STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555736	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure privacy and dignity were maintained for one of 38 sampled residents (Resident 127) when Resident 127's urinary catheter bag (catheter bag - a bag that collects urine draining from the bladder) did not have a privacy cover (a cover designed to discreetly conceal the visible urine in a urinary catheter bag, improving resident dignity, comfort, and self-worth in public or social settings) over it.This failure had the potential to negatively impact Resident 127s feelings of dignity and self-worth.Findings:During an observation on 8/4/25 at 11:15 AM, in Resident 127's room, a urinary catheter bag was observed hanging under Resident 127's bed and it was not covered with a privacy cover.During a concurrent observation and interview on 8/4/25 at 11:32 AM with Certified Nurse Assistant (CNA) 6 in Resident 127's room, CNA 6 confirmed the catheter bag hanging under Resident 127's bed did not have a privacy cover. CNA 6 stated, Resident 127's catheter bag should have been covered with a privacy cover to preserve Resident 127's dignity.During a concurrent observation and interview on 8/4/25 at 12:03 PM with Licensed Nurse (LN 21) in Resident 127's room, LN 21 confirmed a urinary catheter bag was hanging under Resident 127's bed, needed a privacy cover, and did not have one. LN 21 stated, it was important to provide Resident 127 with a privacy cover over his catheter bag to preserve dignity. During an interview on 8/7/25, at 10:20 AM, with the Assistant Director of Nursing (ADON), the ADON confirmed Resident 127's catheter bag should have been covered with a privacy cover to maintain (Resident 127's) dignity. The ADON stated it has always been the facility's policy to use a privacy cover for urinary catheter bags.A review of a facility policy titled, RESIDENT RIGHTS, dated 12/21, indicated, . Employees shall treat residents with kindness, respect and dignity.These rights include the resident's right to. a dignified experience.be treated with respect, kindness and dignity.A review of an undated facility policy titled, Accommodation of Needs, indicated, .In order to accommodate individual needs and preferences, staff attitudes and behaviors must be directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure the storage of bedside self-administered medication was reviewed and approved by a doctor and the care team for one resident (Resident 1) out of 12 sampled residents observed for medication administration when Resident 1's albuterol inhaler (a medication used to treat shortness of breath) was found on her bedside table.This failure had potential to contribute to unsafe and unsecure medication use by Resident 1 and other residents including Resident 1's roommates.During a medication administration observation with Licensed Nurse (LN) 10, at the facility's [NAME] Station hallway, on 8/4/25, at 8:37 a.m., LN 10 was observed giving six medications to Resident 1, which included TRELEGY Ellipta (inhalation drug to treat chronic breathing disease) as a scheduled drug to treat a breathing condition. Further observation of Resident 1's room revealed the presence of an albuterol inhaler (a medication used to treat shortness of breath) at the bedside table.During a concurrent observation and interview with Resident 1 in Resident 1's room, on 8/4/25, at 8:46 a.m., Resident 1 acknowledged having the inhaler at her bedside table. Resident 1 stated she used the inhaler by herself around twice a day. Resident 1 stated she wanted the inhaler with her because it was too much of a hassle to get it from the nurses. Resident 1 stated she did not tell the nurse when she used the inhaler. A review of Resident 1's medical record titled, Order Summary Report, dated 8/2025, indicated the following orders as it related to Resident 1's albuterol inhaler use:1.Resident is (SPECIFY: incapable) of administering own medications.Start Date 03/02/2025. 2.Albuterol .Inhalation Aerosol.(Albuterol) 2 puff inhale orally every 6 hours as needed for wheezing related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE (a chronic breathing disease).Start Date 03/01/2025. Further review of Resident 1's Order Summary Report did not indicate an order for Resident 1's inhaler medication to be kept at the bedside or to be self-administered.A review or Resident 1's Medication Administration Record (MAR, a document showing doctor's orders, instructions, and the nurse's medication administration record) report for the month of 8/2025, did not indicate any nursing documentation on Resident 1's use of the albuterol inhaler. Further review of Resident 1's medical record did not reveal there was a care plan (a roadmap for individualized care, detailing the resident's needs, goals, and the interventions needed to achieve those goals) created for Resident 1 regarding her albuterol inhaler medication kept at the bedside for self-administration. During a concurrent observation and interview with Resident 1, in Resident 1's room, on 8/5/25, at 10:00 a.m., Resident 1's albuterol inhaler was not observed on the bedside table. Resident 1 stated the nurse took the inhaler away. Resident 1 stated she was told she was not allowed to have the inhaler any longer. During an interview with LN 10, on 8/5/25, at 10:35 a.m., LN 10 stated she had no idea how Resident 1 got the albuterol inhaler and would not let the nurses take it from her. LN 10 stated she had attempted to take the albuterol inhaler from Resident 1, but she refused. LN 10 stated she has never been told by Resident 1 if she ever used the albuterol inhaler. During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 8/5/25, at 3:20 p.m., the ADON reviewed Resident 1's medical record and verified Resident 1 had no care plan regarding the self administration of the albuterol inhaler, no documented evidence of the albuterol inhaler use on the MAR report, and no doctor's order in place to self-administer the albuterol inhaler. A review of the facility's policy titled, Self-Administration of Medication, updated on 9/2017, indicated . Policy Statement: If the resident desires to self-administer medication, the Center evaluates the resident's ability.Procedure: 1. If the resident desires to self-administer medications, the Self-Medication Evaluation is completed. This evaluation is completed before the resident is able to self-administer. 2. If it is determined the resident may self-administer medications, the nurse: a. Obtains a physician order for self-administration for the specific medication(s). b. Initiates the Self-Medication Administration Care Plan. c. Determines whether medications will be stored at nursing stations or resident's room. d. Initiates the Bedside Self-Medication Administration Record. If medications are stored in bedside. e. Obtain and initiate proper safety mechanisms if medications are stored at the bedside (i.e. lock box). f. LN has a key to any lock box or locked drawer holding medications.A review of the facility's policy titled, MEDICATION STORAGE IN THE FACILITY, dated 4/2008, indicated .BEDSIDE MEDICATION STORAGE.Policy.Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgement of the facility's interdisciplinary (team approach to care) resident assessment team.Procedures.A. A written order for the bedside storage of medication is present in the resident's medical record. B. Bedside storage of medications is indicated on the

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately inform the Responsible Party (RP - an individual chosen by a resident or appointed by a judge to make personal and/or financial decisions for an adult who cannot care for or make decisions for themselves) for one out of thirty-eight sampled residents (Resident 153), when Resident 153 had a change in condition (any change in a resident's physical, mental, or emotional state from their normal baseline, possibly indicating a new illness or injury or worsening of a condition, recognized and treated to prevent serious complications, and to maintain resident health and safety), was sent to the emergency room (ER), and an RP was not notified in a timely manner.This failure resulted in miscommunication between the facility, the RP, and the ER when medical decisions were made for Resident 153 without input from the RP.Findings:During an interview on 8/5/25 at 12:06 PM, with RP 3, RP 3 stated, Resident 153 had an unwitnessed fall on Saturday, 7/19/25 and the facility did not notify an RP until Sunday, 7/20/25. The RP stated, the notifications on Sunday were left on the office phone of RP 3 even though the facility was given specific direction on how to contact an RP after regular business hours and on weekends via a letter sent to the facility dated 3/13/25. RP 3 further stated, the facility left three voicemails on her desk phone on Sunday, 7/20/25, and the messages were left at 6:36 AM, 7:39 AM, and 7:20 PM. During a concurrent interview and record review on 8/7/2025 at 10:35 AM with the Assistant Director of Nursing (ADON), Resident 153's admission RECORD [a comprehensive collection of documents and information gathered at the time a resident is admitted or readmitted to a facility], dated 1/18/25, was reviewed. The admission Record indicated, Resident 153 had two emergency contacts, RP 3 and RP 4, and each RP contact number listed was an office number. The ADON continued, the numbers listed on the admission Record were the only numbers the facility had to contact the RP, and confirmed the numbers were for (regular) office hours 9 AM to 5 PM. The ADON confirmed, if an RP provided alternate numbers for nights and weekends, the information should have been added to Resident 153's admission Record and used anytime there was a change in condition after hours.During a concurrent interview and record review on 8/7/2025 at 11:23 AM with Social Services Assistant (SSA - a person who assists Residents in addressing their social, emotional, and psychosocial needs) 1, a letter from Calaveras Health and Human Services Agency [CHHSA - a county department that provides RPs to adults in their county], dated 3/25/25, was reviewed. SSA 1 confirmed, she had found the letter with updated contact information for Resident 153 on her desk and it contained the following information, .is dedicated to streamlining our practices to ensure clients and facilities can reach our team during the day, after hours, and on weekends.can also contact the PG [Public Guardian - also referred to as the RP] office during business hours by calling [phone number].if you need to speak with our office after hours, on the weekend, or holiday regarding a conservatee, please contact [phone number].This number is specifically for after-hours emergencies.Please remember, when team members are out, if you email or call a team member directly, your call may be unanswered. SSA 1 stated, she had received the letter in March but had not added the numbers to Resident 153's admission Record, but should have. SSA 1 further stated, the problems of not updating Resident 153's admission Record would be that staff could not contact an RP in case of an emergency occurring after hours or on weekends, and if a voice message was left on office phone numbers, the RPs would not receive information until the next business day.During an interview on 08/07/2025 at 12:48 PM with the Administrator (ADMIN), the ADMIN stated the facility should notify the RP for all changes in condition for Resident 153. The ADMIN stated, if an illness, injury, or any type of incident occurred after regular office hours or on weekends regarding Resident 153, facility staff should not leave voice messages on an RP desk phone or office line but make every attempt to reach an RP via methods provided to the facility via the letter dated 3/25/25. The ADMIN further stated, updated RP contact information should be updated in the facility's computer system as soon as it is received.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 12/21, the P&P indicated, .Federal and State laws guarantee certain basic rights to all residents of this facility.These rights include the resident's right to.appoint a legal representative [a person authorized by the resident or by a judge to make personal, medical, and/or financial decisions for an adult who cannot make decisions for themselves].Notified of his or her medical condition and of any changes in his or her condition. During a review of the facility's P&P titled, Charting and Documentation, dated 7/17, the P&P indicated, .The following is to be documented in the resident medical record Changes in the resident's condition Events

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility compromised the personal privacy and confidentiality of a census of 173 residents when meal tray tickets (a crucial document that ensures each resident receives the correct and personalized meal based on their individual needs and preferences) were thrown into the trash.This failure had the potential to expose personal and medical health information to non-facility staff.During the initial kitchen tour on 8/4/25, at 10:12 a.m., meal tickets with resident names were observed in the garbage can in the dishwashing area.During the initial kitchen tour on 8/4/25 at 10:22 a.m., the path taken of kitchen trash to the outside dumpsters in the parking lot was observed. The parking lot was not gated or secured from the public.During a review of tray tickets for lunch on 8/5/25, the meal tickets included the following information:Resident name, room location, the area the meal was eaten, therapeutic diet order (which may correlate to diagnosis), fluid texture (which may correlate to diagnosis), resident likes/dislikes, resident food allergies, and special instructions.During an interview on 8/6/25, at 2:45 p.m., with the Certified Dietary Manager (CDM), the CDM stated it was his expectation meal tickets should have been placed into a shred bin. The CDM further stated that meal tickets in the garbage were a violation of HIPAA (Health Insurance Portability and Accountability Act, a federal law that sets a national standard to protect medical records and other personal health information).A review of a facility policy titled, Clinical Operations Manual dated 9/2016, indicated, .Residents have the right to privacy and confidentiality for all aspects of care and services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately resolve a grievance and did not respond in writing within five business days to one out of 38 sampled residents (Resident 81), in accordance with facility policy when Resident 81 submitted a grievance form in June 2025, but the facility did not provide a resolution or follow-up until August 2025.This delay in addressing the grievance negatively impacted the psychosocial wellbeing of Resident 81.Findings:A review of Resident 81's Inventory of Resident Personal Items dated 3/9/25 indicated that she brought the following items with her upon admission: 13 pairs of pants, 12 blouses, 7 sweaters, 5 pairs of slippers, and 13 pairs of pajamas among other items.A review of the Grievance/Complaint Resolution Report dated 6/30/25 and signed by the Social Services Director (SSD), showed that Resident 81 reported several missing items, including white slacks, a summer dress and some blouses. The grievance form indicated that an inquiry was made with the laundry department, but the missing items were not found. It was explained to Resident 81 that she would be reimbursed if she could provide receipts for the lost clothing. However, Resident 81 stated that she just wanted her missing items returned. During an interview with Resident 81 on 8/6/25 at 7:57a.m., she stated that she initially reported the missing items to Social Services Assistant (SSA) 1 and was told to file a grievance. Resident 81 confirmed that the facility had contacted the laundry department, but the items were still not found. Resident 81 also stated she was informed that receipts were required for reimbursement. Unfortunately, she does not have any receipts as most of her clothing was purchased by her mother. According to Resident 81, she later on spoke with the SSD, who reassured her that the business office and the facility Administrator (ADMIN) would be contacted regarding possible reimbursement. However, as of 8/6/25, Resident 81 had not received any follow-up or resolution. Additionally, Resident 81 stated that on 7/30/25, during a Resident Council meeting, she brought up the issue with the activities director (AD), who then referred her to the Director of Nursing (DON). Resident 81 expressed confusion as to why this referral was made.During an interview with the Assistant Director of Nursing (ADON) on 8/6/25 at 10:15 a.m., the ADON stated that the facility has a process for finding and reporting missing items, and the nurses were re-educated by Social Services Assistant (SSA) 2 in the afternoon of 8/5/25.During an interview with the SSD on 8/6/25 at 10:49 a.m., the SSD stated that the facility provides residents with a copy of the grievance form and explained to them it was the form to use when submitting complaints such as, missing items, care that they are receiving etc The SSD stated that the grievance process is currently broken and needs to be fixed.During an interview with the Activities Assistant (AA) on 8/7/25 at 8:09 a.m., the AA stated that when a resident reports missing items to them, they would refer the complainant to the social services department. The AA also stated that reports regarding lost items are not included in the Resident Council meeting minutes.During an interview with the Activities Director (AD) on 8/7/25 at 9:00 a.m., the AD stated that Resident 81 informed her during the Resident Council Meeting on July 30, 2025, about the missing items. The AD stated that she directed Resident 81 to file a grievance to social services.During an interview with Certified Nursing Assistant (CNA) 1, on 8/6/25 at 3:06 p.m., CNA 1 stated that if a resident reports a missing item, she would first check the resident's inventory sheet and report the issue to the nurse. Then she would search the resident's room as well as the laundry room. If the item was still not found, she would either call the Social Services Department to report the complaint or fill out a form and slide it under the Social Services Department door, as their mailbox is often full. CNA 1 also stated she would notify the family member. During an interview with Licensed Nurse (LN) 17 on 8/6/25 at 3:08 p.m., LN 17 stated that if a resident reports a missing item, he would search the resident's drawer and closet. If the item is not found, he would contact Social Services by phone and document the issue in the progress notes. LN 17 added that, if the laundry department was open, he would also check there.During an interview with CNA 2, on 8/6/25 at 3:11 p.m., CNA 2 stated that if a resident reported a missing item to her, she would assist by first checking the resident's closet. If the item was not found, she would also check the closet of the resident next door, as items are sometimes misplaced there. If the item was still not located, she would inform her team to keep an eye out for it. She would also notify the Social Services by completing a form. During an interview with CNA 3, on 8/6/25 at 3:16p.m., CNA 3 stated that she was from registry. According to CNA 3, if a resident reported a missing item to her, she would check the laundry area, the roommate's closet, and the closets of neighboring residents. If the item was still not found, she would ask other staff members for assistance.A review of the facility's Theft and Loss Report Form dated 8/6/26 indicated that

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to verify that the Preadmission Screening and Resident Review (PASRR - a federally required screening process designed to ensure that individuals with serious mental illness [SMI], intellectual disability [ID], or related conditions are not inappropriately placed in nursing facilities) was accurate for four out of 38 sampled residents (Resident 11, Resident 81, Resident 131 and Resident 47), when: Resident 81's SMI was not indicated on the PASRR; and,Resident 11's PASRR Level I Screening indicated the need for a Level II Screening, but none was found in the medical record; and, Resident 131 had a positive Level I PASRR screening and the required level II PASRR (Mental Health Evaluation) screening was not completed due to facility not being available on repeated attempts for contact in June of 2025; and, Resident 47's Level II PASRR, recommended specialized services, were not implemented, or followed up on and there was no record of them being reviewed with the medical doctor in August 2023 which resulted in specialized services including psychotherapy/counseling and neuropsychology (studies the physiological processes of the nervous system and relates them to behavior and cognition) consultation not being provided.These failures placed Resident 11, Resident 81, Resident 131, and Resident 47 at risk of not receiving the care and services that could have assisted them in living their highest quality of life. Findings: 1. A review of Resident 81’s previous “admission RECORD” dated 8/17/2021 from the discharging facility indicated that one of her diagnoses included Depressive Schizoaffective Disorder (Depression with episodes of losing touch with reality). A review of Resident 81’s current “admission RECORD” indicated that one of her diagnoses included Depressive Schizoaffective Disorder. A review of Resident 81’s PASRR Level 1 Screening completed by the discharging facility, dated 11/14/2024 indicated that Resident 81 was not diagnosed with SMI. During an interview and concurrent record review with the Assistant Director of Nursing (ADON) on 8/6/25 at 10:15a.m., the ADON stated that the facility does not have any other PASRR on file for Resident 81, and the PASRR Level 1 document they received from the discharging facility was inaccurate. Section III, number 9 which asks if the individual was Diagnosed with Serious Mental Illness was marked “No,” even though Resident 81’s diagnoses included Depressive Schizoaffective Disorder. According to the ADON, they failed to verify the accuracy of the PASRR from the discharging facility because their “…process of checking submitted PASRR’s for accuracy was not in place or not followed . ” A review of the facility’s Policy titled, “PASRR Process Policy and Procedure” published on 1/9/2025 indicated, “…Upon admission to the facility the Admissions Coordinator, Medical Records Director or designee validates a PASRR Level 1…” 2. A review of Resident 11’s “admission Record” indicated that Resident 11 was admitted to the facility in 2024 with diagnoses which included Cerebral Infarction (a result of disrupted blood flow of the brain due to problems with blood vessels that supply it, also known as a stroke), Post-Traumatic Stress Disorder (a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety), and Major Depressive Disorder (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living). (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11’s “PASRR Level I Screening,” dated 4/15/2025 indicated that a Level II Evaluation was needed. A review of a document from “California Department of Health Care Services,” dated 4/17/25, indicated, “…SUBJECT: NOTICE OF ATTEMPTED EVALUATION…In the event of a positive…Level I Screening…Level II Mental Health Evaluation is required to determine if the individual can benefit from specialized services. However .Level II Mental Health Evaluation was not scheduled for the following reason: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening…” During an interview and concurrent record review of Resident 11’s “PASSR Level I Screening and document regarding Level II Screening status on 8/6/25 at 5:15 pm with the Assistant Director of Nursing (ADON), the ADON confirmed that Resident 11’s Level II document indicated that a PASRR Level II Screening was not completed due to facility staff unresponsiveness. The ADON stated that her expectation was for new admissions, staff verified that the PASSRs were completed. The ADON stated that the PASSRs must be done preadmission. The ADON stated that the facility process to have follow-up was broken and needed to be fixed. The ADON stated that the broken process was recently identified. The ADON stated that the risk to Resident 11 if the PASRR II was not completed was that outside services could have been offered to Resident 11. The ADON acknowledged that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, “PASRR Process Policy and Procedure, ” revised 01/01/2025, indicated, “…Procedure…1. Upon admission to the facility the Admissions Coordinator, Medical Records Director, or designee validates a PASRR Level I is included in the admission paperwork. If there is no PASRR Level I, the Medical Records Director or designee contacts the hospital to obtain…3. If a Level II Evaluation is indicated the Social Worker validates, within a timely period, that a LMHP (Licensed Mental Health Provider) is scheduled to evaluate…” 3. A review of Resident 131’s “ admission RECORD,” indicated Resident 131 was admitted in January of 2024 with diagnoses which included, but were not limited depressive disorder (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living) and unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), unspecified severity, with other behavioral disturbance, and anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension that interferes with daily living) During a review of Resident 131's “Department of Health Care Services Letter,” dated 6/5/25, the letter indicated a PASRR Level I screening for Resident 131 was completed on 6/5/25, and indicated Level II Mental Health Evaluation Referral was required for SMI (serious mental illness) and the facility will be contacted within two to four days to schedule an appointment. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During Review of Resident 131’s “Department of Health Care Services Letter,” dated 6/8/25, the letter indicated, “…UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI)…The California Department of Health Care Services (DHCS) administers the PASRR when the Level I Screening returns a positive result for possible SMI. In the event of a positive SMI Level I screening, a SMI Level II Mental Health Evaluation is required to determine if the individual can benefit from specialized services. However, a SMI Level II Mental Health Evaluation was not scheduled for the following reason: Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level I Screening… The case is now closed…To reopen the facility must resubmit a new Level I Screening…” During a concurrent observation and interview on 8/4/25, at 11:32 a.m., Resident 131 was observed sitting in a wheelchair in the hall next to the nursing station. Resident 131 stated she was cold. It was observed Resident 131 was not able to respond to or answer questions. During an interview on 8/4/25, at 11:35 a.m., Licensed Nurse (LN) 4 stated Resident 131 was not verbal, always cold and born delayed (a developmental delay). LN 4 explained Resident 131 had lived at the facility for a long time. During a phone interview on 8/5/25, at 4:30 p.m., Responsible Party (RP) 1 stated Resident 131 was born with intellectual and behavioral delays. RP 1 explained Resident 131 was taken care of by her parents and had always had caregivers. RP 1 stated as a child, Resident 131 had learning disabilities and was not sure if she had received outside services to help address her delays. RP 1 stated prior to coming to this facility she had lived in another facility in a different town. RP 1 stated the facility had never questioned him regarding outside services for Resident 131 or her intellectual or behavioral delays. RP 1 stated he was open to the idea of Resident 131 receiving services. RP 1 stated any service Resident 131 would qualify for could not hurt. RP 1 stated Resident 131 takes medications for some of her behaviors. During a concurrent interview and record review on 8/6/25, at 4:04 p.m., the Social Services Director (SSD) stated Resident 131 sometimes gives staff a hard time with her care. Through record review of Resident 131’s clinical record, the SSD confirmed her Brief Interview for Mental Status (BIMS, structured evaluation aimed at evaluating aspects of cognition in elderly patients) was a 1, indicating severe cognitive impairment. The SSD stated Resident 131 has a history of depression and dementia. The SSD stated she was not aware Resident 131 had intellectual or behavior delays. The SSD stated she does not conduct the PASRR for residents and stated the ADON completes them for all residents. During a concurrent interview and record review on 8/6/25, at 5:15 p.m., the Assistant Director of Nursing (ADON) stated regarding the PASRR process for those that require follow-ups, there was a breakdown in the process as there was no clear indication of who (staff member) should follow-up and make sure the PASRR’s are completed. The ADON stated she and other facility staff just became aware of the broken process this morning. The ADON explained based on the outcome of PASRR level 2 the resident could qualify for outside services, and this would not be provided if staff did not follow up. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/7/25, at 3:51 p.m., the ADON confirmed PASRR level II was not followed up on and the STATE had not been able to schedule the appointment with the facility. 4. A review of Resident 47’s “admission RECORD,” indicated that Resident 47 was admitted with diagnoses which included, but were not limited to, bipolar disorder (a mental illness associated with episodes of mood swings from severe depression to manic highs), other recurrent depressive disorders (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living), bulimia nervosa (a serious, potentially life-threatening eating disorder causing binge eating or eating lots of food at one time and purging or attempts to get rid of the food consumed), and anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension that interferes with daily living). During Review of Resident 47’s “Department of Health Care Services Letter,” dated 6/8/22, the letter indicated, “…In the event of a positive screening, PASRR regulations require a more thorough evaluation by an independent clinician contracted with the Department of Health Care Services (DHCS). The results of this Level II Evaluation are then reviewed by a licensed psychologist in DHCS and determinations are made regarding the appropriate level of care and recommendations for specialized services…The results of this Level II Evaluation are provided in the PASRR Determinization Report attached to this letter. Facility staff will receive a copy of this Determination report, will discuss the results with you in a timely manner, and will incorporate the recommendations in your plan…” During Review of Resident 47’s “Individualized Determination Report,” dated 6/8/22, the letter indicated, “…This Determination Report is based on a review of the applicant’s medical and social history which reveals a significant medical condition with mental stressors that require nursing care…Recommended Specialized Services…Medication Education and Training…Psychotherapy/Counseling…Individual and/or group and/or family treatment by a licensed mental health professional…Neuropsychology Consultation…services to gain a better understanding of cognitive functioning, clarify the primary diagnosis, and provide treatment direction…” During a concurrent observation and interview on 8/4/25, at 12:06 p.m., Resident 47 was observed on her bed in her room and stated she had lived in the facility for six years. During a concurrent interview and record review on 8/7/25 at 11:26 p.m., the Social Service Assistant (SSA) 3 stated Resident 47 had been at the facility for a little bit and had diagnoses of bipolar, anxiety, and depressive disorder. Through review of Resident 47’s electronic clinical record the SSA 3 confirmed Resident 47 did not have a mental health provider and stated it was her understanding she had not been seen by one while at the facility. The SSA confirmed Resident 47 had not had a mental health consult while at the facility. The SSA 3 stated Resident 47 was on medications to treat her mental health diagnoses. SSA 3 stated the mental health consult could help with management of her mental health diagnoses and medications. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/7/25, at 3:51 p.m., the Assistant Director of Nursing (ADON) stated Resident 47’s PASRR report recommendations should have been followed up on but were not. The ADON stated her expectation was the mental health consult and neuropsychology recommendations from Resident 47’s PASRR II should have been shared with her medical doctor and the consultations should have been ordered. The ADON stated she thought they were completed as the PASRR was from 2022 and would check to see if the recommendations were implemented. ADON stated the expectation was these recommendations were followed up on and consults scheduled within two weeks. The ADON stated the risk if the resident did not receive the PASRR recommendations would be delay of specialized services and additional therapy and services Resident 47 was entitled to and could benefit from would not be provided or delayed. Review of https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-screening-and-resident-review/index.html, accessed on 8/20/25, indicated “…PASRR is an important tool for states to use in rebalancing services away from institutions and towards supporting people in their homes, and to comply with the Supreme Court decision, [NAME] vs L.C. (1999), under the Americans with Disabilities Act, individuals with disabilities cannot be required to be institutionalized to receive public benefits that could be furnished in community-based settings. PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care…In brief, the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care .”

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop a comprehensive care plan for one of seven sampled residents (Resident 3) who received hospice care services (a specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life), when a hospice care plan was not developed for Resident 3.This failure had the potential to have a negative impact on Resident 3's quality of life, as well as the quality of care and services received.Findings:Review of Resident 3's admission Record indicated, Resident 3 was admitted with multiple diagnoses which included but not limited to chronic obstructive pulmonary disease (COPD - a common lung disease causing restricted airflow and breathing problems), chronic respiratory failure with hypoxia (a condition where the lungs can't adequately oxygenate the blood, leading to low blood oxygen levels), and chronic kidney disease (a condition characterized by progressive damage and loss of function in the kidneys).Review of Resident 3's Hospice Care Coordination Note dated 7/29/25 indicated, Resident 3 was admitted to hospice care services due to terminal diagnosis of COPD.During a concurrent interview and record review on 8/7/25 at 8:09 a.m., the assistant director of nursing (ADON) stated Resident 3 was receiving hospice care services. Resident 3's care plans were reviewed with the ADON. The ADON verified a hospice care plan was not developed for Resident 3. The ADON stated hospice care plan was important to identify the interventions and care plans. The ADON further stated risks of not having a hospice care plan was that staff might not know what care and services to provide to Resident 3 and placed Resident 3 at risk of not receiving appropriate care and services. Review of the facility's policy and procedure titled, Hospice - Provision of Care by Outside Providers, dated September 2017, indicated, . The hospice and Center communicate, establish, and agrees upon a coordinated Plan of Care (POC) reflecting the hospice philosophy and based on an evaluation of the individual needs of the resident. The POC includes directives for managing pain and other uncomfortable symptoms, and the care and services the Center and hospice provide to be responsive to the unique needs of the resident and his/her expressed desire for hospice care.Review of an undated facility policy and procedure titled, Care Plans, Comprehensive Person-Centered indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.The interdisciplinary team reviews and updates the care plan.when there has been a significant change in the resident's condition.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update and revise the comprehensive care plan for one of three sampled residents (Resident 19) who had a pressure ulcer (a skin and tissue injury caused by prolonged pressure, typically on bony areas of the body), when Resident 19's pressure ulcer care plan was not updated to reflect his current treatment plan and pressure ulcer stage (pressure ulcers are categorized into stages based on their severity, ranging from early warning signs to deep tissue damage) after a change on 6/26/25.This failure placed Resident 19 at risk of not receiving adequate wound care, delayed wound healing, potential wound complications, and worsen wound condition.Findings:Review of Resident 19's admission Record, indicated Resident 19 was admitted to the facility with multiple diagnoses which included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (refer to paralysis or weakness, respectively, on one side of the body due to brain damage from stroke), acute posthemorrhagic anemia (low red blood cell count), and generalized muscle weakness.Review of Resident 19's clinical record titled, Nursing Progress Note dated 6/19/25 indicated, . Full assessment done upon admission.Skin: During skin assessment, resident was noted with unstageable (a deep wound where the extent of tissue damage cannot be determined) pressure ulcer to her right buttocks.Review of Resident 19's wound care assessment dated [DATE] indicated, . Assessment Notes: We debrided [the process of removing dead, damaged, or infected tissue from a wound] Wound . Wound Type: Pressure Ulcer, Stage: Stage 4 [most serious wound stage of full thickness tissue loss with exposed bone, tendon, or muscle] . Review of Resident 19's physician order dated 6/27/25 indicated, Resident 19's right buttock unstageable pressure ulcer treatment was discontinued, and new treatment was initiated for right buttock stage 4 pressure ulcer.During a concurrent interview and record review on 8/6/25 at 2:34 p.m., LN 7 stated wound doctor assessed and debrided Resident 19's unstageable pressure ulcer on 6/26/25. LN 7 added after debridement the wound doctor staged Resident 19's pressure ulcer as stage 4 that was previously unstageable. LN 7 confirmed Resident 19's wound care plan was not up to date. LN 7 stated Resident 19's pressure ulcer care plan should reflect his current wound condition of stage 4 pressure ulcer instead of unstageable. LN 7 stated it was important to update the pressure ulcer care plan to provide consistent care as planned. LN 7 added care plans were a communication tool for other staff to follow and guide the provision of care. LN 7 further stated if a resident's pressure ulcer care plan was not updated then it could lead to a bad outcome including all the way to death of the resident.During a concurrent interview and record review on 8/6/25 at 10:21 a.m., Licensed Nurse (LN) 5 stated nurses were responsible for updating and revising resident's wound care plan. LN 5 confirmed Resident 19's pressure ulcer care plan indicated Resident 19 had unstageable pressure ulcer to right posterior buttock. LN 5 stated Resident 19's pressure ulcer care plan was not updated to reflect current status of stage 4. LN 5 stated wound care plans were for directing staff and providing guidance on how to care for the wound properly and deliver appropriate interventions.During an interview on 8/6/25 at 11:25 a.m., the nurse practitioner (NP) 1 stated that his expectation was for staff to update residents' pressure ulcer care plans to reflect wound changes and new wound care orders as prescribed.During a concurrent interview and record review on 8/7/25 at 8:09 a.m. the assistant director of nursing (ADON) confirmed Resident 19's pressure ulcer care plan did not reflect his current pressure ulcer stage and treatment. The ADON stated Resident 19's pressure ulcer care plan should have been updated when wound changed from unstageable to stage 4 pressure ulcer. The ADON stated she expected nurses to update residents' pressure ulcer care plan timely including the change in treatment orders. The ADON stated it could affect residents' wound care if not identified correctly in their care plan. Review of the facility provided document, Wound Care/Treatment Nurse job description, revised July 2022, indicated, . wound care/treatment nurse . Consult and coordinate with the interdisciplinary team [IDT - is a group of professionals from different fields who collaborate to achieve a common goal, often involving the integration of diverse perspectives and expertise] and healthcare professionals to plan, implement and evaluate individualized resident care plan.Review of the facility's policy and procedure titled, Skin Integrity, dated July 2025, indicated, . In an effort to maintain the resident's optimal level of skin integrity and promote healing of skin ulcers/pressure ulcers/wounds, the facility has a systematic approach and monitoring process for evaluating and documenting skin integrity. 6. If skin impairment is noted after admission . c. Implement new interventions as needed. Document on the resident's care plan. 9. f. Update the care plan

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure the safe storage and handling of hazardous medications (HD - medications that pose potential risks to healthcare workers, patients, or the environment during handling, preparation, administration, or disposal). Additionally, continuous glucose monitoring (CGM) was not used safely according to standards of practice and manufacturer specifications with a census of 172, when:1. Hazardous drugs were stored in active storage areas without warning labels in the facility's medication cart at North-B station, and Finasteride (HD), a drug that blocks hormone production, was administered to one resident (Resident 169) out of 12 residents observed for medication administration without gloves on at South station.2. The facility lacked a policy, staff training, and physician review of medications that could affect or interfere with accurate blood sugar measurement when using a Continuous Glucose Monitoring device on diabetic (blood sugar disease) residents. This issue was observed in three out of 12 residents (Resident 1, Resident 27, and Resident 104).These practices could potentially contribute to adverse health outcomes for both nursing staff and residents.Findings:1.During a concurrent observation and interview of the facility's medication cart at North-B station, on 8/5/25, at 9 AM, accompanied by Licensed Nurse (LN) 9, the cart stored medications in a bubble pack (a card that packages the pills within small and clear plastic bubbles (or blisters)) for the HD finasteride for two residents, and divalproex (drug used for mood disorder) for one resident without any warning label for safe handling. LN 9 stated having the hazard warning on the label or in the Medication Administration Record (or MAR) would be helpful and a good reminder to use gloves when handling them. During a medication administration observation, with LN 4, at South station, on 8/6/25, at 8:30 AM, LN 4 administered the finasteride pill along with other medications to Resident 169 without the use of gloves on her hands.During an interview with LN 4, at South hallway, on 8/6/25, at 8:53 AM, LN 4 stated she forgot to have gloves on and the medication label or the MAR lacked hazardous warnings for this drug. LN 4 stated she had seen the hazard label on finasteride and other drugs in the past and was not sure why Resident 169's finasteride did not have the warning label.During an interview with the Assistant Director of Nursing (ADON), on 8/7/25, at 2:12 PM, the ADON stated the facility relied on the pharmacy to label the medications for hazard risks and the nurses should enter the risks in the medication administration record (MAR) for safe use and administration.A review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, federal agencies that set standards of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 12/2024, indicated .Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes . Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. NIOSH suggests careful precautions and safeguards to protect workers, fetuses, and breastfed infants. Further review of the document indicated to use a single glove for handling intact tablets and double gloves for handling oral liquid forms of the hazardous medications as directed. The NIOSH list included finasteride and divalproex as HD to be handled with gloves during medication administration. https://www.cdc.gov/niosh/docs/2023-130/default.html and https://www.cdc.gov/niosh/docs/2025-103/default.htmlA review of the facility's policy, titled Hazardous Medication Administration , dated 10/2019, indicated . The purpose of this policy is to outline safe handling precautions and standard processes for healthcare providers to minimize exposure when handling hazardous drug.Hazardous drugs are drugs that pose a potential health risk to workers who may be exposed to them during receipt, transport, preparation, administration, or disposal. These drugs require special handling because of their potential to cause toxicity. Health care professionals handling hazardous drugs will receive appropriate training.Pharmacy will include standard warnings on medication labels to alert HCPs (Health care Professionals).2a. During a medication pass observation, in the [NAME] hallway, accompanied by LN 6, on 8/4/25, at 9 AM, LN 6 entered Resident 1's room while she was having her breakfast. LN 6 administered six oral medications then measured Resident 1's blood sugar by using a CGM reader device. LN 6 then administered insulin Humalog (a drug to treat blood sugar disease) based on the blood sugar readings. The CGM reader device had a faded handwritten marker with Resident 1's name on it.A review of Resident 1's MAR, dated 8/2025, indicated a doctor's order to attach a sensor patch to Resident 1's skin and replace it every 2 weeks as follows. (brand

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide appropriate interventions for one of thirty-eight sampled residents (Resident 14), when Resident 14's hand splint (a device designed to protect and support painful, swollen or weak joints and their surrounding structure) used to address Resident 14's hand contractures (a permanent shortening of muscle, tendon, or scar tissue producing deformity or distortion) were not followed up by Occupational Therapy or facility staff. This deficient practice placed Resident 14 at risk for further decline related to her hand contractures. Findings:Review of Resident 14's admission RECORD, indicated Resident 14 was admitted with diagnoses which included, but were not limited to spinal stenosis (occurs when the space around the spinal cord becomes too narrow and irritates the spinal cord and/or nerves that branch off it causing symptoms of back or neck pain and tingling in your arms or legs), multiple sclerosis (MS, an autoimmune disease that attacks the protective sheath around nerve cells in the brain and spinal cord, disrupting communication between the brain and the body and causing symptoms like vision problems, weakness, numbness, and loss of coordination), traumatic hemorrhage of cerebrum (occurs when blood flow to a part of the brain is interrupted, leading to brain cell death from lack of oxygen and nutrients) muscle weakness, and depression (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living). Review of Resident 14's OT (Occupational Therapy) Evaluation & Plan of Treatment, dated 4/28/25, indicated .Objective Progress / Short-Term Goals.New Goal.Patient will perform OT recommended AARM [assisted active range of motion] of R [right] hand digits and fine motor skill exercises for B [both] hands for 10+ [plus] min [minutes].rest breaks as needed in order to increase independence during self care and decrease stiffness, tone, pain and risk for further contracture. Musculoskeletal System Assessment.RUE [right upper extremity].Hand = Impaired.Contracture.Functional Limitations Present d/t [due to] Contracture = Yes.Functional Limitations as Result of Contracture.R hand. Device.Current Orthotic Device [splint].To further assess and order/fabricate.During a concurrent observation and interview on 8/4/25, at 3:10 p.m., with LN 22 in Resident 14's room, LN 22 confirmed Resident 14 was not wearing a hand splint on her right hand. Resident 14's right hand was observed to be curled up and she was observed not to be able to open her right hand. Resident 14 stated she had had a hand splint in her dresser drawer next to her bed. Resident 14 stated the hand splint helps her when she wears it, but it does not get placed on her. During an interview on 8/7/25, at 10:41 a.m., Restorative Nurse Assistant (RNA) 1 stated she was familiar with Resident 14 and had placed her hand splints on her a few hours ago. RNA 1 said she only started working with Resident 14 RNA this past Monday (8/4/25) and prior to then Resident 14 did not receive RNA services. RNA 1 stated Resident 14 wears hand splints on both hands. RNA 1 explained that Resident 14 wears a right-handed splint during the day and her left hand uses a different splint that was applied at night. RNA 1 stated the OT 1 provided her training on how she was to place Resident 14's hand splints. RNA 1 explained Resident 14 feels better with the use of her hand splints. RNA 1 stated that for residents with hand contractures the use of hand splints help relieve pressure and prevent the clenched hand from digging nails into their skin.During a concurrent observation and interview on 8/7/25, at 11:44 a.m. , Resident 14 was observed in the therapy room. Resident 14 stated she had been at the facility since April (4/2025), and stated she had MS and claw hands. Resident 14 stated PT (physical therapy) was helping her and stated as of this week staff had been consistent in placing her hand supports on her to wear each day. During a concurrent observation and interview on 8/7/25, at 1:48 p.m., Resident 14 was observed wearing a hand/wrist support device on her right hand. Resident 14 explained starting earlier this week, facility staff were applying and removing her hand support device. Resident 14 explained before this, while at the facility her family member had been applying and removing the hand splint that had been brought from home. Resident 14 further explained she wore a hand splint at home prior to coming to the facility. During an interview on 8/7/25, at 2:30 p.m., the Occupational Therapist (OT) stated she started working at the facility recently and was not working at the facility when Resident 14 was admitted and did not perform her initial OT assessment. The OT stated it was her understanding Resident 14's family was involved with her use of splints. The OT stated the splints used for Resident 14 are called Static Resting Hand splints. The OT stated it was her understanding after Resident 14 was admitted her family was applying the splints. The OT stated she was not able to preview Resident 14's previous OT assessments and was not sure if she had been seen previously at the facility for use of the splint. The OT stated the use of hand splints was needed for Resident

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Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure resident's environment remained free of accident hazards for a census of 173 when:1. oxygen signage was not posted outside the door of Resident 36 who was receiving oxygen; and,2. Resident 119, diagnosed with dementia (a decline in mental ability severe enough to interfere with daily life) and a history of exit-seeking behavior, eloped (leaving a healthcare facility or care setting without authorization or discharge, often due to confusion, disorientation, or a lack of safety awareness, putting them at risk of injury or even death) from the facility unsupervised, and was missing for an unknown period of time before being found down the street by family. This failure placed residents at risk of injury due to fire hazards and placed Resident 119 at risk for injury. Findings:1. Review of Resident 36's admission Record indicated Resident 36 was admitted with multiple diagnoses which included but not limited to chronic obstructive pulmonary disease (COPD - a common lung disease causing restricted airflow and breathing problems) and heart failure (a condition where the heart cannot pump enough blood to meet the body's needs).Review of Resident 36's physician order dated 7/22/25, indicated, Oxygen 2 liters per minute via nasal cannula [a flexible tube used to deliver oxygen into the nostrils] as needed for oxygen level below 90During a concurrent observation and interview on 8/4/25 at 10:45 a.m., the director of nursing (DON) confirmed Resident 36 was receiving oxygen via nasal cannula in her room. The DON confirmed an oxygen in use signage was not posted outside of Resident 36's room. The DON stated a signage should have been posted outside of Resident 36's room indicating oxygen was in use inside the room. The DON further stated that oxygen signage was important to alert staff and visitors that residents were using oxygen to prevent fire hazards and ensure safety.Review of the facility's Policy and Procedure titled Respiratory Care; Oxygen Administration dated December 2017, indicated, . Policy Statement: Oxygen is provided in accordance with physician's orders, state and federal regulation, and standards of practice. Oxygen Administration: c. No Smoking signs are posted in accordance with State and Federal regulation. d. Smoking material is not used, maintained, or stored, in resident rooms or areas where oxygen is in use. 5. The Center observes precautions to prevent explosions, fire, etc. that are associated with oxygen use and storage. a. Smoking is prohibited in areas where oxygen is in use.2. A review of Resident 119's admission RECORD, indicated Resident 119 was admitted with diagnoses which included difficulty walking and dementia.Review of Resident 119's BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) (a tool that healthcare providers use to assess a person's cognitive function), dated 7/19/25, indicated, Resident 119 had a BIMS score of 10, which indicated moderate impairment (when a person has some trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). Review of Resident's 119's behavior monitors care plan (a document that outlines a patient's care needs, diagnosis, treatment goals, and nursing orders), dated 7/19/25, indicated . Behavior Monitors. [Resident 119] has a diagnosis of: Dementia.Physical Behaviors Directed at Others.Verbal Behaviors Directed at Others.Socially Inappropriate Behaviors.[Resident 119] will have reduced and manageable behaviors through the review date.Review of Resident's 119's fall care plan, dated 7/19/25, indicated . [Resident 119] is a high risk for falls r/t [related to] Confusion, Gait/balance problems, Unaware of safety needs.A review of Resident 119's Progress Notes, dated 8/2/25, at 12:37 p.m., indicated .Alert Charting Elopement.Physical and mental status prior to elopement, functional/cognitive ability, staff response to event. Resident left facility AM shift charting.Vitals.Spoke with dtr: [daughter, name redacted, Responsible Party (RP) 2] @ [at] SNF [Skilled Nursing Facility] and said that she came to p/u [pick up] her mother for lunch and she found her on a street: [name of street, redacted]: dtr, signed her out @ 10:45 and returned @ 12:15. Dtr, is requesting wonder guard. [provides a wander management solution for senior patients and resident safety] Will f/u [follow up] and monitor.During a concurrent observation and interview on 8/5/2025, at 8:43 a.m., Resident 119 was observed in her room, and stated she likes to walk as much as she can and enjoys the sun outside. Resident 119 stated she had a bracelet on her left ankle that was placed on her last night. Resident 119 stated last Saturday or Sunday she was outside by herself, and her family member witnessed that she was outside and told her to get in the car. During a phone interview on 8/5/25, at 11:00 a.m., Family Member (FM) 1 stated he and RP 2 had found Resident 119 outside of the facility at the end of the road. FM 1 explained Resident 119 was by herself, and they asked her to get into their car, and she did. FM 1 stated Resident119 told them she went out for a walk. FM 1 stated Resident 119 was forgetful. FM 1 explained they drove back to the facility to check her out for lunch. FM 1 stated they told the facility where they had found

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate health treatment and services to meet the urological (the branch of medicine focused on the urinary tract/system) health needs for two of 38 sampled residents (Resident 70 and Resident 12) when: 1. There was no record of indwelling catheter (urinary catheter, a tube which is inserted into the bladder and left in place to drain urine) care being provided to Resident 70's urinary catheter every shift each day per physician order, and Resident 70's urine output was not documented every shift each day per physician order. 2. Resident 12's urology (specializes in conditions that affect the urinary and reproductive systems in adults and children) consult ordered on 5/17/25 and referral to urologist (medical doctor that specializes in urology) for chronic urinary tract infection (UTI, are an infection in your urinary system. Bacteria cause most UTIs, and symptoms include problems peeing and pain in your side) ordered on 7/10/25 were not carried out timely. These failures put Resident 70 and Resident 12 at risk for potential complications such as fluid retention (edema, a buildup of fluid in the body) and urinary tract infection (a condition in which bacteria invade and grow in the urinary tract) in addition to unnecessary pain and suffering.Findings: A review of Resident 70’s “admission Record,” indicated that Resident 70 was admitted to the facility in 2021 with diagnoses which included Heart Failure (a chronic condition in which the heart does not pump blood as well as it should, causing fluid to back up into the lungs), and Urinary Retention (the inability to completely empty the bladder). A review of Resident 70’s “Physician Order Summary,” dated 11/19/24, indicated, “…Provide [urinary] catheter care every shift…” A review of Resident 70’s “Physician Order Summary,” dated 11/19/24, indicated, “…[Urinary] Catheter: measure and record output every shift…” A review of Resident 70’s “Physician Order Summary,” dated 5/6/25, indicated, “…Catheter Care…clean [urinary] catheter site every shift…” A review of Resident 70’s “Care Plan Report,”, indicated, “…Problem… [Resident 70] has a…indwelling catheter…Date initiated: 10/27/24…Target Date: 9/10/25…Goal…the resident will be/remain free from catheter-related trauma…Interventions…Monitor and document intake and output as per facility policy…” During an observation and interview with Resident 70 in his room on 8/4/25 at 12:00 p.m., Resident 70 stated that he needed the urinary catheter because he was not able to empty his bladder. A review of Resident 70’s “Treatment Administration Record May 2025 (TAR, list of prescribed treatments),” indicated that urinary catheter care was not documented on 5/10, 5/11, and 5/17, and urinary output was not documented on 5/10, 5/11, 5/17, 5/19, and 5/23. A review of Resident 70’s “TAR June 2025” indicated that urinary catheter care was not documented on 6/16, and urinary output was not documented on 6/5, 6/6, 6/8, 6/11, 6/16, 6/24, 6/26, 6/28, and 6/30. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 70’s “TAR July 2025” indicated that urinary catheter care was not documented on 7/18, and urinary output was not documented on 7/5, 7/6, 7/18, 7/25, and 7/31. During an interview on 8/6/25 at 4:30 p.m. with Licensed Nurse (LN) 11 at the medication cart, LN 11 stated that the LNs emptied urinary catheter bags and measured the urinary output each shift. LN 11 stated that LNs performed urinary catheter care every shift. LN 11 stated that the urinary catheter care and urinary output were documented in the residents' electronic medical records' in the progress notes or on the TAR if there was a physician order and the LNs confirmed the physician order. LN 11 stated that the risk of not providing urinary catheter care every shift was infection. LN 11 stated that the risk of not emptying the urinary catheter collection bag and measuring the output was that the staff would not know the output and whether the resident retained fluid. During an interview and concurrent record review of Resident 70’s “TAR” with the facility Assistant Director of Nursing (ADON) on 8/6/25 at 4:35 p.m., the ADON stated that it was her expectation that urinary catheter care was done each shift and documented in the residents' medical record, that the urinary catheter bag was emptied every shift and the output was recorded every shift. The ADON confirmed that urinary catheter care and urinary output was not documented every shift for the months of May 2025, June 2025, and July 2025 per the physician's orders in Resident 70’s “TAR”. The ADON stated that the risks were infection, hematuria (blood in the urine), and inaccurate output. The ADON acknowledged that the facility policy was not followed. A review of a facility policy and procedure (P&P) titled, “Evaluation for Indwelling Catheters,” updated May 2025, the P&P indicated, “…3. Catheterization may be unavoidable when the following clinical conditions are present…b. Acute urinary retention…” A review of Resident 12’s “admission RECORD,” indicated Resident 12 was originally admitted in May of 2025 with diagnoses which included, but were not limited to hemiplegia and hemiparesis following cerebral infarction (paralysis or inability to control or move one side of the body following a stroke caused when blood flow to the brain is interrupted causing cell death) and anxiety disorder (a nervous disorder characterized by a state of excessive uneasiness and apprehension that interferes with daily living). A review of Resident 12’s “Order Summary Report,” indicated, “…Urology Consult for evaluation and treatment…Order Date 5/17/2025…Order Status…Discontinued…Referral to Urologist for Chronic UTI’s one time only…for fourteen days…Order Date 7/10/2025…Order Status…Completed…” During a concurrent observation and interview on 8/4/25, at 9:56 a.m., Resident 12 was observed laying in her bed with Responsible Party (RP) 5 standing at her bedside. RP 5 stated he was Resident 12’s family member and she had a left-sided stroke, was not able to speak, and had been at the facility for six weeks. RP 5 stated Resident 12 had recurring UTI’s which were causing her to regress in her physical therapy progress. RP 5 stated they were trying to get a urologist to examine Resident 15 to get to the root cause of the recurrent UTI’s. RP 5 stated Resident 12 was previously at a stroke center and the medical doctor (MD) stated Resident 12 needed a urologist because they felt she was leaking urine causing repeat UTI’s. RP 5 stated he had spoken to the head of the nurses (name retracted, ADON) and the Social Service Assistant (SSA) 2 and had not been successful in getting Resident 12 an appointment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/7/25, at 11:15 a.m., CNA 7 stated she was familiar with Resident 12 and RP 5 told her the resident had a prolapsed bladder (when the bladder drops from its place in the pelvis). CNA 7 stated RP 5 was concerned because Resident 12 had symptoms of a UTI, and he was concerned it was caused by the prolapsed bladder. During an interview on 8/7/25, at 11:44 a.m., Licensed Nurse (LN) 3 stated earlier today RP 5 had mentioned his concern regarding Resident 12’s prolapsed bladder and her need for a urology consultation. LN 3 stated she was going to notify the medical doctor or nurse supervisor regarding his request. LN 3 explained when a family member or patient has a concern or request it was important to inform the doctor. LN 3 stated she was not aware of a urology consultation being scheduled for Resident 12. During an interview on 8/7/25, at 11:51 a.m., the Minimum Data Set Nurse (MDS, monitors, assesses, and documents patients' health at a residential or long-term care facility) stated she was aware RP 5 was requesting Resident 12 be seen by a urologist because RP 5 mentioned it to the medical doctor when he came to see her during her readmission to the facility. The MDS stated the Transporter and Scheduler ([NAME]) had made a urology appointment today for Resident 12. The MDS stated the [NAME] was going to notify RP 5 of the date and time of the appointment. The MDS stated it was important to notify RP 5 of the urology appointment information since he was asking staff about it repeatedly. During an interview on 8/7/25, at 11:55, RP 5 stated he had been provided with Resident 12’s urology appointment information slip earlier that included the time and day of her appointment. RP 5 stated he had talked to the ADON a few weeks ago regarding the scheduling and she said she was working on it. During an interview and record review on 11:51 a.m., the MDS reviewed Resident 12’s electronic clinical record and stated she was readmitted on [DATE] from the hospital. The MDS stated the ADON entered the order for the urology consult on 7/10/25 and the information was shared with the [NAME]. The MDS stated the expectation was the appointment should have made timelier. The MDS stated the sooner the better in terms of medical outcomes and put the family and residents at ease. During a concurrent interview and record review on 8/7/24, at 12:10 p.m., the Transporter and Scheduler ([NAME]), stated she worked out of the Maintenance office, and she transported residents to their appointments including medical appointments. The [NAME] stated she was responsible for calling doctors’ offices, sending referrals, and scheduling appointments for residents. Regarding Resident 12, the [NAME] stated the MD signed her urology referral on 7/10/25, and she sent the referral to the urology office for scheduling of their appointment on 7/14/25. Record review of [NAME] fax cover sheet did not include a facsimile record of date and time sent. The [NAME] stated she was able to schedule the appointment this morning for 9/23/25 and gave RP 5 the appointment date and time earlier today. The [NAME] stated she does not have access to the resident’s electronic clinical record and does not inform the nursing staff of the resident’s appointment information until the week before the scheduled appointment. The [NAME] stated she provides a weekly calendar with names of residents being transported for the following week and hangs the list at the nursing station at the beginning of each week. The [NAME] stated there was a binder at the nursing stations that she used to use to update nursing staff of resident’s appointments, but she had not been using it due to use of registry staff and high staff turnover. The [NAME] acknowledged there was a disconnect between nursing staff obtaining needed information regarding residents scheduling of outside medical appointments. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 8/7/25, at 3:51 p.m., the Assistant Director of Nursing (ADON) stated regarding Resident 12’s order for urology consultation, the [NAME] does not have access to the residents’ electronic clinical record and was not able to add clinical notes regarding appointment status to the resident’s clinical record. The ADON stated the [NAME] usually communicates with her regarding consultation appointments in person. The ADON explained she was not informed of Resident 12’s urology consultation appointment or its pending status. The ADON stated her expectation was residents’ consultation appointments were scheduled within two weeks of receipt of order, and the updates are communicated to her timely. The ADON further explained this allows the residents to receive the appointment details and this should also be updated in residents electronic charting, so nursing staff are aware. The ADON acknowledged their process needed better communication and stated the risk to the residents was medical issues not addressed timely, prolonged symptoms, and excessive worrying for the resident and family.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, observation, and record review the facility failed to ensure safe pharmaceutical services with resident census of 172 when:1. Non-controlled prescription medications (drugs that can only be prescribed by a doctor for a specific resident) were not disposed and documented to reflect safe and accountable drug disposition.2. Emergency Kits (or Ekit, box of medications for emergency use) for IV (Intravenous- Into the Vein) and oral medications were not replaced in a timely manner, narcotic (opioid) medication removal documented without provider pharmacy approval code and opened Ekit medications were co-mingled unsafely at the East and North station medication rooms.3. Controlled medications (narcotic opioid- drugs of abuse) use and pain level were not accurately documented in Medication Administration Record (or MAR) for Resident 122 and Resident 160. These unsafe medication handling practices could pose health risks to residents, the staff and the risk of drug diversion (unlawful use of medications). Findings:1. During a concurrent interview and inspection of the facility's East Station medication room, accompanied by Licensed Nurse (LN) 1, on 8/4/25, at 10:01 AM, the medication room stored a large plastic container full of residents discontinued or expired medications sitting on top of another plastic container. LN 1 stated she was not sure who was responsible for the destruction of the medications.During a concurrent interview and inspection of the facility's North station medication room, accompanied by LN 2, on 8/4/25, at 2:35 PM, the medication room stored a large plastic container full of residents discontinued or expired medications inside a black plastic container. LN 2 stated the medications were waiting to be destroyed by the staff.During a concurrent interview and review of facility non-controlled prescription drug disposition documents, accompanied by the Director of Nursing (DON) and Assistant Director of Nursing (ADON), on 8/5/25, at 3:09 PM, the undated disposition record sheet had stickers (name of the resident and medication) from various patient medications but no marking for the quantity of each medication or the signature of two licensed staff. The ADON stated as time allowed, the night shift licensed staff should have followed the facility's policy on documenting individual prescription medication with the quantity, date, and co-signature of another licensed staff. The ADON stated the pills, and the liquid medications were disposed of inside a liquid drug destroyer. The ADON stated the disposition sheet should have had a supervisor review to ensure the tasks were done safely and in a timely manner.Review of the facility's policy, titled Medication Destruction, dated 10/2017, indicated .Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed.Non-controlled medication destruction occurs in the presence of two licensed nurses.Medication is destroyed within 90 days from the date the medication was discontinued .2a. During a concurrent interview and inspection of the facility's East station medication room, accompanied by LN 1, on 8/4/25, at 10:01 AM, the Ekit for oral medications was observed to have a yellow tag, indicating it had been opened by nursing staff (the pharmacy seals the Ekit with a Red tag and when nursing opens the kit it would be resealed with a yellow tag). The oral medication Ekit contained a yellow sheet of paper listing the medications that were removed by nursing staff. Further review of the removal sheet indicated the earliest removal was on 7/30/25, then 8/1/25, and again on 8/4/25, for the removal of antibiotic medications. LN 1 stated for each removal the nurse should have filled out a new form and faxed the sheet to the pharmacy for replacement. LN 1 stated if the pharmacy was not notified to refill the emergency medication, then it would not be available for next resident if needed.During a concurrent interview and inspection of the facility's East station medication room, accompanied by LN 1 and LN 3, on 8/4/25, at 10:26 AM, the Ekit medication removal binder (contains documentation of what was removed and when) was reviewed. The documents for Norco (narcotic medication) medication removal on 7/31/25, did not have a pharmacy authorization code. Further inspection of the medication room revealed an undated Ekit Procedure sheet that was posted in the medication room. The Ekit Procedure sheet indicated Call the pharmacy and get prior Authorization code.Document information on the pharmacy form for each med [medication] taken.Fax medication refill form immediately to the pharmacy so they can replace Ekit, staple fax verification to the back of the form and place in designated area (binder or folder). LN 3 stated the nursing staff should have followed the posted procedure.2b. During a concurrent interview and inspection of the facility's North station medication room, accompanied by LN 2, on 8/4/25, at 2:35 PM, the Ekit for injectable medication had a yellow seal indicating it was opened by nursing staff at some point. The Ekit for injectable medications did not have a record of medication removal. Further review of the Ekit contents indicated two medications, digoxin (a medication used to lower heartbeat) and chlorpromazine (medication

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Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with resident census of 172. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of three errors out of 57 opportunities which resulted in a facility wide medication error rate of 5. 26% in 3 out of 14 residents (Resident 30, Resident 45, and Resident 169) observed for medication administration. The medication errors were as follows: 1. Resident 30 received the wrong formulation of aspirin (medication used to help prevent stroke or heart attack); 2. Resident 45 received the wrong formulation of aspirin; and, 3. Resident 169 received the wrong formulation of metformin (medication to manage high blood sugar levels). These failures may result in unsafe medication use affecting residents' health and well-being.1. During a medication administration observation with Licensed Nurse (LN)18, at the facility's East Station hallway, on 8/4/25, at 9:24 a.m., LN 18 was observed giving five medications that included aspirin EC (or Enteric Coated- a type of drug with a special coating that protects the stomach lining) tablet to Resident 30. A review of Resident 30's Medication Administration Record (MAR, a document showing doctor's order, instructions, and the nurse's medication administration record), indicated Resident 30's aspirin medication order was not ordered as Enteric Coated product. The order in the MAR was written as follow: Aspirin Tablet 81 MG (MG is milligram, a unit of measure); Give 1 tablet by mouth one time a day . -Start Date 3/27/2018. During a concurrent interview and record review with LN 1, on 8/5/25, at 1:00 p.m., LN 1 reviewed Resident 30's electronic health record and verified Resident 30 had an order for plain aspirin. The aspirin order was originally entered in 2018 where there were two options to enter the medication into the system as either EC or chewable. LN 1 stated Resident 30's aspirin order was confusing for the nurse to know which type of aspirin should be used and needed to be clarified with the doctor.During an interview with LN 18, on 8/5/25, at 1:15 p.m., LN 18 stated Resident 30's aspirin order did not specify if it was chewable or EC. LN 18 verified Resident 30's aspirin medication order should have been clarified with the doctor to know which kind or type of aspirin was needed. 2. During a medication administration observation with LN 18, at the facility's East Station hallway, on 8/4/25, at 9:06 a.m., LN 18 was observed giving nine medications that included aspirin EC tablet to Resident 45.A review of Resident 45's Medication Administration Record (MAR), indicated Resident 45's aspirin medication order was not ordered as Enteric Coated product. The order in the MAR was written as follow: Aspirin Tablet 81 MG (MG is milligram, a unit of measure); Give 1 tablet by mouth one time a day . -Start Date 4/10/2018.During a concurrent interview and record review with LN 1, on 8/5/25, at 1:00 p.m., LN 1 reviewed Resident 45's electronic health record and verified Resident 45 had an order for plain aspirin. The aspirin order was originally entered in 2018 where there were two options to enter the medication into the system as either EC or chewable. LN 1 stated Resident 45's aspirin order was confusing for the nurse to know which type of aspirin should be used and needed to be clarified with the doctor.During an interview with LN 18, on 8/5/25, at 1:15 p.m., LN 18 stated Resident 45's aspirin order did not specify if it was chewable or EC. LN 18 verified Resident 45's aspirin medication order should have been clarified with the doctor to know which kind or type of aspirin was needed. During a concurrent interview and record review with the Assistant Director of Nursing, on 8/5/25, at 3:14 p.m., ADON stated the nursing staff should have verified Resident 30 and Resident 45's aspirin orders with the doctor to determine which kind of aspirin should have been given. 3. During a medication administration observation with LN 5, at the North Station hallway, on 8/6/25, at 8:30 a.m., LN 5 observed giving seven medications that included metformin tablet to Resident 169.A review of Resident 169's Medication Administration Record (MAR), indicated Resident 169's metformin medication order was not ordered as plain immediate release (drug absorbs in body right after administration) product. The order written in the MAR indicated an Extended-Release product should have been given as follow: MetFORMIN ER [Extended Release - is a slow-release form of the medication] Tablet Extended Release .; Give 500 MG by mouth two times a day .-Start Date 07/05/2025. During a concurrent interview and record review with ADON, on 8/7/25, at 2:12 p.m., ADON reviewed Resident 169's medication orders and verified the metformin order as metformin ER. ADON further reviewed Resident 169's admission orders and confirmed the order was for metformin ER. ADON verified Resident 169's metformin medication sent from pharmacy was not the Extended-Release product. ADON confirmed Resident 169's medication order in his electronic health record and the medication supply on hand did not

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure safe medication storage and labeling practices in two out of four medication rooms (a locked room used to store medications and supplies) and three out of 7 medication carts (a mobile cart stored medication and supplies for immediate use) with census of 172 when:The medication room in East station stored expired (the date after which the drug should not be used), undated and unlabeled medications and the sink was kept in an unclean condition. The medication room in the North station stored expired blood tube supplies (a test tube is a cylindrical, transparent container used to store and transport samples of blood for testing) and opened an undated over-the counter medication bottle.Medication cart at North-B station stored undated open inhaler called INCRUSE Ellipta (inhalation medicine used to relieve the symptoms of chronic lung disease) and a pill cutter with white dust inside.Medication cart for wound care at North station stored multiple unlabeled prescription ointments called Santyl (a topical prescription product used to remove damaged tissue from chronic skin ulcers and severely burned areas), open and undated sterile wound cleaning solution, and opened sterile wound care dressing packet.Medication cart at West-B station stored undated open inhaler called TRELEGY Ellipta (inhalation medications used to treat breathing problems) and a pill cutter with white dust inside.These failed practices could contribute to unsafe medication use; medication error, and risk of using contaminated products or supplies on residents.Findings:During a concurrent interview with Licensed Nurse (LN) 1 and LN 3 and inspection of the facility's medication room at East station, on 8/4/25, at 10:38 AM, the following observations were noted:Medication room refrigerator stored expired medications called lorazepam or Ativan in a pre-filled syringes form (drug used to treat anxiety) with expiration date of 7/27/25 on the drug label.The testing agent for Tuberculosis called Aplisol (or TB- a drug in shot form used to test for TB, a serious and contagious lung infection) was open and not dated. The label on the drug box indicated Once entered [open], vial should be discarded after 30 days.Two Insulin products in pen shape form, called Glargine (a long-acting form of insulin used to treat blood sugar disease) did not have an individual label to identify the resident name on it.One bottle of beverage containing alcohol labeled as Cold Hard Mike's in the refrigerator did not have a resident name on it.The double sink in the medication room was unclean with white and yellow stains, dust and pieces of unknown substances. The cabinet under the sink stored cleaning supplies, drug disposition (destruction) containers, a ringing type bell, and a cutting saw.LN 1 stated the expired Ativan should have been discarded, the TB testing vial should have been dated when first opened. LN 1 stated each insulin pen should have a resident name on it so when transferred to the medication cart for daily use it was clearly marked for who it should be used. LN 1 stated the bottle of beverage belongs to a resident and was not labeled as such. LN 3 stated the sink in the medication was not used, but it should be kept clean.2. During a concurrent interview with Licensed Nurse (LN) 2 and inspection of the facility's medication room at North station, on 8/4/25, at 2:35 PM, the following observations were noted:The cabinet in the medication room stored multiple expired blood tube supplies including blue top, red top and yellow top containers (the colors indicated the type of blood test done with these tubes) with expiration dates of 11/30/24, 6/30/24, and 11/30/24 respectively.One opened bottle of a product labeled as Optimum Acidophilus with Pectin (Probiotics used to improve digestion and restore normal flora in the stomach) was stored in the cabinet along with other house supplies of the over-the-counter medication pills. The label on the bottle indicated .Refrigerate after opening to help maximize potency .LN 2 stated the expired blood tubes should have been disposed of and was not sure why the opened bottle was kept in the medication room main supply cabinet.3. During a concurrent interview with LN 9 and inspection of North-B medication cart on 8/5/25, at 9 AM, the following were noted:The pill cutter had white powder-like residue inside and looked unclean. The inhaler called INCRUSE Ellipta was not dated when it was first opened for use. The label on the drug box indicated . Discard the inhaler 6 weeks after opening the moisture-protective foil tray or when the counter reads 0. whichever comes first.LN 9 stated the pill cutter should have been cleaned after each use and stated the inhaler should have been dated.4. During a concurrent interview with LN 21 and inspection of North station treatment cart, on 8/5/25, at 9:30 AM, the following were noted:Multiple tubes of Santyl ointment did not have a prescription label or resident names on them. The cream marked as Rx Only (means should be acquired or dispensed based on a doctor's prescription).Bottles of sterile normal Saline (salt solution used to clean skin wound) was open and half used, and the label indicated .No antimicrobial or other substances added . Content sterile unless container is open or damaged.Opened packet of wound dressing labeled

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food served was prepared by methods that conserve nutritive value, flavor and appearance for 172 of 172 residents that consumed facility prepared meals. These failures had the potential for decreased meal intake which could result in weight loss, malnutrition, and negatively impact the residents' quality of life. Findings:1. During an observation of the Journey dining room on 8/4/25 at 11:50 a.m. the lunch meal was served. One resident meal out of the 13 meals served had a heating element (induction chargers) under the plate to maintain the temperature of the hot items. During an interview on 8/4/25 at 12:38 p.m., Resident 15 stated, Food comes semi warm and there is a lack of edible food.During an interview on 8/4/25 at 12:54 p.m., Resident 28 stated, The food could be hotter. During an interview on 8/4/25 at 12:54 p.m., Resident 34 stated, Food could be hotter.During a review of Resident Council notes, dated 8/5/25 at 10:00 a.m., the Resident Council notes indicated Resident 10 stated, food was cold and has no taste. The food is bland.During an interview on 8/5/25 at 10:26 a.m. with the Certified Dietary Manager (CDM) in the kitchen, the CDM stated, we do not have enough induction chargers, some resident units in the facility do not receive them.A review of the facility's policy titled, Food: Preparation (Healthcare Services Group, Inc., Revised 2/25) indicated in the policy statement .All foods are prepared in accordance with the FDA Food Code . It further indicated in bullet #4 .The Dining Services Director/ Cook(s) will be responsible for food preparation techniques which minimize the amount of time that food items are exposed to temperatures greater than 41 degrees F (Fahrenheit which is a unit of measurement) and/or less than 135 degrees F, per state regulation . 2. During the initial kitchen tour on 8/4/25 at 8:41 a.m. in the dry storage, several black bananas were observed in a box. During an interview with the CDM on 8/4/25 at 8:57 a.m., he verified that there were overripe bananas in storage and took several to discard.During an observation on 8/4/25 at 9:50 a.m. during the initial kitchen tour, two hotel pans of cooked zucchini were found being held in the hot box, approximately an hour and 40 minutes before the lunch meal plating would begin.During an interview on 8/4/25 at 12:54 a.m., Resident 15 stated, The food is too dry and hard to chew. During an interview on 8/4/25 at 3:00 p.m., Resident 84 stated, The vegetables are often overcooked.During an interview on 8/5/25 at 8:12 a.m., Resident 54 stated, I received wrinkled, old fruits and vegetables and wilted lettuce. I also received a black banana.During an observation on 8/5/25 at 2:15 p.m. in the kitchen, Dietary [NAME] (DC) prepared for the dinner meal. DC had green beans and broccoli cooking on the stove. The sign on the wall of kitchen stated that dinner meal service would start at 4:55 p.m.During an interview on 8/6/25 at 2:50 p.m. with the CDM, the CDM confirmed that the cook was preparing food (including vegetables) hours before meal service and it could cause issues with palatability (pleasure of taste for foods), nutrient value and toughness of meats.A review of the facility's policy titled, Food Storage: Cold Foods indicated .All Time/ Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code.According to the USDA Food Code 2022, Section 3-302.11 titled Packaged and Unpackaged Food - Separation, Packaging, and Segregation indicated .(A) FOOD shall be protected from cross contamination by.(7) Storing damaged, spoiled, or recalled food being held in the food establishment as specified under S 6-404.11.3. During a report from the Department on 8/4/25 at 11:15 a.m. Resident 174 stated the menu would change without resident knowledge and Resident 54 stated that the lettuce was often wilted and eggs often cold, and meals were not aligned with the menu. During an interview on 8/4/25 at 12:54 a.m. Resident 34 stated, Food is too dry and needs more sauces and gravies. During an interview on 8/4/25 at 2:54 p.m. Resident 147 stated, Food is always dry.During a review of Resident Council notes dated 8/5/25 at 10:00 a.m. the Resident Council notes indicated that Resident 10 stated that the food is cold and has no taste. Food is described as bland.During an interview on 8/5/25 at 10:26 a.m. with the CDM during a visit to the kitchen, the CDM stated the menu is provided by the Healthcare Services Group and changes to the menu may be made based on the cook's time constraints.During the lunch meal on 8/6/25 at 12:45 p.m., two test trays were removed from the tray cart (a regular diet and pureed texture diets). The food items tested included Sesame Chicken, rice, green peas (instead of the sugar snap peas that were on the menu), a roll, and a brownie. Three out of three of the Department's employees found that the sesame chicken appeared as a baked chicken breast without the expected sauce. The chicken lacked flavor and was tough and dry. The rice was unseasoned and lacked sauce, leaving it bland, and the pureed rice was gummy in the mouth. During a

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to provide alternate food choices with similar nutritive value to the main meal for 172 residents who received food from the kitchen. These failures had the potential of not meeting estimated nutrient needs and potential weight loss. During an initial kitchen tour on 8/4/25 at 8:11 a.m., the alternate menu was reviewed. The alternate menu included chef's salad, grilled cheese sandwich, cottage cheese and fruit, and hamburgers.During a subsequent interview on 8/4/25 at 8:15 a.m. with the Certified Dietary Manager (CDM), the CDM confirmed that the alternate meal choices were chef's salad, grilled cheese sandwich, cottage cheese and fruit, and hamburgers.During an interview on 8/4/25 at 2:54 p.m. Resident 84 stated that they used to get alternatives like sandwiches but all they get now are snack type items. Resident 84 also stated the new company has decreased the portion sizes.During an interview on 8/4/25 at 2:54 p.m. Resident 1 stated they are not getting alternatives to the main meal anymore. During an interview on 8/5/25 at 10:26 a.m. with the CDM during a visit to the kitchen, the CDM stated the menu was provided by the Healthcare Services Group and that they may make changes to the menu based on the cook's time constraints.During an interview on 8/6/25 at 2:47 p.m. with the CDM, the CDM stated that the alternate grilled cheese sandwich comes with a vegetable and side dish of the day. The CDM confirmed additional protein was not added to the alternate meal. During a review of Sandwich, Grilled Cheese Corporate Recipe Number: 4173, the recipe indicated that it included 4 slices of .5 oz of cheese which is a total of 14 grams of protein for an alternate meal.During a review of Chicken, Sesame, Corporate Recipe Number: 7731, the recipe indicated that it included 4 oz of chicken which is a total of 35 grams of protein for the main entree.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to store, prepare, and serve food per safety standards when:Cool down log was not followed consistently.Sugar and flour were stored in the same container.Bowls and pans were found stored wetSmall wares (pans, bowls, cutting board, can opener) were not replaced when worn.Shelves were found discolored and worn (under microwave and grill).Fans were found with black residue (dust) Forks stored in a manner causing fingers to touch the eating surface. Resident refrigerator logs were not acted upon when out of range, and had foods improperly labeled and not discarded per policy.These failures had the potential to lead to cross contamination and food borne illness for the 172 residents eating facility prepared meals. 1. During the initial kitchen tour on 8/4/25, at 9:41 a.m., macaroni salad with a preparation date of 8/4/25, was observed in the walk-in refrigerator at 76 degrees F. During an interview on 8/6/25, at 2:45 p.m., with the Certified Dietary Manager (CDM), the CDM stated the macaroni salad was made earlier that morning and should have been logged in the cool down logbook for temperature monitoring but was not.During a trayline observation on 8/5/25, at 11:30 a.m., several cold food items were above 41 degrees F and needed to be re-chilled.During an interview on 8/6/25, at 2:45 p.m., the CDM stated cold foods were above 41 degrees F and needed to be chilled prior to starting trayline causing a delay in food being plated and sent to residents.During a review of the facility's policy and procedure (P&P) titled, Food Storage: Cold Foods dated 2/2023, the P&P indicated, .all perishable foods will be maintained at a temperature of 41 degrees F or below, except during necessary periods of preparation and service.Review of US Food and Drug Administration's (FDA) 2022 Food Code section 3-501.14 on Cooling indicated .(A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from .135 degrees Fahrenheit (F, a unit of measurement) to . 70 degrees F: and (2) Within a total of 6 hours from .135 degrees F to .41 degrees F or less. (B) TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled within 4 hours to 41 degrees F or less if prepared from ingredients at ambient temperature, such as reconstituted FOODS and canned tuna . It further indicated that .Safe cooling requires removing heat from food quickly enough to prevent microbial growth. Excessive time for cooling of time/temperature control for safety foods has been consistently identified as one of the leading contributing factors to foodborne illness . 2. During the initial kitchen tour on 8/4/25, at 8:57 a.m., in the dry storeroom the sugar container dated 7/8/25, had a mixture of sugar and flour.During the initial kitchen tour on 8/4/25, at 9:00 a.m., with the CDM, the sugar container was observed. The CDM verified that it was likely a mixture of sugar and flour. The CDM stated this could lead to undesired thickening of foods or liquids.During an interview on 8/6/25, at 2:45 p.m., with the CDM, the CDM stated the flour mixed with sugar could cause an allergic reaction for a resident with a gluten allergy. Review of US FDA 2022 Food Code section 3-302.12 on Food Storage Containers, Identified with Common Name of Food indicated, .Certain foods may be difficult to identify after they are removed from their original packaging. Consumers may be allergic to certain foods or ingredients. The mistaken use of an ingredient, when the consumer has specifically requested that it not be used, may result in severe medical consequences. The mistaken use of food from unlabeled containers could result in chemical poisoning . 3. During the initial kitchen tour on 8/4/25, at 8:57 a.m., small pans stored under the steamer were observed still wet and bowls on top of the steamer were stored still wet.During the initial kitchen tour on 8/4/25, at 9:40 a.m., six bowls stored next to the dry storeroom were still wet inside. During an interview on 8/6/25, at 2:45 p.m., with the CDM, the CDM stated it was his expectation that bowls and pans should be stored once fully dried.Review of the 2022 US Food and Drug Administration's Food Code section 4-901.11 on Equipment and Utensils, Air-Drying Required indicated that .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils . 4. During the initial kitchen tour on 8/4/25, at 8:57 a.m. observations included:Six cups were worn and deglazed by the steamer and by the dry storeroom.Two out of four pans were noted with grime stored in a ready to use area.Three out of three soup containers under the microwave were worn with dark areas on surface.The tip of the can opener was missing metal.Two out of four skillets were observed with dark areas on the surface of the pan.A yellow cutting board was worn with deep gouges.During an interview on 8/6/25, at 2:45 p.m., with the CDM, the CDM stated worn bowls needed to be replaced, they cannot be cleaned properly. The CDM further stated the can opener was worn and could cause food contamination if not changed timely. The CDM

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to maintain the garbage storage area when 2 out of 6 dumpsters were observed overflowing the sides of the dumpster and the lids could not close. This had the potential of attracting pest potentially leading to food contamination for the 172 residents' eating facility prepared meals. During the initial kitchen tour on 8/4/25 at 10:12 a.m., the dumpster area was observed. Two of the six dumpsters were noted to have garbage exceeding the side walls of the dumpsters, interfering with the closure of the lids. One lid was noted to rest approximately 6 inches above the bin, supported by bags of garbage. The second lid had been left open. The dumpsters were housed in an area approximately 15 to 20 feet from the door to the hallway of the kitchen.During an interview on 8/6/25 at 2:50 p.m., the certified dietary manager stated that it was important for the lids to be closed to limit the pests being attracted to the building. Review of the facility provided policy titled Dispose of Garbage and Refuse (HCSG Policy 030, Healthcare Services Group, Inc. revised 2/2025) indicated in bullet 2 that .All trash will be properly disposed of in external receptacles (dumpsters) with lids covered when not in use .Review of the US Food and Drug Administration's 2022 Food Code section 5-501.116 on Cleaning Receptacles indicated . Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. In addition, such storage areas must be large enough to accommodate all the containers necessitated by the operation in order to prevent scattering of the garbage and refuse. All containers must be maintained in good repair and cleaned as necessary in order to store garbage and refuse under sanitary conditions as well as to prevent the breeding of flies. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents .

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	555736	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Sonora Care Center	19929 Greenley Road Sonora, CA 95370

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for one out of thirty-eight sampled residents (Resident 153), when the facility did not update Resident 153's admission Record (a comprehensive collection of documents and information gathered at the time a resident is admitted or readmitted to a facility) with afterhours and weekend phone numbers for notification to the Responsible Party (RP - an individual chosen by a resident or appointed by a judge to make personal, medical, and/or financial decisions for an adult who cannot care for or make decisions for themselves) when status changes and health updates occurred.This failure resulted in Resident 153's RP 3 and RP 4 not receiving notification when Resident 153 had a change in condition that occurred after regular business hours or on weekends.Findings:During an interview on 8/5/25 at 12:06 PM, with RP 3, RP 3 stated, Resident 153 had an unwitnessed fall on Saturday 7/19/25, and the facility did not notify an RP until Sunday 7/20/25. The RP stated, the notifications left on Sunday were on the office phone (a phone number used during regular business hours) of RP 3 even though the facility was given specific direction on how to contact an RP after regular business hours and on weekends via a letter sent to the facility dated 3/13/25. RP 3 further stated, the facility left three voicemails on her office phone on Sunday 7/20/25, and the messages were left at 6:36 AM, 7:39 AM, and 7:20 PM.During a concurrent interview and record review on 8/7/25 at 9:29 AM with Licensed Nurse (LN) 4, Resident 153's admission RECORD, dated 1/18/23, was reviewed. The admission Record indicated, Resident 153 had two emergency contacts, RP 3 and RP 4, and each RP contact listed was an office number. LN 4 stated, if Resident 153 had a fall, was sent to the Emergency Room, or had a change in condition she would use the admission Record to call an RP. LN 4 further stated, if she called RP 3 and did not get an answer, she would call RP 4 and assumed one of the numbers would be for afterhours contact. LN 4 stated, she could not think of another way to contact Resident 153's RP after normal business hours or on weekends, nor did she see any additional numbers listed on the admission Record to call.During a concurrent interview and record review on 8/7/2025 at 10:35 AM with the Assistant Director of Nursing (ADON), Resident 153's admission RECORD, dated 1/18/25, was reviewed. The admission Record indicated, Resident 153 had two emergency contacts, RP 3 and RP 4, and each RP contact number listed was for an office phone. The ADON continued, the numbers listed on the admission Record were the only numbers the facility had in their computer system to contact the RP. The ADON confirmed, if an RP provided alternate numbers for nights and weekends, the information should have been added to Resident 153's admission Record and used anytime Resident 153 had a change in condition. During a concurrent interview and record review on 8/7/2025 at 11:23 AM with Social Services Assistant (SSA 1 - a person who assists Residents in addressing their social, emotional, and psychosocial needs), a letter from (county department that provides RPs to adults in their county), dated 3/25/25, was reviewed. SSA 1 confirmed, she had found the letter with updated contact information for Resident 153 on her desk and it contained the following information, .is dedicated to streamlining our practices to ensure clients and facilities can reach our team during the day, after hours, and on weekends. can also contact the PG [Public Guardian - also referred to as the RP] office during business hours by calling [phone number].if you need to speak with our office after hours, on the weekend, or holiday regarding a conservatee, please contact [phone number].This number is specifically for after-hours emergencies.Please remember, when team members are out, if you email or call a team member directly, your call may be unanswered. SSA 1 stated, she had received the letter in March but had not added the additional numbers to Resident 153's admission Record, but should have. SSA 1 further stated, the problem of not updating Resident 153's admission Record would be that staff could not contact an RP in case of an emergency occurring after hours or on weekends, and if a voice message was left on office phone numbers, the RPs would not receive information until the next business day.During an interview on 8/7/2025 at 12:48 PM with the Administrator (ADMIN), the ADMIN stated the facility should notify the RP for all changes in condition for Resident 153. The ADMIN stated, if Resident 153 had any change in condition that occurred after regular office hours or on weekends, facility staff should not leave voice messages on the RP office phone but make every attempt to reach an RP through methods provided to the facility via the letter dated 3/25/25. The ADMIN further stated, current RP contact information should be updated in the facility's computer system as soon as it is received.During a review of Resident 153's Progress Notes [Prog Note - a legal document written by healthcare staff that

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper infection prevention practices (a set of measures taken to stop the spread of germs and infections) were implemented and followed for a census of 172 when there were two unlabeled urinals (portable, bottle-shaped containers designed for male patients to urinate into when they cannot reach a toilet) on the nightstand next to Resident 133's bed.This failure had the potential to place residents at risk for developing an infection and the potential to result in transmission of infection in the facility.During an observation on 8/4/25 at 11:40 AM, in Resident 133's room, there were two urinals on the nightstand next to Resident 133's bed and they were not labeled with a name, initials or other identifying information indicating to whom they belonged.During a concurrent observation and interview on 8/4/25 at 3:00 PM with Licensed Nurse (LN) 21 in Resident 133's room, LN 21 confirmed, there were two unlabeled urinals on the nightstand next to Resident 133's bed and that the urinals should be labeled with resident (Resident 133's) information and room number but were not. LN 21 stated, it was important to label urinals so that other residents would not use one that did not belong to them and cause cross contamination (the transfer of harmful bacteria from one surface, person, or object to another, potentially causing an infection). LN 21 further stated, using a urinal that belonged to another resident could cause infection and make residents sick.During an interview on 8/7/25 at 9:53 AM with the Infection Preventionist (IP - a healthcare professional responsible for overseeing and implementing a facility's Infection Prevention and Control Program [IPCP]), the IP stated, urinals in the facility should be labeled with resident (Resident 133's) identifying information to prevent cross contamination that could lead to infection. The IP stated, urinals that were in use but not labeled did not meet the expectations for infection control practices in the facility.During an interview on 8/7/25 at 10:14 AM with the Assistant Director of Nursing (ADON), the ADON confirmed the problem with unlabeled urinals was an infection control problem. The ADON stated, it was unsanitary to have unlabeled urinals on the nightstand in resident (Resident 133's) room and unlabeled urinals could be inadvertently picked up and used by a roommate or other resident in the facility. The ADON further stated, it was the expectation of the facility that all urinals were to be labeled with identifying information to indicate who they belonged to.During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/21, the P&P indicated, .Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.characteristics include.clean, sanitary, and orderly environment.During a review of the facility's P&P titled, Infection Control Policies and Practices, dated 3/25, the P&P indicated, .Policies and practices are observed to maintaining a safe, sanitary, and comfortable environment and to support infection prevention, identification, and transmission.Objectives of facility infection control policies, protocols, and practices are to.Support prevention, detection, investigation, and transmission.Support maintenance of a safe, sanitary, and comfortable environment.Establish guidelines for implementing appropriate precautions.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to maintain complete and accurate antibiotic monitoring documentation and failed to implement all core elements of the Antibiotic Stewardship Program (ASP, antibiotic use protocols and a system to monitor antibiotic use) for a census of 173 residents when the facility did not have:1. A current infection Surveillance Plan (a written guide that explains how to watch for and track infections), 2. Complete antibiotic tracking data (the information collected by the facility regarding how antibiotics are used and how effective they are against bacteria),3. Documented evidence of antibiotic time-outs (a planned pause usually 48-72 hours after starting antibiotics, to ensure the medication is still appropriate).These failures had the potential to result in incomplete infection tracking, lack of timely antibiotic review, and inappropriate antimicrobial use which may contribute to the development of multidrug resistant organisms (MDRO - germs that have developed the ability to survive antibiotics that were previously used to kill them) and negatively impact resident care.Findings:During a concurrent interview and record review with the Infection Preventionist (IP) on 8/6/25 at 8:22 a.m., the IP stated the facility uses both the Loeb Criteria (set of guidelines that tells when a resident has enough symptoms to safely start antibiotics) and the McGreer Criteria (guidelines used to help determine when an infection in a nursing home resident may not need antibiotics) to evaluate antibiotic use, and reviews laboratory (lab) results to determine antibiotic susceptibility (determines which antibiotic will kill the germ causing the infection). The IP stated these same criteria's are used for monitoring, tracking and evaluating antimicrobial adherence (taking the medication as directed by a healthcare professional, including the correct dosage, frequency, and duration of treatment). The IP reported her daily process includes reviewing progress notes and orders from the previous day, updating the facility's line list (a spreadsheet that tracks residents with infections and antibiotic use), and following up on pending lab results. The IP reviewed records of Resident 86 by going back and forth between their electronic medical record and their line list. Their electronic records showed Resident 86 received Macrobid (antibiotic) every 12 hours for five days for a urinary tract infection (an infection in the urinary tract) which was started on 7/31/25 with a stop date of 8/4/25. Lab results indicated that the urine culture grew Enterococcus Faecalis (a type of bacteria) and was sensitive to Macrobid (the germ would be killed by the antibiotic prescribed). The Line list review for Resident 86 indicated the following: ETIOLOGY: indicated, In house (used to indicate where the illness was contracted instead of the cause of illness) ONSET DATE: indicated, 7/28? (Question mark noted without explanation) TREATMENT: Blank DOT ATB (Days of Therapy [Antibiotics]): Blank MDRO [multi-drug resistant organism]: Blank SIGNS AND SYMPTOMS: indicated, Per Resident and MD Request MEETS CRITERIA: Blank DATE RESOLVED: BlankDuring the same interview, the IP stated the facility's line list does not include the antibiotic start and stop dates. When asked how antibiotic time-outs are conducted for newly admitted residents, the IP explained that newly admitted residents were evaluated during the Interdisciplinary Team (IDT, a group of professionals) meeting. She further stated the physician, or provider was not always present during IDT but can be contacted as needed. When the IP was asked if she could show a sample documentation of antibiotic time-out for a newly admitted resident, she was not able to provide one. The IP also stated that they have no formal antibiotic time-out process or form in place. Furthermore, the IP stated the facility does not have an antibiogram (Antibiograms are used to inform antibiotic selection, particularly in cases where rapid test results are not yet available. They also help track antibiotic resistance patterns within a facility) available and she would work on it. Lastly, the IP stated she was responsible for preparing infection surveillance and antibiotic usage reports and communicates directly with the physician to provide personalized feedback. When asked to present the facility's infection Surveillance Plan, the IP was unable to provide one.During a follow-up interview with the IP and Assistant Director of Nursing (ADON) on 8/7/25 at 10:47 a.m., the IP reiterated that the line list was updated daily, and that antibiotics, including time-outs, are reviewed during IDT meetings and that all information was maintained in the facility's electronic system. However, the IP was unable to provide documentation of their antibiotic time-out reviews. When asked about track & trend data for antibiotic use against infections, the IP and ADON stated that they do not have tracking capabilities at the moment because it was not in their system anymore. During an interview with the Administrator (Admin) on 8/7/25 at 12:00 p.m., the Admin stated she would discuss antibiotic start dates with IP. The Admin stated that they were still searching for their infection Surveillance Plan.Review of document published by the Centers for Medicare and Medicaid (CMS) dated November 22, 2019, with Reference number QSO-20-03-NH, under

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview and record review, the facility failed to maintain an effective pest control program when multiple flies were seen in the food preparation area. This failure had the potential of contamination of food and food poisoning for the 172 residents eating facility prepared meals. Findings:During the initial kitchen tour on 8/4/25 at 8:21 a.m. a fly was observed in the kitchen.During the initial kitchen tour on 8/4/25 at 8:44 a.m. in the dry storeroom which was separated by a closed door from the kitchen, another fly was observed.During the initial kitchen tour on 8/4/25 at 10:12 a.m. the dumpsters were observed. The door to the dumpster area was noted to be propped open with rock. The dumpsters were approximately 15 to 20 feet from the hallway door.During the lunch plating observation on 8/5/25 at 11:30 a.m., multiple flies were observed in the kitchen. The food for lunch was mostly uncovered and staff were swatting at the flies to keep them off of the meal.During an interview on 8/6/25 at 2:50 p.m., with the Dietary Director (DD), the DD concurred that the number of flies had increased over the past few days which was a risk for food contamination. He went on to state that the lunch meal should have been covered to minimize the risk to residents. Review of facility provided policy title Pest Control (HCSG Policy 029, Healthcare Services Group, Inc. revised 2/2025) indicated in the policy statement that A program will be established for the control of insects and rodents for the Dining Services Department. It further indicated in bullet 2 that All food preparation, service, and storage areas will be monitored regularly for any signs of pest/vermin. The center staff will be notified immediately of any concerns verbally and in writing .Review of the Illinois Department of Public Health information on flies indicated that The habits of flies favor the spread of bacteria and other disease-causing organisms. Flies often feed and lay eggs on garbage and manure before contaminating human foods and food preparation surfaces by landing on them. When feeding, house flies regurgitate their stomach contents onto food to liquefy it before ingesting it. They also may contaminate food and surfaces by defecating on them .Review of the Ecolab website indicated that Large flies enter through windows and doors and feed on the food debris . Large flies . can . spread foodborne illness, by landing on various . surfaces and landing on . food .