated when Resident 150 asked for a shower he should have received a shower.</p> <p>During an interview on 6/20/24, at 11:08 a.m., with the DON, the DON stated she expected CNAs to give residents a shower. The DON further stated if Resident 150 preferred a shower, he should have received shower.</p> <p>A review of Resident 150's Care plan initiated on 1/8/24, indicated, .[Resident 103] requires extensive assistance by (1) staff to provide .shower and as necessary .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Dignity, revised 2/2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .When assisting with care, residents are supported in exercising their rights .</p>		

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 06/20/2024
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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>47369</p> <p>Based on interview and record review the facility failed to ensure a process was in place for 42 residents, who had funds in the facility trust account (a legal arrangement through which funds are held by a third party), to request and receive personal funds on the weekends or after hours.</p> <p>This failure had the potential to result in residents not having access to their personal funds for dining, shopping, or other resident centered activities after business hours and on the weekend which could adversely affect their psychosocial well-being.</p> <p>Findings:</p> <p>1. A review of Resident 28's ADMISSION RECORD, indicated she was readmitted to the facility in 2022.</p> <p>During an interview on 6/18/2024, at 7:20 AM, Resident 28 stated the facility held her money and she was not able to access cash on the weekends.</p> <p>During an interview and record review on 6/18/2024, at 4:07 PM, the Business Office Manager Assistant (BOMA) stated residents' funds were deposited directly into the facility trust account and stayed there until the residents requested it. The BOMA further stated if a resident wanted cash, they could request it from the business office and receive their cash during business hours. The BOMA stated after hours and on weekends, cash was available at the nurse's stations. The BOMA further stated there was a total of twenty dollars available at each nurse's station.</p> <p>During an interview on 6/18/24, at 8:34 AM, on the south nurse's station, Licensed Nurse (LN) 9 stated she worked full time and was not aware of petty cash being available at the nurse's station for residents. LN 9 stated there were occasions when the business office would leave an envelope designated for a particular resident, but cash was not always available for the residents.</p> <p>During an interview on 6/20/24, at 8:34 AM, the Administrative Assistant (AA) stated if residents requested more than twenty dollars or multiple residents requested cash they would have to wait until the following Monday to get funds or a nurse could call the business office and they would come in.</p> <p>During an interview on 6/20/24, at 8:50 AM, on the east nurse's station, LN 3 stated he worked full time including weekends and was not aware of any cash being available at the nurse's station for residents who had accounts.</p> <p>During an interview on 6/20/24, at 8:53 AM, on the north nurse's station, LN 10 stated there was no petty cash available at the nurse's station. LN 10 stated she did not know what she would do if a resident asked for cash on the weekend.</p> <p>During an interview on 6/20/2024, at 10:55 AM, the Assistant Director of Nurses (ADON) stated the residents had the right to have money available to purchase the items they needed or wanted. The ADON further stated there was the potential for residents to be unhappy if their needs were not met or staff could not accommodate their requests.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49823</p> <p>2. A review of Resident 98's Admission Record, indicated Resident 98 was admitted to the facility in 2023.</p> <p>During an interview on 06/18/24, at 10:55 a.m., with Resident 98, Resident 98 stated, I got thirty-five dollars a month.</p> <p>During an interview on 06/18/24, at 11:20 a.m., with the Business Office Manager (BOM), in the Business Office, the BOM was asked what the process was for residents with a trust account to access their personal funds. The BOM stated that during the weekdays, the residents came to the Business Office and filled out a form, then the BOM got their money from the safe. When asked what the process was for after hours and weekends, the BOM stated that on the weekends, twenty dollars was left at each nurses' station in case a resident wanted money, as the Business Office was not open on the weekends. When asked if the twenty dollars was per resident or twenty dollars only, the BOM stated that it was twenty dollars on each unit only in case a resident wanted cash on the weekends.</p> <p>During an interview on 06/20/24 at 08:44 a.m. with Licensed Nurse LN 14, at the [NAME] Unit nurses' station, LN 14 stated that she was not sure of the facility process for fulfilling resident requests for money at the facility. LN 14 stated that she would have to ask someone.</p> <p>During an interview on 06/20/24 at 08:46 a.m. with LN 15, at the [NAME] Unit nurses' station, LN 15 stated that she was not sure of the facility process for fulfilling resident requests for money at the facility. LN 15 stated that she wasn't sure if there was money at the nurses' station for resident requests for money after hours or on the weekends. LN 15 stated that she did not know where the money for residents would be kept on the unit after hours or on the weekends.</p> <p>During a review of a facility policy and procedure (P&P) titled, Deposit of Residents' Personal Funds, revised March 2021, the P&P indicated, .Policy Interpretation and Implementation .2. If a resident chooses for the facility to hold, safeguard, and manage his or her personal funds, the facility: .d. provides the resident access to funds of one hundred dollars (fifty dollars for long term care residents on Medicaid [low income health insurance]) or less within twenty-four (24) hours .</p>		

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 06/20/2024
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>47369</p> <p>Based on interview and record review, the facility failed to coordinate assessments with the Preadmission Screening and Resident Review (PASRR, a federal requirement to screen all potential nursing home residents for mental illness and intellectual disability, to help ensure that individuals are not inappropriately placed in a nursing home, and to ensure they receive any specialized services that are required) program for 1 of 39 sampled residents (Resident 26) when Resident 26's PASRR level I screening assessment did not include her mental illness diagnosis of schizophrenia (a serious mental illness that affects how a person thinks, feels and behaves).</p> <p>These failures had the potential for Resident 26 to not receive the necessary services to meet her mental and psychosocial (link between social factors and individual thought and behavior) needs.</p> <p>Findings:</p> <p>A review of Resident 26's ADMISSION RECORD, indicated, she was readmitted to the facility in 2023.</p> <p>A review of Resident 26's - Minimum Data Set (MDS, a resident assessment and screening tool) Section I-Active Diagnoses, dated 10/18/2023, indicated, .Psychiatric/Mood Disorder .Schizophrenia .</p> <p>A review of Resident 26's care plan revised 11/22/2023, indicated, .deficit r/t [related to] dementia and schizophrenia .strikes out at staff, bites, hits, kicks, yells and screams at staff .</p> <p>A review of Resident 26's HISTORY AND PHYSICAL, dated 12/4/2023, indicated, .readmitted for schizophrenia .</p> <p>A review of Resident 26's Preadmission Screening and Resident Review (PASRR) Level I Screening dated, 4/25/2023, indicated, Facility Information .Result of Level I screening: Level I- Negative .Reason Code: No Serious Mental Illness .Section III-Serious Mental Illness-Definition .Does the Individual have a serious diagnosed mental disorder such as . Schizophrenia .or symptoms of Psychosis, Delusions, or Mood Disturbance? . No .</p> <p>During an interview on 6/20/24, at 7:04 AM, the Health Information Services (HIS) staff stated when residents were admitted from the hospital the HIS performed an audit to ensure the PASRR was received. The HIS further stated she was not sure who was responsible to ensure the accuracy of the completed form. The HIS stated if a resident was admitted with a psychiatric medication, she checked to ensure the diagnosis for the medication was included on the PASRR. The HIS further stated if there was a change in a resident's condition the MDS coordinator would inform them and the Assistant Director of Nurses (ADON) would complete a new PASRR.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/18/2024, at 11:30 AM, the ADON confirmed Resident 26's PASRR level I did not include her mental illness diagnosis. The ADON stated when there was a new or updated diagnosis for a resident the MDS coordinator would open a significant change MDS and notify the ADON to redo the PASSR. The ADON further stated the purpose of the PASRR was to determine if residents with a mental illness could benefit from outside services and to provide specialized services for their care needs.</p> <p>A review of an undated facility policy titled, PASRR Completion Policy, indicated, .The Center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASRR) completed . Center Administrator will designate either the Admissions Director or Social Worker to make sure that the PASSRR [sic] .is done on all potential residents .Administrator is accountable for monitoring the process of completing the necessary paperwork .</p>		

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 06/20/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>49823</p> <p>Based on observation, interview, and record review, the facility failed to ensure an environment free of accidents or hazards for one resident (Resident 80) in a census of 170 with access to smoking paraphernalia when Resident 80 went to the sidewalk in front of the facility to smoke unsupervised.</p> <p>This failure had the potential to place Resident 80 at risk for accidental burns and injuries.</p> <p>Findings:</p> <p>A review of Resident 80's Admission Record, indicated, Resident 80 was admitted to the facility in mid-2023 with diagnoses which include chronic obstructive pulmonary disease (COPD, a long-term lung disease that causes shortness of breath and cough), pulmonary embolism (occurs when a blood clot gets stuck in an artery in the lung blocking blood flow to the lung), and diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).</p> <p>During an observation and interview with Resident 80 outside the facility near the front entrance on 06/18/24 at 2:20 p.m., Resident 80 was observed walking outside of the facility toward the street with a walker. Resident 80 was observed to have an unsteady gait. When Resident 80 was asked where she was going, Resident 80 stated she was going to smoke.</p> <p>During a concurrent observation and interview with Resident 80 in her room on 6/19/24 at 1:05 p.m., Resident 80 was observed eating lunch and wore an oxygen nasal cannula (a small flexible tube that contains two open prongs intended to sit just inside the nostrils allowing additional oxygen to be breathed in thru the nose). Resident 80 was asked about walking outside facility toward the street the day before. Resident 80 stated that she went to smoke. Resident 80 stated that she went to the front of the facility, went out the door, then went down to the sidewalk in front of the facility to smoke twice a day. Resident 80 stated that she did not take her oxygen with her when she went to smoke. Resident 80 stated that there was no smoking on facility grounds, so she went to the sidewalk to smoke so that she was off the property. Resident 80 stated that she received a notice that there was no smoking on the property as of June 1st. Resident 80 stated that the facility staff were aware that she left the building twice a day to smoke on the sidewalk in front of the facility. Resident 80 stated that she kept her cigarettes and a cigarette lighter in a canvas bag tied to her walker; Resident 80 pointed to the canvas bag tied to one of the handles of her walker. Resident 80 stated that a family member brought the cigarettes to her.</p> <p>During an interview with Licensed Nurse (LN) 16 on 06/19/24 at 1:17 p.m. at the medication cart on the [NAME] Unit, LN 16 stated that all the residents who smoked cigarettes on the [NAME] Unit had nicotine patches, so none of them smoked cigarettes anymore. LN 16 stated that licensed staff did not keep cigarettes for any of the residents. LN 16 stated that if any residents on the unit had cigarettes and/or cigarette lighters, they were not supposed to.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LN 10, at the East Unit Nurses' station on 06/19/24 at 3:24 p.m., LN 10 stated that notice was given to the residents that no smoking was allowed on the property. LN 10 stated that on the East Unit, two residents smoked when out with family, but not at the facility. LN 10 stated both residents refused a nicotine patch (a patch that sticks on the skin and contains a small dose of nicotine, which enters the blood by being absorbed through the skin. A nicotine patch is used to help people stop smoking cigarettes).</p> <p>During an interview with Certified Nursing Assistant (CNA) 5 on the East Unit on 06/19/24 at 3:28 p.m., CNA 5 stated that residents who smoked were offered nicotine patches. CNA 5 stated that she hadn't smelled cigarette smoke in the facility for weeks.</p> <p>During an interview with CNA 3 on 06/19/24 at 3:30 p.m. on the East Unit, CNA 3 stated none of the residents on the East Unit smoked.</p> <p>During an interview with the facility Administrator (ADM) on 06/19/24 at 5:31 p.m. in the Activity Room, the ADM stated that all facility residents had been notified that the facility had become a no smoking facility. The ADM stated that residents who smoked were given the option of nicotine patches at no cost to them to help them quit smoking. The ADM stated that Resident 80 had been offered nicotine patches, and Resident 80 had refused nicotine patches and had been non-compliant with the no smoking policy. The ADM stated that she was aware that Resident 80 had left the facility to smoke, and that Resident 80 had yelled profanities at facility staff when they talked to her about it.</p> <p>During a review of a facility policy and procedure (P&P) titled, Accidents and Incidents - Investigating and Reporting, revised July 2017, the P&P indicated, .All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator .1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident .5. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident .7. Incident/Accident reports will be reviewed by the Safety Committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities .</p>

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 06/20/2024
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>47369</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of thirty nine sampled residents (Resident 189) was provided services consistent with professional standards of practice when Resident 189's Peripherally Inserted Central Catheter (PICC line; a thin, soft long tube that is inserted into a vein in the arm with the tip of the catheter positioned in a large vein that carries blood to the heart in order to provide medications) dressing was not changed per physician orders.</p> <p>This failure had the potential to result in a PICC line malfunction and/or infection for Resident 189.</p> <p>Findings:</p> <p>A review of Resident 189's ADMISSION RECORD, indicated he was admitted to the facility in mid-2024 with diagnoses which included bacteremia (an infection of the blood).</p> <p>During a concurrent observation and interview on 6/17/2027, at 3:52 PM, Licensed Nurse (LN) 4 confirmed Resident 189's PICC line dressing was dated 6/8/2024. LN 4 stated the PICC line dressing should be changed every week on the night shift.</p> <p>During an interview on 6/17/2024, at 5:41 PM, LN 3 confirmed Resident 189's PICC line dressing should have been changed weekly on the evening shift. LN 3 stated if the dressing was not changed as ordered Resident 189 was at risk of further infection.</p> <p>A review of Resident 189's care plan, revised 6/3/24, indicated, . [Resident 189] is on IV [intravenous, in the vein] medication for antibiotic therapy .The resident will not have any complications related to IV Therapy .IV DRESSING: Observe dressing every shift. Change dressing and record observations of site .</p> <p>A review of Resident 189's Medication Administration Record (MAR), dated June 2024, indicated, Change PICC line dressing every evening shift every Friday-Order Date- 6/3/2024 . there was no documentation to indicate the dressing was changed on Friday, 6/7/2024. The MAR indicated the PICC line dressing was changed on 6/14/2024.</p> <p>During a concurrent interview and record review on 6/18/24, at 11:22 AM, the Assistant Director of Nurses (ADON) confirmed the MAR indicated Resident 189's dressing was changed on 6/14/24. The ADON stated the nurse who had documented the dressing as changed had reinforced the dressing and had not changed it. The ADON further stated it was her expectation that PICC line dressings would be assessed daily, and the dressings would be changed per facility protocol and as ordered. The ADON stated the purpose of changing the dressing weekly was to prevent infection, and to ensure the catheter did not get occluded (obstructed) or dislodged.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility policy and procedure titled, Central Venous Catheter Dressing Changes, revised April 2016, indicated, .The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings .Apply and maintain sterile dressing on intravenous access devices. Dressings must stay clean, dry, and intact .Change .dressings at least every 5-7 days .</p>

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 06/20/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>47046</p> <p>Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided in accordance with professional standards of practice for one of 39 sampled residents (Resident 52) when Resident 52's oxygen tubing was not changed per physician order.</p> <p>This failure had the potential to result in a negative impact on the Resident 52s' health and safety.</p> <p>Findings:</p> <p>A review of Resident 52's Admission Record indicated Resident 52 was admitted to the facility with diagnoses which included respiratory failure (a condition in which a person's blood doesn't have enough oxygen).</p> <p>During an observation on 6/17/24, at 2:56 p.m., Resident 52 was observed in her room with the oxygen concentrator (a machine that uses room air to deliver pure oxygen) on and running at a flow rate of 3 liters per minute (LPM, unit of measurement for oxygen delivery) via nasal cannula (a small flexible tube that contains two open prongs intended to sit just inside the nostrils). When asked, Resident 52 stated she had been using oxygen since her last stay at the hospital.</p> <p>During a concurrent observation and interview on 6/17/23, at 3:05 p.m., with the Licensed Nurse (LN) 5 in Resident 52's room, LN 5 confirmed Resident 52's oxygen tubing was dated 6/3/24. LN 5 stated Resident 52's oxygen tubing should be changed once a week.</p> <p>During an interview on 6/19/24, at 3:52 p.m. with the Director of Nursing (DON), the DON stated, all residents' oxygen tubing should be changed weekly and should be dated. The DON stated oxygen tubing was changed to avoid an infection.</p> <p>Review of Resident 52's active physician order indicated, .Start Date: 6/3/24 .Order Summary: Change Oxygen tubing . every week .</p>

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 06/20/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>47369</p> <p>Based on interview and record review, the facility failed to ensure one of thirty nine sampled residents (Resident 71) received services consistent with professional standards of practice when Resident 71's pre and post dialysis (treatment of kidney failure that rids the blood of unwanted toxins, waste products, and excess fluids by filtering the blood) documentation (documentation that communicates the residents weight, blood pressure, temperature and heart rate,vital signs), dialysis catheter site (flexible tube placed in the blood vessel inserted in the chest consisting of two tubes one to take blood to the dialysis machine and one to return blood to the body) assessment, medication changes, changes in condition, and other pertinent clinical information, between the facility and dialysis center) was incomplete for 5 out of 6 days of treatment.</p> <p>This failure resulted in a lack of communication between the dialysis center and the facility and had the potential to result in adverse health consequences for Resident 71.</p> <p>Findings:</p> <p>A review of Resident 71's ADMISSION RECORD, indicated, he was admitted to the facility in early 2024 with diagnoses which included end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids).</p> <p>A review of Resident 71's Order Summary Report, indicated, .Dialysis Post Assessment: Complete the Dialysis Post Assessment form when resident returns from dialysis. every day shift Mon, Wed, Fri Complete as soon as possible after resident returns from dialysis .Order Date 3/29/2024 . and .Pre-Dialysis Assessment and communication form: Assessment and communication form to be completed prior to appointment time and send form to Dialysis with resident in the morning every Mon, Wed, Fri .Order Date 3/10/2024 .</p> <p>A review of Resident 71's Progress Notes, indicated, .6/12/2024 04:40 [4:40 AM] .Pre-Dialysis Evaluation . There was no post dialysis documentation in the electronic health record (EHR) for 6/12/24.</p> <p>During an interview on 6/20/24, at 12:01 PM, Licensed Nurse (LN) 2, stated dialysis paperwork was filled out to document the resident's clinical assessment before and after dialysis treatments. LN 2 further stated staff needed to monitor Resident 71's weight and vital signs. LN 2 stated there was a potential for Resident 71's blood pressure to drop after dialysis, for bleeding at his catheter site and a change in his alertness. LN 2 further stated if staff did not assess Resident 71 when he returned from dialysis, they would not be able to respond immediately if he had an issue and they could miss a potential adverse outcome.</p> <p>(continued on next page)</p>

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 06/20/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/20/2024, at 11:45 AM, the Assistant Director of Nurses (ADON) provided documents titled, .NSG [nursing] Dialysis -Pre- Dialysis Assessment & Communication . dated 6/3/2024, at 5:25 AM, and .NSG Dialysis Post Assessment . dated 6/5/2024, at 9:45 AM. The ADON confirmed there was no post dialysis documentation completed on 6/3/2024 and 6/12/24, no pre dialysis documentation completed on 6/5/2024, and no pre or post dialysis documentation completed on 6/7/24 or 6/10/24. The ADON confirmed there was no documentation in Resident 71's EHR to indicate he had declined dialysis treatments on 6/7/24 or 6/10/24. The ADON stated it was her expectation that dialysis documentation would be completed for Resident 71 before and after his dialysis treatments. The ADON further stated the purpose of the documentation was to maintain communication between the dialysis center and the facility. The ADON stated there was potential for negative outcomes to the resident if there was a lack of communication between the facility and the dialysis center.</p> <p>A review of a facility policy titled, End-Stage Renal Disease, Care of a Resident with, revised September 2012, indicated, .Residents with end -stage renal disease (ESRD) will be cared for according to currently recognized standards of care .Education and training of staff includes .the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis .signs and symptoms of worsening condition .how to recognize and intervene in medical emergencies .how information will be exchanged between the facilities .</p>		

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 06/20/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>43943</p> <p>Based on interview and record review, the facility failed to ensure accurate dispensing and administering of narcotic drugs (regulated and highly addictive pain medication) for one of 39 sampled residents (Resident 545).</p> <p>This failure resulted in Resident 545 not being administered pain medication for the management of pancreatic (pancreas, an organ in the body that makes juices that help break down food into substances the body can use) cancer and lung cancer.</p> <p>Findings:</p> <p>Review of Resident 545's clinical record titled, Admission Record (a document that contained the resident's demographic information), indicated Resident 545's diagnoses included pancreatic and lung cancer.</p> <p>During a concurrent observation, interview, and record review on 6/20/24, at 10:06 AM, with the Licensed Nurse (LN) 10, the locked narcotic drawer for Medication Cart B on the North station and the Antibiotic or Controlled Drug Record document (a record of when a narcotic was administered from the medication cart) was reviewed. Inside Medication Cart B was Resident 545's medication card (a sealed medicine card that had clear blisters which are numbered to quickly and easily see if medications have been taken) titled, oxycodone HCL [pain medication] 5 mg tab [tablet], indicated Resident 545 had two tablets remaining on the card. The document Antibiotic or Controlled Drug Record indicated one oxycodone 5 mg tablet was pulled from the medication card on 6/19/24 at 11:30 PM and on 6/20/24 at 4:30 a.m. LN 10 stated the process for counting narcotics was that the ongoing and incoming nurse reconciled the narcotic medications that were left on the medication card with the Antibiotic or Controlled Drug Record, and the counts were supposed to be the same. LN 10 stated after LN 10 and LN 13 reconciled the two documents and the counts were not the same (there was supposed to be zero tablets left on the medication card, and there were two remaining on the card), LN 10 stated LN 13 crossed out the medication administration times at 11:30 p.m. and 4:30 a.m. and wrote, not given.</p> <p>A review of Resident 545's clinical record titled, Medication Administration Record (MAR), indicated LN 13 administered Oxycodone 5 mg 1 tablet to Resident 545 for a 6 out of 10 pain level (pain scale 0-10 with 0 = no pain and 10=the worst pain), on June 19 at 10:46 PM.</p> <p>During an interview on 6/20/24, at 10:30 a.m., with Resident 545, Resident 545 stated she didn't sleep well during the night, and she was in pain. Resident 545 stated she requested pain medication at night but was unsure if she received the medication.</p> <p>During an interview on 6/20/24, at 10:36 a.m., with the Assistant Director of Nursing (ADON), the ADON stated after investigating the discrepancy between the Antibiotic or Controlled Drug Record book and the medication card, the conclusion was that LN 13 had documented the Oxycodone 5 mg 1 tablet had been given to Resident 545, but the medication had not been given, as evidenced by two extra medications in the medication card. The ADON stated Resident 545 was at risk for uncontrolled pain because the pain medication was not given the requested amount of times.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/20/24, at 12:23 p.m., with the Director of Nursing (DON), the DON stated her understanding of the events was LN 13 signed out the oxycodone 5 mg (1 tablet) medication but failed to administer the medication to Resident 545 the requested amount of times.</p> <p>During an interview on 6/20/24, at 1:45 p.m., with the Assistant Director of Nursing (ADON), the ADON stated she was unable to verify if the oxycodone medication was given to Resident 545 on 6/19/24 or 6/20/24 by LN 13 based on the oxycodone medication card count. The ADON stated based on the oxycodone medication card count, the medication was not given because there were 0 expected medications, and 2 medications were found.</p> <p>During a phone interview on 6/20/24, at 3:21 p.m., with LN 13, LN 13 stated she was unsure how many times she administered oxycodone to Resident 545 during her shift. LN 13 stated there were more pills on the oxycodone medication card than there was supposed to be, and she was unsure how that happened. LN 13 stated she owned her mistake, and the Antibiotic or Control Drug record book and Oxycodone medication card should have matched and LN 13 verified the count was not correct.</p> <p>During a review of Resident 545's clinical record titled, Care Plan, dated 6/17/24, indicated Resident 545 had pain related to pancreatic cancer and an intervention was to respond immediately to any complaint of pain.</p> <p>During a concurrent interview and record review on 6/20/24, at 3:30 p.m., with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Pain Assessment and Management, dated 10/22, was reviewed. The P&P indicated, . The system of reconciling the receipt, dispensing and disposition of controlled substance includes . Nursing staff count controlled medication inventory at the end of each shift, . the nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing . The DON stated the oxycodone medication count did not match the count of medication signed out and the P&P not followed.</p>		

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 06/20/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>43943</p> <p>Based on interview and record review, the facility failed to ensure proper use of psychotropic drugs (affecting brain activity) for 1 of 39 sampled residents (Resident 155) when:</p> <p>The physician did not document a rationale for extending PRN (as needed) medication beyond 14 days for Resident 155.</p> <p>This failure could have resulted in the use of unnecessary medications and placed the residents at risk for injury.</p> <p>Findings:</p> <p>A review of Resident 155's medical record titled, Order Audit Report, dated 4/1/24, by the PHYS (Physician), indicated, Resident 155 was ordered to receive Lorazepam (psychotropic/anti-anxiety medication) 0.5 milligrams (mg - unit of measurement) every 12 hours as needed for agitation for a duration of 6 months.</p> <p>During an interview on 6/19/24, at 10:23 a.m., with the Medical Director (MD), the MD stated the ordering physician should have documented the rationale for continuing Resident 155's Lorazepam PRN order past the two-week time period.</p> <p>During an interview on 6/19/24, at 10:30 a.m., with the Administrator (ADM), the ADM stated she was unable to find any documentation in Resident 155's clinical record that indicated the reason to extend Lorazepam PRN past the two-week time period.</p> <p>During a phone interview on 6/19/24, at 10:37 a.m., with the Pharmacy Consultant (PC), the PC stated the physician should have had a justification noted in the clinical record for extending the PRN medication past the two-week duration time period. The PC stated there are times the two week PRN medication is extended and that was when a resident was on hospice (end of life care).</p> <p>During an interview on 6/19/24, at 1:35 p.m., with Licensed Nurse (LN) 6, LN 6 stated physicians usually wrote PRN orders for up to two weeks. LN 6 stated the importance of the two-week time frame was to re-evaluate the need and effectiveness of the medication.</p> <p>During an interview on 6/20/24, at 7:22 a.m., with LN 8, LN 8 stated the usual duration for PRN medications is 10 days. LN 8 stated physicians will sometimes write the PRN order for 60 or 90 days if the resident was on hospice. LN 8 stated it was not the normal practice to exceed 14 days.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview at facility record review on 6/20/24, at 9:05 a.m., with the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Psychotropic Medication Use, dated 6/21, was reviewed. The P&P indicated, . For psychotropic prn medications, . if the attending physician . believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record . The DON stated PRN medication was valid for two weeks and then the physician should have reassessed the resident and re-ordered the medication if needed. The DON stated the risk for death among the elderly with psychotropic medications was a concern. The DON acknowledged the P&P was not followed.</p> <p>A review of the facility's Policy and Procedure (P&P), titled, Administering Medications, dated 4/2019, indicated, . Medications are administered in accordance with the prescriber orders . Medication administration times are determined by resident need and benefit .</p>		

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 06/20/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>40583</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were labeled and stored appropriately when:</p> <ol style="list-style-type: none"> 1. Medication bottles had spillage on them, and there was a sticky substance on the bottom of the medication storage drawers in the medication carts; and, 2. An insulin pen (a device used to inject insulin, a medication to control blood sugar) for Resident 92, was available for use past its expiration date. <p>These failures had the potential to cause illness in residents receiving medications from bottles of medications with spillage on them and Resident 92 was at risk of receiving insulin that had lost its efficacy (potency).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1a. During a concurrent interview and inspection of the facility's [NAME] Hall Medication Cart B, on 6/20/24, at 9:30 AM, accompanied by licensed nurse (LN) 15, the medication cart's third drawer, on the right-hand side, contained bottles of liquid medications with spillage on the outside for the following medications and supplements; Liquid Protein, Milk of Magnesia, and Valproic Acid. LN 15 confirmed the bottles contained a sticky residue and that there was a sticky residue on the bottom of the drawer as well. b. During a concurrent interview and inspection of the facility's East Hall Medication Cart B, on 6/20/24, at 9:47 AM, accompanied by LN 17, the drawer containing liquid medications contained a bottle of cough syrup with spillage on the outside and a sticky residue was noted on the bottom of the drawer. LN 17 confirmed the findings. <ol style="list-style-type: none"> 2. A review of Resident 92's Admission Record indicated Resident 92 was admitted to the facility with Type 2 Diabetes Mellitus (a disease due to a problem in the way the body regulates and uses sugar as a fuel). <p>During a concurrent interview and inspection of the facility's South Hall Medication Cart B, on 6/20/24, 11:43 AM, accompanied by LN 2, an insulin pen for Resident 92 indicated it was opened on 5/18/24 and was to be discarded 28 days after opening, on 6/15/24. LN 2 stated Resident 92 received the insulin every day, and confirmed it was the only insulin pen in the medication cart for Resident 92. LN 2 explained the importance of not using an insulin pen past its expiration date was to ensure effectiveness of the medication.</p> <p>(continued on next page)</p>

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 06/20/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON), on 6/20/24, at 9:42 AM, the DON stated the drawers need to be kept clean. The DON explained if the drawers were not kept clean the residual medications could attract microorganisms and there could be a risk for infection in residents. The DON further explained her expectations were for the medication drawers to be kept clean and organized every shift.</p> <p>A review of the facility policy titled, Insulin Administration, revised 9/2014, indicated, .To provide guidelines for the safe administration of insulin to residents with diabetes .Check expiration date .If opening a new vial, record expiration date and time on the vial (follow manufacturer recommendations for expiration after opening).</p> <p>A review of the facility policy titled, Storage of Medication, revised 11/2020, indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed .</p>		

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 06/20/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>47046</p> <p>Based on observation, interview, and record review, the facility failed to ensure food being served for the lunch meal on 6/19/24 was accurate for 10 residents when 10 residents with an order for Double Protein instead received double of each food item for a census of 171.</p> <p>This failure had the potential for all 10 residents' nutritional needs not to be met and could lead to nutritional related health complications.</p> <p>Findings:</p> <p>During an observation of the lunch meal service on 6/19/24 in the kitchen, 10 residents whose meal tickets indicated an order for DOUBLE PROTEIN were instead served double portions of each food item plated on the meal tray.</p> <p>During an interview on 6/20/24 at 3:27 p.m., with the District Manager (DM), the DM stated, staff should prepare and serve what was ordered. The DM also stated the Dietary Manager should have been present during tray line to make sure the process was done correctly.</p> <p>A review of a facility provided document titled, TRAYLINE ACCURACY/MENU COMPLIANCE, dated 2010, indicated, .The end results of tray line accuracy .are .residents maintain nutritional adequacy .</p>

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 06/20/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47046</p> <p>Based on observation, interview, and record review, the facility failed to follow proper food handling practices for 171 residents who received food from the kitchen when:</p> <ol style="list-style-type: none"> 1. Multiple food items were found not labeled with a use by date (the last date recommended for the use of the product while at peak quality) in the refrigerator, freezer, and the dry storage area (foods that do not require to be kept cold), and were available for resident consumption (to eat/drink); 2. Expired (outdated) food products were not removed from the kitchen, and were available for resident consumption; 3. A fan above the double coffee maker in the kitchen had dust and lint; 4. Plastic cups in the kitchen were stacked wet after washing; 5. Three opened boxes of plastic silverware were opened and uncovered in the dry storage area; 6. The [NAME] Unit nursing station's nourishment (food) refrigerator contained unlabeled food items; and, 7. The East Unit nursing station refrigerator contained hair, spilled liquid, and stains. <p>These failures had the potential to cause an outbreak of food borne illnesses (eating or drinking something that is contaminated with germs or chemicals that can make people sick) among the 171 residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1a. During a concurrent observation and interview on [DATE] at 9:56 a.m., with the kitchen's Assistant Manager (AM) in the walk-in refrigerator, the AM confirmed an opened 1.3 Kg (Kilogram- a unit of weight) bottle of No sugar added [brand name] Apple Sauce was not labeled with a use by date. b. During a concurrent observation and interview on [DATE] at 10:07 a.m., with the AM in the walk-in refrigerator, the AM confirmed a bottle of yellow mustard was opened on [DATE] and had no use by date. c. During a concurrent observation and interview on [DATE] at 10:08 a.m., with the AM in the walk-in refrigerator, the AM confirmed four opened 1lb (pound- a unit of weight) bags of whipped topping were not labeled with a use by date. d. During a concurrent observation and interview on [DATE], at 10:10 a.m., with the AM in the walk-in refrigerator, the AM confirmed six open bags of one doenz English muffins had no use by date. <p>(continued on next page)</p>		

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 06/20/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. During a concurrent observation and interview on [DATE] at 10:16 a.m., with the AM in the walk-in freezer, the AM confirmed there was an opened box containing 16 individually packed deep pie shells with no opened and use by date.</p> <p>2a. During a concurrent observation and interview on [DATE] at 9:25 a.m., with the AM in the walk-in refrigerator, the AM confirmed a plastic bottle containing 5 liters (a unit of volume/liquid) of Balsamic vinegar had a use by date of [DATE]. The AM confirmed the balsamic vinegar was expired and should not be in the refrigerator.</p> <p>b. During a concurrent observation and interview on [DATE] at 10:02 a.m., with the AM in the walk-in refrigerator, a clear bag of 11 lemons with a use by date of [DATE] was available for use. The AM confirmed the lemons were expired and should not be in the refrigerator.</p> <p>c. During a concurrent observation and interview on [DATE] at 10:11 a.m., with the AM in the walk-in refrigerator, an opened box of 20, and a box of 100, 1 ounce sour cream containers with a use by date of [DATE] were available for use. The AM confirmed the boxes of sour cream were expired and should not be in the refrigerator.</p> <p>3. a. During a concurrent observation and interview on [DATE], at 9:45 a.m., with the AM in the kitchen, the fan above the double coffee maker was observed to be dusty and had lint accumulated on the metal front cover. The coffee makers under the fan had no lids to cover the filters holding the coffee grounds. The AM confirmed the finding.</p> <p>4. During a concurrent observation and interview on [DATE], at 9:46 a.m., with the kitchen's District Manager (DM) in the kitchen, washed plastic cups were observed stacked wet. The DM confirmed the plastic cups were stacked wet, and stated the wet cups should not be stacked and could cause food borne illness among the residents.</p> <p>5. During a concurrent observation and interview on [DATE] at 10:36 a.m., with the AM in the dry storage room, an opened clear bag with 1000 pieces of knives, an opened bag of 2000 pieces of forks, and an opened bag of 1000 pieces of spoons were not covered. The AM confirmed the finding. The AM stated all silverware should be covered. The AM explained using uncovered silverware could make the residents sick.</p> <p>6. During a concurrent observation and interview on [DATE] at 8:52 a.m., with Licensed Nurse (LN) 8 at the [NAME] Unit Nursing Station, LN 8 confirmed the unit refrigerator contained 5 cups of unlabeled applesauce prepared by the kitchen. LN 8 confirmed the applesauce was available for use and should have been discarded.</p> <p>7. During a concurrent observation and interview on [DATE] at 8:45 a.m., with the Director of Nursing (DON) at the East Unit Nursing Station, the DON confirmed the unit's refrigerator was noted to contain stains, stuck on food, and hair stuck to spilled liquid. The DON stated the refrigerator needed to be cleaned.</p> <p>(continued on next page)</p>

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 06/20/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 11:14 a.m. with the Registered Dietitian (RD), the RD stated all food products should be labeled with a use by date. The RD also stated expired food should not be in kitchen and should be thrown away. The RD explained residents could be exposed to food borne illnesses if served expired food. The RD also explained the kitchen should be clean and sanitary. The RD further explained the dirty fan in the kitchen could cause food borne illness.</p> <p>During a review of the facility policy titled, LABELING AND DATING, undated, indicated, .Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a First In First Out manner. This will minimize waste and also ensures that the items that are passed their due date are discarded .Food labels must include . The use by date .</p>

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 06/20/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43943</p> <p>Based on observation, interview, and record review the facility failed to maintain its infection control program when:</p> <p>1a. The facility did not ensure enhanced barrier precautions (targeted gown and glove use during high contact care activities for those with indwelling devices and/or certain infections) were observed when completing a dressing change for Resident 126;</p> <p>1b. The facility did not ensure the dressing changes were dated, timed, and initialed for Resident 126;</p> <p>2. A clean linen cart, containing clean linen items, was transported with the cover flap open; and,</p> <p>3. Hand hygiene was not performed during wound care for Resident 2.</p> <p>These failures had the potential to spread infections to residents residing in the facility, negatively impacting their health and well-being.</p> <p>Findings:</p> <p>1a. A review of the facility's document titled, Admission Record (a document that contained the resident's demographic information), indicated Resident 126's diagnoses included cancer of the right ureter (tube that transports urine from the kidneys to the urinary bladder), complications with the nephrostomy catheter (a tube that lets urine drain from the kidney through an opening in the skin on the back), and type 2 diabetes mellitus (inability to control blood sugar which increases risk of infection).</p> <p>During a concurrent observation and interview on 6/17/24, at 10:35 a.m., with Resident 126, a sign was observed on the outside of Resident 126's door that indicated, Enhanced Barrier Precautions. Resident 126 stated he had the nephrostomy tube for a couple months and he had pain at the insertion site. Resident 126 stated the Enhanced Barrier Precaution sign was placed on his door on 6/17/24.</p> <p>A review of the document titled, Order Summary Report, dated 5/28/24, indicated Resident 126's nephrostomy tube insertion site required cleaning and a new dressing placed over the wound every shift.</p> <p>During a concurrent observation and interview on 6/17/24, at 11:01 a.m., with Licensed Nurse (LN) 1, LN 1 removed the old dressing over the nephrostomy tube insertion site (right lower side of the back). LN 1 was wearing gloves but not a gown. The dressing did not have a date, time, or initials documented on the dressing. The wound had redness around the insertion site. LN 1 cleaned the site and placed a clean dressing over the wound. LN 1 did not date, time, or initial the new dressing. LN 1 acknowledged she failed to label the new dressing and it was important to date, time and initial the new dressing to ensure the dressing was changed each shift and to help minimize the risk for infection. LN 1 stated she should have had a gown on while performing Resident 126's dressing change. LN 1 stated, I caught myself after the dressing change and it was 100% my fault. LN 1 stated the extra infection prevention precautions were in place to decrease the chance of infection into the kidney.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/19/24, at 1:49 p.m., with the Infection Preventionist (IP), the IP stated when the dressing change was performed for Resident 126, the LN should have been wearing proper Personal Protective Equipment (PPE- gown and gloves) for Enhanced Barrier Precautions. IP stated enhanced barrier precautions were in place for Resident 126 due to the high risk for infection with an open wound.</p> <p>A review of Resident 126's clinical record titled, Care Plan, dated 6/14/24, indicated the facility was supposed to follow policies and protocols for the prevention of skin breakdown.</p> <p>During a concurrent interview and facility document review, on 6/20/24, at 8:51 a.m., with the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Enhanced Barrier Precautions - F880, dated 3/2024, was reviewed. The P&P indicated, . gown and glove use . during high contact resident care . examples of high-contact resident care activities requiring the use of gown and gloves . include . device care . (. catheter) . wound care . The DON stated Resident 126's diagnosis included ureter cancer and type 2 diabetes which placed the resident at higher risk for infection. The DON acknowledged the P&P was not followed when the LN did not wear a gown when she provided wound and catheter care for Resident 126.</p> <p>1b. A review of the facility's document titled, Admission Record (a document that contained the resident's demographic information), indicated Resident 126's diagnosis included cancer of the right ureter (tubes that transport urine from the kidneys to the urinary bladder), complications with the nephrostomy catheter (a tube that lets urine drain from the kidney through an opening in the skin on the back), and type 2 diabetes mellitus (inability to control blood sugar which increased risk of infection).</p> <p>During an interview on 6/17/24, at 10:35 a.m., with Resident 126, Resident 126 stated he had had the nephrostomy tube for a couple months and he has had pain at the insertion site.</p> <p>A review of the document titled, Order Summary Report, dated 5/28/24, indicated Resident 126's nephrostomy tube insertion site required cleaning and a new dressing placed over the wound every shift.</p> <p>During a concurrent observation and interview on 6/17/24, at 11:01 a.m., with Licensed Nurse (LN) 1, LN 1 removed the old dressing over the nephrostomy tube insertion site (right lower side of the back). The dressing did not have a date, time, or initials documented on the dressing. The wound had redness around the insertion site. LN 1 cleaned the site and placed a clean dressing over the wound. LN 1 did not date, time, or initial the new dressing. LN 1 acknowledged that she failed to label the new dressing and it was important to date, time and initial the new dressing to ensure the dressing was changed each shift and to help minimize the risk for infection.</p> <p>During an interview on 6/19/24, at 1:49 p.m., with the Infection Preventionist (IP), the IP stated when the dressing change was performed for Resident 126, the LN should have dated, timed, and initialed the dressing to ensure dressing changes were being completed as ordered. IP stated during the dressing changes, assessment of the wounds should be completed.</p> <p>A review of Resident 126's clinical record titled, Care Plan, dated 6/14/23, indicated the facility was supposed to follow policies and protocols for the prevention of skin breakdown.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and facility document review, on 6/20/24, at 8:51 a.m., with the Director of Nursing (DON), the Policy and Procedure (P&P) titled, Wound Care, dated 10/10, was reviewed. The P&P indicated, .Dress wound . mark tape with initials, time, and date and apply to dressing . The DON stated Resident 126's diagnosis included ureter cancer and type 2 diabetes which placed the resident at higher risk for infection. The DON acknowledged the P&P was not followed when the LN did not date, time, and initial the new dressing change.</p> <p>49823</p> <p>2. During an observation on 06/19/24 at 10:38 a.m. in the hallway near the East Unit Nurses Station, Laundry Aide (LA) 1 was observed with a linen cart. LA1 pushed the linen cart with clean linen in it, down the hall with the cover open, and the clean linen on the linen cart was exposed.</p> <p>During an interview with LA1 and the Housekeeping/Laundry Manager (EVSMgr) near the Maintenance Office on 6/20/24 at 7:48 a.m., LA1 was asked about the clean linen delivered with the linen cart cover open. EVSMgr stated that LA1 didn't understand the question due to a language barrier. Explained to EVSMgr that LA1 was observed with a linen cart with the linen cart cover open, and the clean linen on the cart was exposed as the linen cart was pushed down the hall on 6/19/24 at 10:38 a.m. EVSMgr stated there was a risk of contamination (physical movement or transfer of harmful bacteria [germs] from one person, object, or place to another) to the clean linen on the cart.</p> <p>During a review of a facility policy and procedure (P&P) titled, Departmental (Environmental Services) - Laundry and Linen, revised January 2014, the P&P indicated, .Purpose. The purpose of this procedure is to provide a process for the safe and aseptic (clean) handling, washing, and storage of linen .7. Clean linen will remain hygienically clean (free of pathogens[germs] in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts .</p> <p>Review of an online document published by the Centers for Disease Control and Prevention (CDC) titled, Best Practices For Environmental Cleaning in Global Healthcare Settings, Appendix D-Linen and Laundry Management, last reviewed dated 3/19/24, indicated, .Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items .</p> <p>40583</p> <p>3. A review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility in early 2024 with diagnoses which included osteomyelitis (bone infection).</p> <p>During an interview with Resident 2 on 6/18/24, at 12:39 PM, Resident 2 stated she had a pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time).</p> <p>A review of Resident 2's clinical document titled, Order Summary Report, printed 6/19/24, indicated the following orders for a pressure ulcer, stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle):</p> <p>Apply Lidocaine spray to stage IV [4] sacrococcygeal (tailbone) PI [pressure injury/ulcer] before treatment . with a start date of 6/17/24.</p> <p>(continued on next page)</p>		

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 06/20/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Cleanse stage IV PI to sacrococcygeal area with Dakin's Solution [used to clean wounds], pat dry, apply Medi honey [used to treat wounds] to wound bed, then loosely pack with Calcium Alginate with silver [wound dressing with germ fighting attributes], cover with super absorbent silicone dressings . with a start date of 5/14/24.</p> <p>Monitor stage 4 PI to sacrococcygeal area for s/s [signs and symptoms] of infection or deterioration . with a start date of 2/21/24.</p> <p>During an observation with licensed nurse (LN) 18, on 6/19/24, at 9:16 AM, LN 18 was observed doing wound care treatment for Resident 2. LN 18 was observed doffing (removing) a pair of gloves after cleansing the wound bed area with Dakin's solution. LN 18 then sprayed the area with additional lidocaine spray and donned (put on) a new pair of gloves without performing hand hygiene, and proceeded with wound care by applying calcium alginate and medi-honey, and covered the wound without performing hand hygiene.</p> <p>During an interview with LN 18 on 6/19/24, at 9:44 PM, LN 18 confirmed he did not perform hand hygiene after doffing gloves and prior to donning a new pair of gloves. LN 18 stated he was not aware he was supposed to wash his hands in between glove changes.</p> <p>A review of the facility policy titled, Wound Care, revised 10/2010, indicated, .The purpose of this procedure is to provide guidelines for the care of wounds to promote healing .Put on exam glove. Loosen tape and remove dressing .Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly .Put on gloves .Apply treatments .Dress wound .</p>