DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

POC Approved 9/27/23 Tm
BIC 9/22/23 GSS, HFEN

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a Federal Recertification survey. Representing the Department of Public Health: Health Facilities Evaluator Nurse (HFEN), 47465 HFEN, 47039 HFEN, 44971 HFEN, 41054 HFEN, 47138 HFEN, 48874 HFEN, 40841 Registered Dietician, 40830 Pharmaceutical Consultant II, 43258 The facility census was 52. The sample size was 19. One (1) facility reported incident #CA00857564 was investigated during the Recertification Survey. The Department was unable to substantiate a violation of the regulations for facility reported incident #CA00857564.	F 000	BIC during revisit: 10/6/23 cm	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doug Hawkins | TITLE: Admin | (X6) DATE: 09/08/2023

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.

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F 558	Continued From page 1	F 558		

Based on observation, interview, and record review, the facility failed to reasonably accommodate the needs of two of 19 sampled residents (Resident 22 and Resident 31) when their call lights were not within reach.

This failure had the potential to result in residents being unable to request assistance when needed.

Findings:

In a concurrent observation and interview, on 8/21/23 at 9:49 a.m., Resident 31 was lying asleep in bed and her call light was on the floor approximately three feet away. Certified Nursing Assistant 4 (CNA 4) confirmed the call light was on the floor and out of Resident 31's reach.

In a concurrent observation and interview, on 8/21/23 at 10:20 a.m., Resident 22 was asleep in bed and his call light was not seen. When asked where the resident's call light was, CNA 3 stated she did not know and went to the resident's bedside table where she removed a manilla folder and 2 boxes of tissues and found it coiled beneath them. CNA 3 confirmed the call light was not within Resident 22's reach.

In an interview, on 8/24/23 at 11:07 a.m., the Director of Nursing (DON) stated it was her expectation residents' call lights were always within reach. The DON stated if not, residents would not be able to ask for assistance and it could be a safety issue.

A review of the facility's policy titled, "Answering the Call Light," revised 9/22, stipulated, "Ensure

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F 558	Continued From page 2 that the call light is accessible to the resident ..."	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to	F 578		

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F 578	Continued From page 3	F 578		

provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the Physician Orders for Life-Sustaining Treatment (POLST) form for one resident (Resident 29) of 19 sampled residents was valid in the electronic health record (EHR).

This failure decreased the staff's potential to safely follow Resident 29's POLST during emergencies.

Findings:

A review of an admission record indicated Resident 29 was initially admitted to the facility in May 2023 and readmitted in July 2023 with diagnoses including sepsis (blood infection; a life-threatening medical emergency).

A review of Resident 29's POLST, dated 5/26/23, indicated if Resident 29 had no pulse and was not breathing "Do Not Attempt Resuscitation/DNR (Allow Natural Death)."

A review of Resident 29's "Order Summary Report," dated 7/12/23, indicated to attempt cardiopulmonary resuscitation (CPR) for Resident 29.

During an interview on 8/22/23 at 2:36 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated, if a resident had no pulse and was not breathing she

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F 578	Continued From page 4	F 578		

would check the EHR's order whether to attempt CPR or not. LN 3 further stated Resident 29's POLST form, dated 5/26/23, did not match with the order dated 7/12/23, and she would follow the order in EHR.

During an interview on 8/22/23 at 2:43 p.m. with LN 4, LN 4 stated if a resident had no pulse and was not breathing she would check the EHR's order whether to attempt CPR or not and if there was no order, then she would check the resident's chart and follow the POLST form. LN 4 further stated if Resident 29's POLST form and EHR's order did not match then that would have been unsafe and she would be scared and unsure about what to do in case of emergency.

During a concurrent interview and record review on 8/22/23 at 3:57 p.m. with the Director of Clinical Operations (DCO) and Director of Nursing (DON), Resident 29's POLST, dated 5/26/23, and EHR's order, dated 7/19/23 were reviewed. DON and DCO confirmed Resident 29's POLST and order did not match. DCO stated, the charge nurses should have followed the order in the EHR, and the order should have reflected the most updated version of Resident 29's POLST; otherwise "it's not valid." DON stated, a POLST and an order that did not match could have led the nurses to attempt CPR against the residents' wishes or wills to DNR and also could have delayed care for residents and led to their death if charge nurses did not attempt CPR.

A review of the facility's policy titled, "Advance Directives," dated 12/16, indicated, "The plan of care for each resident will be consistent with his

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F 578	Continued From page 5 or her documented treatment preferences and/or advance directive ... A resident will not be treated against his or her own wishes ..." A review of the facility's policy titled, "Do Not Resuscitate Order," dated 3/21, indicated, " ...DNR orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR order."	F 578		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within	F 640		

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F 640	Continued From page 6 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely submit an MDS (Minimum Data Set, an assessment tool) for one of 19 sampled residents (Resident 24) when a discharge MDS from 4/23 had not yet been submitted. This failure had the potential to result in incomplete information being submitted to CMS (Centers for Medicare and Medicaid Services). Findings: A review of Resident 24's admission record	F 640		

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F 640	Continued From page 7 indicated she was admitted to the facility in 3/23 and discharged on 4/6/23. In an interview, on 8/24/23 at 10:58 a.m., the Assistant Director of Nursing (ADON) confirmed Resident 24's discharge MDS had not yet been submitted to CMS and was overdue. In an interview, on 8/24/23 at 11:16 a.m., the Director of Nursing (DON) stated she expected staff to follow the required timeframes for MDS submission. A review of the facility's policy titled, "MDS Completion and Submission Timeframes," revised 7/17, indicated the facility would conduct and submit resident assessments in accordance with current federal and state submission timeframes as published in the Resident Assessment Instrument (RAI) Manual. A review of CMS's RAI Manual, dated 10/23, indicated the discharge MDS was to be submitted within 7 days of completion.	F 640		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		

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F 655	Continued From page 8 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and complete a baseline care plan (BCP) within 48 hours of admission for one resident (Resident 29) of 19 sampled residents.	F 655		

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F 655	Continued From page 9	F 655		

This failure decreased the facility's potential to communicate the initial plan of care with residents, promote their continuity of care, and increase their safety.

Findings:

A review of an admission record indicated Resident 29 was initially admitted to the facility on 5/26/23, and readmitted on 7/12/23, with diagnoses including sepsis (blood infection; a life-threatening medical emergency).

During a concurrent interview and record review on 8/24/23 at 10:25 a.m. with the Director of Nursing (DON), Resident 29's BCPs were reviewed. DON confirmed Resident 29 had no BCP after she was initially admitted on 5/26/23, and the BCP dated 7/12/23, was incomplete after she was readmitted. DON stated the BCP should have been initiated by the nursing supervisors upon Resident 29's admission, completed by other departments, and closed with 48 hours. DON further stated, if the BCP was not completed within 48 hours of admission, then staff would not be able to focus on the residents' care areas, and residents and families would not have an idea of the provided care and services.

A review of the facility's policy titled, "Baseline Care Plans," dated 3/22, indicated, "A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission ...The resident and/or representative are provided a written summary of the baseline care plan ..."

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656		

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F 656	Continued From page 11 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to develop and complete a comprehensive person-centered care plan for one out of 19 sampled residents (Resident 19). This failure had the potential for Resident 19 to not receive appropriate care, services, and treatment. Findings: A review of Resident 19's medical record indicated she was admitted to the facility on 2/15/23 with diagnoses including bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). A review of Resident 19's medical record indicated the following active physician's orders for psychotropic (drugs that affects brain activities associated with mental processes and behaviors) medications: - Lorazepam (a medication to treat anxiety) 0.5 milligrams (mg, a unit of measure): 1 tablet two times a day, dated 5/26/23; - Lorazepam 1 mg: 1 tablet at bedtime, dated	F 656		

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F 656	Continued From page 12 5/26/23; - Lorazepam 0.5 mg: 1 tablet every 12 hours as needed for breakthrough anxiety/agitation related to bipolar disorder, dated 3/16/23; - Mirtazapine (a medication to treat mood disorders) 15 mg: 1 tablet at bedtime related to bipolar disorder, dated 2/15/23; and, - Quetiapine (a medication to treat bipolar disorder) 50 mg: 1 tablet once daily and 3 tablets at bedtime, dated 2/15/23 During an interview on 8/22/23 at 4:21 p.m. with Director of Nursing (DON), DON stated there should have been care plans developed for Resident 19's behaviors for which the psychotropic medications were prescribed. During a review of the facility's policy and procedure (P&P), titled "Care Plans, Comprehensive Person-Centered," dated March 2022, indicated, "1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident ... 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being ..."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 13 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise care plans at least quarterly for one of 19 sampled residents (Resident 31) when her risk for pressure ulcer and risk for incontinence care plans had not been revised since 4/19/23. This failure had the potential to result in unmet nursing needs for Resident 31. Findings: A review of Resident 31's admission record	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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F 657	Continued From page 14 indicated she was admitted in 1/23 with diagnoses including Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar) and unspecified urinary incontinence (lack of voluntary control over urination). A review of Resident 31's clinical record included the following documents: A Prevention of Pressure Ulcer Risk Care Plan, initiated 1/19/23, was last revised 4/19/23. A Risk for Incontinence Care Plan, initiated 1/19/23, was last revised 4/19/23. In an interview, on 8/23/23 at 9:30 a.m., the Assistant Director of Nursing (ADON) stated resident care plans were updated at least quarterly and confirmed Resident 31's incontinence and risk for pressure ulcer care plans had not been updated quarterly. In an interview, on 8/24/23 at 11:12 a.m., the Director of Nursing (DON) stated it was her expectation care plans were updated at least quarterly per facility policy. A review of the facility's policy titled, "Goals and Objectives, Care Plans," revised 4/09, indicated care planned goals and objectives were reviewed and/or revised at least quarterly.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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F 676	Continued From page 15 provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide baths/showers as scheduled for two out of 19	F 676		

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	555180	A. BUILDING _____ B. WING _____	08/25/2023

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GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 676	Continued From page 16	F 676		

sampled residents (Resident 16 and Resident 13) when Resident 16 and Resident 13 did not have a shower as scheduled.

These failures had the potential to decrease cleanliness and comfort for the residents.

Findings:

During a review of the Admission Record, Resident 16 was first admitted to the facility on 7/6/23, with diagnoses including lower spine fracture and abnormal gait and mobility (the pattern and way a resident walks).

A review of a Minimum Data Set (MDS, a standardized assessment tool) dated 8/23/23, indicated Resident 16 required extensive assistance with bathing.

A review of the Census List, Resident 16 was in the facility on 7/6/23 to 8/14/23, and was readmitted on 8/17/23 to present date.

During a review the Shower Schedule, Resident 16 was on a Wednesday and Saturday day-time shower schedule.

During an interview on 8/21/23 at 10:03 a.m., Resident 16 stated she would like more showers since it had been 1 week since her last shower.

During a concurrent interview and record review on 8/22/23 at 1:06 p.m., Licensed Nurse 2 (LN 2) confirmed the last shower given for Resident 16 was 7/26/23. She checked the "shower sheet," dated 8/12/23, and there was no nurse signature on the shower sheet. LN 2 confirmed there was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 676	Continued From page 17	F 676		

no shower sheet found for 8/19/23, and stated if it was not documented, it was not being done. LN 2 confirmed Resident 16 could feel uncomfortable, have odor, and skin break down.

During an interview on 8/23/23 at 10:09 a.m., Resident 16 stated she felt better after she received a shower.

During an interview on 8/23/23 at 10:34 a.m., Certified Nursing Assistant 1 (CNA 1) confirmed the CNA is responsible to get a signature from the nurse to verify that a shower was given.

A review of the facility's care plan document titled, "Unable to perform own [Activities of Daily Living] ..."dated 8/17/23, indicated the intervention tasks included: shower/bathing schedule at least twice per week as indicated.

A review of the facility's document titled, "Follow Up Question Report," dated 7/1/23 to 7/31/23 and from 8/1/23 to 8/31/23, indicated there was one shower given on 7/26/23. There was no shower documented from 8/4/23 to 8/22/23 for Resident 16.

A review of the facility's document titled, "Shower Sheets," dated 8/12/23, indicated there was no nurse signature or refusal of a shower.

During a review of the Admission Record, Resident 13 was admitted to facility on 8/11/23 with diagnoses including spine fracture and abnormal gait and mobility.

Review of the facility's document titled, "Follow Up Question Report," dated 8/1/23 to 8/24/23,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 676	Continued From page 18 indicated there were no showers given to Resident 13. During an interview on 8/24/23 at 1:37 p.m., the Assistant Director of Nursing (ADON) confirmed there was no documentation of showers for Resident 13. Review of the facility's policy titled, "Bath, Shower/Tub," revised 2/2018 indicated, "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin."	F 676		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement measures to prevent the development of a pressure ulcer (PU, injury to the skin and underlying tissue resulting from prolonged pressure on the skin) on the sacrum (tailbone) for one of 19 sampled	F 686		

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	555180	A. BUILDING _____ B. WING _____	08/25/2023

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F 686	Continued From page 19 residents (Resident 31) when: 1. A Risk for Pressure Ulcer Care Plan was not updated; 2. Shower/Bath skin assessments were not completed as scheduled; 3. Nursing weekly summary assessments did not include direct observation of the resident's skin; and 4. Turning and repositioning documentation was not accurate. These failures resulted in Resident 31 developing a facility acquired Stage 3 (affecting the top 2 layers of the skin as well as the fatty tissue) PU. Findings: A review of Resident 31's admission record indicated she was admitted in January 2023 with diagnoses including Type 2 diabetes (a chronic condition that affects the way the body processes blood sugar) and unspecified urinary incontinence (lack of voluntary control over urination). A review of Resident 31's clinical record included the following documents: Review of a Minimum Data Set (MDS, an assessment tool), dated 8/3/23, indicated Resident 31 had severe memory impairment. It also indicated Resident 31 required the extensive assistance of one person for bed mobility, was frequently incontinent of urine and bowels and had no pressure ulcers but, was at risk for developing them. Review of a Prevention of Pressure Ulcer Risk	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 686	Continued From page 20	F 686		

Care Plan, initiated 1/19/23 and last revised 4/19/23, included interventions to perform body audits per protocol and to observe and record the condition of the skin every day during care and on assigned shower days.

A review of bathing documentation dated 7/23-8/10/23, indicated Resident 31 had been given showers on 7/26/23, 7/28/23, and 8/5/23.

A review of a Weekly Nursing Summary, dated 8/9/23 and written by Licensed Nurse 5 (LN 5), indicated Resident 31's skin condition was good, dry, and fragile and there was no current wound or skin impairment.

A review of a nursing progress note, dated 8/10/23, indicated the resident was found to have a new Stage 3 PU on her sacrum measuring 3.6 x 2 x 0.2 cm (centimeter, a unit of measurement).

1. In a concurrent record review and interview, on 8/23/23 at 9:30 a.m., the Assistant Director of Nursing (ADON) stated resident care plans were updated at least quarterly and confirmed Resident 31's risk for pressure ulcer care plan had not been updated since 4/19/23, and prior to her developing a pressure ulcer on 8/10/23.

2. In a concurrent record review and interview, on 8/23/23 at 9:18 a.m., the Infection Preventionist (IP) reviewed the facility's shower logbook and stated Resident 31 was scheduled for showers on Wednesdays and Saturdays. The IP confirmed shower sheets, which contained an area to document a skin assessment, were missing for scheduled showers on 7/29/23, 8/2/23, 8/5/23 and 8/9/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 686	Continued From page 21 In an interview, on 8/23/23 at 9:20 a.m., the ADON stated she did not believe Resident 31's Stage 3 PU developed overnight and that usually a PU began with a deep tissue injury (non-blanchable area of injury to the underlying tissues below the skin's surface) and a color change. The ADON stated if skin assessments had been completed with Resident 31's showers the PU could have been identified earlier. 3. In an interview, on 8/23/23 at 9:30 a.m., the ADON stated when completing the Weekly Nursing Summaries, the nurses should have checked the resident's skin, but they probably had not. In an interview, on 8/23/23 at 1:06 p.m., LN 5 stated when she completed the Weekly Nursing Summary on 8/9/23, she did not actually inspect Resident 31's skin. LN 5 stated she did not actually do a complete skin inspection whenever she completed the summary and instead reviewed the clinical record, looked for any changes in the progress notes and often asked the CNA (Certified Nursing Assistant) if there had been any changes with the resident. 4. In an observation, on 8/22/23 at 7:51 a.m., Resident 31 was in her wheelchair in the dining room for breakfast. In an observation, on 8/22/23 at 11:50 a.m., Resident 31 was lying on her back in bed. In an observation, on 8/22/23 at 12:06 p.m., Resident 31 was in her wheelchair and being transported to the dining room for lunch.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 686	Continued From page 22 In an observation, on 8/22/23 at 2:30 p.m., Resident 31 was lying on her back in bed. In an observation, on 8/23/23 at 7:26 a.m., Resident 31 was in her wheelchair in the dining room for breakfast. In an observation, on 8/23/23 at 8:27 a.m., Resident 31 was lying on her back in bed asleep. In an observation, on 8/23/23 at 1:34 p.m., Resident 31 was out of bed and not in her room. A review of Resident 31's turning and repositioning documentation, on 8/23/23 at 1:35 p.m., indicated Nursing Assistant 1 (NA 1) had documented the resident was repositioned at 1:34 p.m. In an interview, on 8/23/23 at 1:38 p.m., NA 1 was asked how she turned and repositioned Resident 31 at 1:34 p.m. if she was not in bed. NA 1 stated the documentation was for when she put the resident in her wheelchair at around 11:20 a.m. NA 1 stated that she included putting Resident 31 in and out of her wheelchair in the turning and repositioning documentation. When asked if Resident 31 could have been lying on her back, placed in her wheelchair, and then returned to bed on her back again, NA 1 stated it was possible because the documentation did not indicate what position she was placed in. In an interview, on 8/24/23 at 9:26 a.m., the ADON stated if nursing did not update the resident's care plan at least quarterly, an evaluation of how effective the nursing	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 686	Continued From page 23	F 686		

interventions were in preventing a pressure ulcer was not done. The ADON confirmed that without shower sheets between 7/26/23 and 8/10/23, documenting a skin assessment, she had no way of knowing if the CNAs had been checking Resident 31's skin. The ADON reiterated nurses should have been physically assessing the resident's skin when completing the Nursing Weekly Summary. The ADON stated she was aware from staff Resident 31 liked to lay on her back, was difficult to reposition on her side and frequently slid herself off any pillows or wedges they had used to attempt to reposition her on her side. When asked if Resident 31 had a non-compliance care plan, the ADON stated she did not and further confirmed there was no documentation her Responsible Party (RP) had been made aware of the non-compliance and provided education regarding the risks of her not complying with repositioning. The ADON agreed if the resident was lying on her back, placed in her wheelchair, and returned to bed on her back, she was having pressure applied to the same sacral area with each position change and the documentation did not reflect effective turning and repositioning of the resident. The ADON confirmed Resident 31's pressure ulcer was avoidable and could have been prevented.

In an interview, on 8/24/23 at 11:18 a.m., the Director of Nursing (DON) agreed Resident 31's PU was avoidable.

A review of the facility's policy titled, "Goals and Objectives, Care Plans," revised 4/09, indicated care planned goals and objectives were reviewed and/or revised at least quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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F 686	Continued From page 24 A review of the facility's policy titled, "Bath, Shower/Tub," revised 2/18, indicated that one of the purposes of a bath or shower was to observe the condition of the resident's skin. It also indicated documentation for the bath or shower included, "All assessment data [e.g. any reddened areas, sores, etc. on the resident's skin] obtained during the shower/tub bath."	F 686		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 25 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Ensure accurate accountability and effective storage of controlled medications (those with high potential for abuse or addiction) when random controlled medication audits for two out of two residents (Residents 21 and 303) did not reconcile. The medications were signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications) but were not documented accurately on the Medication Administration Record (MAR) to indicate they were given to the residents; 2. Have an efficient system in place to accurately document and secure emergency medications (E-Kit) for a census of 52; 3. Store discontinued controlled medications in accordance with facility policy and procedure (P&P); and, 4. Ensure medications were safely administered to two out of four sampled residents (Residents 3 and 13). These failures resulted in the facility not having accurate accountability of controlled medications and potential for abuse or misuse of these medications, the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents'	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 26	F 755		

therapeutic needs or worsening of their medical conditions.

Findings:

1. Resident 21 had a physician's order dated 7/7/23, for hydrocodone/acetaminophen (a medication to treat pain) 5/325 milligrams (mg, a unit of measurement), 1 tablet every 6 hours as needed for pain. The CDR indicated 1 tablet was signed out on 7/13/23 at 11:33 p.m., 7/22/23 at 11:20 a.m., 8/2/23 at 8:30 a.m., 8/10/23 at 5:15 p.m., 8/13/23 at 5 p.m., 8/14/23 at 10:30 p.m., 8/17/23 at 7:50 p.m., and 8/19/23 12:51 a.m. The MAR did not indicate hydrocodone/acetaminophen was administered to Resident 21 on these dates or times. The MAR indicated 1 tablet was administered to Resident 21 on 7/13/23 at 4:20 a.m., 8/1/23 at 3:45 a.m., 8/2/23 at 4:40 a.m., 8/11/23 at 5:16 p.m., and 8/13/23 at 9:31 a.m. The CDR did not indicate the medication was signed out on these dates or times.

Resident 303 had a physician's order, dated 8/9/23, for oxycodone (a medication to treat pain) 10 mg, 1 tablet every 3 hours as needed for severe pain. The CDR indicated 1 tablet was signed out on 8/17/23 at 4:45 a.m., 9 a.m., 12:08 a.m., and 6 a.m., and 8/18/23 at 12:20 a.m., 4:50 a.m., and 10:19 a.m. The MAR did not indicate oxycodone was administered to Resident 303 on these dates or times. The MAR indicated 1 tablet was administered to Resident 303 on 8/18/23 at 4:16 a.m. but the CDR did not indicate the medication was signed out on that day or time.

During an interview on 8/22/23 at 10:39 a.m. with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 27	F 755		

Director or Nursing (DON), DON stated nursing staff were expected to document administered doses of controlled medication on the CDR and the MAR and the two documents should match. She stated it was important for documentation to be completed in both places to know when the dose of a medication given as needed was next due.

During a review of the facility's P&P titled, "Controlled Medications," dated March 2018, the P&P indicated, "Procedures... D. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration 2) Amount administered 3) Signature of the nurse administering the dose, completed after the medication is actually administered."

2. During an inspection of the Medication Storage Room on 8/21/23 at 9:25 a.m. with Licensed Nurse 1 (LN 1), the E-Kit containing intravenous (IV, into the vein) supplies and medications was observed with a red tag (indicating that the E-Kit had been opened by the facility). The E-Kit log which was attached to the kit did not have any documentation to indicate it had been opened. During an inspection of the E-Kit with LN 1 present, normal saline (used to treat dehydration) 0.9% 1000 liter (L, a unit of measurement), two Insyte catheters (device that is used to administer fluids, medications, and other substances directly into a vein), two IV start kits, two extension valve ports (used to extend an infusion line), one dial a flow tubing (a medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 28	F 755		

device that is used when regulating the flow of a liquid or fluid through an IV), five sodium chloride 0.9% 10 milliliter (ml, a unit of measurement) flushes (used to clear the IV line) were missing from the E-Kit inventory. LN 1 acknowledged the finding and stated when supplies were removed from the E-Kit, the removal was to be documented on an E-Kit log. He stated one copy of the log documenting what was removed was stored in the kit.

During the inspection of the Medication Storage Room on 8/21/23 at 9:27 a.m. with LN 1, the E-Kit containing first dose oral medications was observed with a red tag. Inside was an E-Kit log which indicated two Keflex (a medication to treat infection) 250 mg capsules were removed on 8/16/23. LN 1 confirmed the finding and stated the E-Kit should have been replaced immediately after use but was not.

During an interview on 8/22/23 at 10:16 a.m. with DON, DON stated when medication was removed from the E-Kit, the log was completed, and a replacement was requested from the pharmacy. She stated it was important to request a replacement right away because, "Once you pull things you don't know when you'll need those things again."

During a review of the facility's P&P titled, "Emergency Pharmacy Service and Emergency Kits," dated March 2018, the P&P indicated, "Procedures... G. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit by transmitting the entire order for the resident and indicated that the first

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 29	F 755		

dose was used from the kit... K. If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening..."

3. During an inspection of the medication storage room on 8/21/23 at 10 a.m. with DON, a bubble pack containing oxycodone/acetaminophen (a controlled medication to treat pain) 5/325 mg was identified inside an unlabeled cabinet. DON confirmed the finding and stated discontinued controlled medications were not to be stored in the storage room and should have been brought directly to her.

During a review of the facility's P&P titled, "Medication Destruction," dated March 2018, the P&P indicated, "Procedures... E. Controlled substances are retained in a securely locked area with restricted access."

4. During a medication pass observation on 8/21/23 at 8:42 a.m. with LN 2, LN 2 handed Resident 3 a medicine cup full of her morning medications. Resident 3 began taking them and before she had finished, LN 2 walked out of the resident's room.

During a medication pass observation on 8/21/23 at 8:57 a.m. with LN 2, LN 2 placed Resident 13's medication cup full of her morning medications on her bedside table. LN 2 then left Resident 13 unattended with the medications to get applesauce from the medication cart.

During an interview on 8/21/23 at 11:52 a.m. with LN 2, LN 2 agreed it was not appropriate to leave a resident unattended in the middle of medication administration. When asked if it was ever

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 30 acceptable to leave a resident with medications on their bedside table she stated, "No not at all." During an interview on 8/22/23 at 1:33 p.m. with DON, DON stated it was never acceptable to leave a resident unattended with medications for their or their roommate's safety. During a review of the facility's P&P titled, "Medication Administration," dated March 2018, the P&P indicated, "Procedures... B. Administration... 15) The resident is always observed after administration to ensure that the dose was completely ingested..."	F 755		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 31	F 758		

drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure two of 19 sampled residents (Resident 19 and Resident 202) were free of unnecessary medications when:

1. Resident 202 was prescribed three psychotropic (a drug that affects behavior, mood, thoughts, or perception) medications without adequate indication and behavior monitoring, a PRN psychotropic had no end date and consent was not obtained prior to its administration; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 32	F 758		

2. Resident 19 was prescribed four psychotropic medications without adequate side effect and behavior monitoring.

These failures placed the residents at risk for use of unecessary psychotropic medications.

Findings:

1. A review of Resident 202's admission record indicated she was admitted in 8/23 with diagnoses including anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities) and depression.

A review of Resident 202's clinical record included the following documents:

A physician's (MD) order, dated 8/15/23, indicated an order for duloxetine (an antidepressant) delayed release capsule, 60 mg (milligrams, a unit of measurement), 1 capsule daily for depression.

An MD order, dated 8/15/23, indicated an order for buspirone (an antianxiety), 7.5 mg tablet, 1 tablet 3 times a day for anxiety.

An MD order, dated 8/15/23, indicated an order for hydroxyzine (an antihistamine), 25 mg tablet, 1 tablet every 8 hours PRN (as needed) for anxiety. The order's end date was indefinite.

In an interview, on 8/22/23 at 1:15 p.m., the Director of Clinical Operations (DCO) stated psychotropic medication orders were to include a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 33	F 758		

targeted behavior and an order for monitoring of that behavior. The DCO confirmed the medication orders for Resident 202's duloxetine, buspirone and hydroxyzine did not indicate a targeted behavior and there were no orders for behavior monitoring. The DCO further stated the hydroxyzine was being used as a psychotropic medication and required consent before administering, all PRN psychotropic medications were to have a 14 day end date and confirmed the hydroxyzine did not.

In an interview, on 8/22/23 at 2:14 p.m., the DCO confirmed consent had not been obtained for the hydroxyzine prior to its administration.

A review of the facility's policy titled, "Psychotropic Medication Use," dated 7/22, stipulated, "Psychotropic medication management includes ...Indications for use ...Adequate monitoring for efficacy ...Categories of medications which affect brain activity such as antihistamines ...That are prescribed as a substitute or an adjunct to a psychotropic medication are monitored and managed as psychotropic medications ...PRN orders for psychotropic medications are limited to 14 days."
2. A review of Resident 19's medical record indicated she was admitted to the facility on 2/15/23 with diagnoses including Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 34 A review of Resident 19's medical record indicated the following active physician's orders for psychotropic medications: - Lorazepam (a medication to treat anxiety) 0.5 mg: 1 tablet two times a day, dated 5/26/23; - Lorazepam 1 mg: 1 tablet at bedtime, dated 5/26/23; - Lorazepam 0.5 mg: 1 tablet every 12 hours as needed for breakthrough anxiety/agitation related to bipolar disorder, dated 3/16/23; - Mirtazapine (a medication to treat mood disorders) 15 mg: 1 tablet at bedtime related to bipolar disorder, dated 2/15/23; - Quetiapine (a medication to treat bipolar disorder) 50 mg: 1 tablet once daily, dated 2/15/23; - Quetiapine 50 mg: 3 tablets at bedtime, dated 2/15/23; and, - Escitalopram (a medication to treat depression) 20 mg: 1 tablet on time a day for depression, dated 8/22/23 During an interview on 8/22/23 at 4:14 p.m. with Director of Nursing (DON), DON confirmed Resident 19 was not monitored for side effects related to the use of lorazepam and mirtazapine. DON confirmed the resident was not monitored for target behaviors related to the use of mirtazapine and escitalopram. DON stated side effect and behavior monitoring should have been completed for every psychotropic that was prescribed for a resident. During a review of the facility's P&P, titled "Psychotropic Medication Use," dated July 2022, the P&P indicated, "Policy Interpretation and	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 35 Implementation... 3. Residents, families and/or the representative are involved in the medication management process. Psychotropic medication management includes: a. indication for use; b. dose (including duplicate therapy); c. duration; d. adequate monitoring for efficacy and adverse consequences; and e. precenting, identifying and responding to adverse consequences... 13. Residents receiving psychotropic medications are monitored for adverse consequences."	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility had a 32.26% error rate when ten medication errors out of 31 opportunities were observed during a medication pass for three out of four residents (Residents 3, 13 and 47). This failure resulted in medications not given in accordance with the prescriber's orders and potential to affect the residents' clinical conditions. Findings: During a medication pass observation on 8/21/23 at 8:33 a.m. with Licensed Nurse 2 (LN 2), LN 2 was observed preparing three medications, including metoprolol succinate (a medication to	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 36	F 759		

treat high blood pressure) ER (ER, a long acting formulation) 50 milligrams (mg, a unit of measurement), magnesium oxide (a mineral to treat heartburn) 400 mg, and lisinopril (a medication to treat high blood pressure) 10 mg for Resident 47. LN 2 took Resident 47's blood pressure but did not measure the resident's heart rate.

A review of Resident 47's medical record indicated the following physician's orders:

- Metoprolol succinate ER 50 mg: 1 tablet one time a day for HTN (hypertension, high blood pressure). Hold for SBP (systolic blood pressure, the pressure when your heart pushes blood out) < 100 or HR (heart rate) < 60, dated 7/21/23;
- Magnesium oxide 400 mg: 1 tablet one time a day for supplement. Take 1 hour after breakfast, dated 7/21/23; and,
- Lisinopril 10 mg: 1 tablet one time a day for HTN. Hold for SBP< 100 or HR< 60, dated 7/21/23.

During an interview on 8/21/23 at 11:39 a.m. with LN 2, LN 2 stated breakfast was served between 7 a.m. and 7:30 a.m. She stated the magnesium oxide was timed for 8 a.m. in the computer system but should have been timed at 9 a.m. so would be administered 1 hour after breakfast. LN 2 stated she did not know what time Resident 47 had eaten breakfast.

During an interview on 8/22/23 at 10:27 a.m. with DON, DON stated nursing staff were expected to check to see if a resident had eaten and know approximately what time they ate if a medication was to be timed around a meal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 37 During a review of the facility's policy and procedure (P&P) titled, "Medication Administration- General Guidelines," dated March 2023, the P&P indicated, "B. Administration... 2) Medications are administered in accordance with written orders of the attending physician... 10) Medications are administered within 60 minutes of a scheduled time, except before or after meal orders, which are administered based on mealtimes..." During a medication pass observation on 8/21/23 at 8:42 a.m. with LN 2, LN 2 was observed preparing six medications, including potassium chloride (a medication to treat low potassium levels) ER 20 milliequivalents (mEq, a unit of measurement), furosemide (a medication to treat fluid retention) 40 mg, and losartan (a medication to treat high blood pressure) 25 mg for Resident 3. The potassium chloride package had a yellow sticker affixed by the pharmacy indicating not to crush the medication. LN 2 took Resident 3's blood pressure but did not measure the resident's heart rate. A review of Resident 3's medical record indicated the following physician's orders: - Potassium chloride ER 20 mEq: 1 tablet in the morning for supplement. Do not crush. Give with 4-6 oz fluid, dated 6/14/23; - Furosemide 40 mg: 1 tablet in the morning for CHF (congestive heart failure). Hold for SBP< 100 or HR< 60; and, - Losartan 25 mg: 1 tablet in the morning for HTN. Hold for SBP< 100 or HR< 60.	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 38	F 759		

During an observation on 8/21/23 at 8:45 a.m. with LN 2, LN 2 entered Resident 3's room and gave the medication cup to the resident. Resident 3 stated she did not want to take the potassium tablet whole so LN 2 stated she would dissolve it for her. LN 2 took the potassium in the medication cup and placed approximately 5 milliliters water in the cup. LN 2 waited for the tablet to start bubbling, then added a half spoonful of applesauce on top and gave it to Resident 3 to take.

During an interview on 8/21/23 at 11:46 a.m. with LN 2, LN 2 stated even though the potassium chloride tablet had a do not crush sticker affixed to it, it was ok to dissolve the tablet. When asked if Resident 3 had an order from the physician indicating it was ok to crush or dissolve the medication she stated, "I kind of want to say yes." LN 2 reviewed Resident 3's physician's orders but did not see an order indicating it was ok to crush the resident's medications.

During an interview on 8/22/23 at 10:13 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to contact the pharmacist for each resident and each medication to confirm whether it was appropriate to crush or dissolve a medication.

During a review of the facility's P&P titled, "Medication Administration- General Guidelines," dated March 2018, the P&P indicated, "A. Preparation... 6) ... a. Long-acting or enteric coated dosage forms should generally not be crushed; an alternative should be sought... f. The need for crushing medications may be indicated on the resident's record so that all personnel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 39 administering medications are aware of this need..." A review of the manufacturer's specifications for potassium chloride ER tablet indicated, "To take each dose without crushing, chewing or sucking the tablets. If those patients are having difficulty swallowing whole tablets, they may try one of the following alternate methods of administration: a. Break the tablet in half, and take each half separately with a glass of water. b. Prepare an aqueous (water) suspension as follows: 1. Place the whole tablet(s) in approximately 1/2 glass of water (4 fluid ounces). 2. Allow approximately 2 minutes for the tablet(s) to disintegrate. 3. Stir for about half a minute after the tablet(s) has disintegrated. 4. Swirl the suspension and consume the entire contents of the glass..." During a medication pass observation on 8/21/23 at 8:57 a.m. with LN 2, LN 2 was observed by two surveyors preparing ten medications including metoprolol succinate ER 25 mg and spironolactone (a medication to treat blood pressure) 25 mg for Resident 13. LN 2 stated the resident had two physician's orders for prednisone and she would give 1 tablet for each. LN 2 was observed preparing one prednisone (a medication to treat inflammation) 1 mg tablet and one prednisone 5 mg tablet for Resident 13. LN 2 stated the resident was scheduled for tramadol (a medication to treat pain) but it was not available in the medication cart. LN 2 took Resident 13's blood pressure but did not measure the resident's HR. A review of Resident 13's medical record indicated the following physician's orders:	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 40	F 759		

- Metoprolol succinate ER 25 mg: ½ tablet in the morning for hypertension. Hold if SBP<100 and HR< 60, dated 8/12/23;
- Prednisone 1 mg: 4 mg (4 tablets) one time a day for inflammation. Take a 5 mg tablet with 4 mg (9 mg total in the AM), dated 8/12/23;
- Prednisone 5 mg: 1 tablet one time a day for inflammation. Give 5 mg tablet with 4 mg (9 mg total in the AM), dated 8/11/23;
- Spironolactone 25 mg: 1 tablet one time a day for hypertension. Monitor BP (blood pressure) and HR, dated 8/12/23; and,
- Tramadol 50 mg: 1 tablet two times a day for chronic pain at 8 a.m. and 2 p.m., dated 8/11/23.

During an interview on 8/21/23 at 11:33 a.m. with LN 2, LN 2 confirmed she only took the blood pressure but not the heart rate of the residents that received blood pressure medications with hold parameters. She stated, "It [measure the HR] is something that we should do, yes." LN 2 stated it was important to measure the resident's HR when ordered by the physician because, "If HR is too low these [medications] can make it go lower."

During a concurrent interview and record review on 8/21/23 at 11:52 a.m. with LN 2, Resident 13's physician's order for prednisone 1 mg tablet and confirmed the order stated to administer 4 tablets. LN 2 stated she prepared and administered 4 tablets during the medication pass (this did not happen).

During an interview on 8/21/23 at 3:12 p.m. with LN 6, LN 6 stated, "If you pass the meds, you take it [blood pressure and heart rate]." She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 41 stated nursing staff were expected to follow physician's orders. During a review of Resident 13's Medication Administration Record (MAR) dated August 2023, the MAR indicated Resident 13 did not receive tramadol 50 mg that was scheduled for 8 a.m. on 8/21/23. During an interview on 8/22/23 at 10:21 a.m. with DON, DON confirmed nursing staff were expected to administer medications as ordered by the physician. She stated nursing staff were expected to follow hold parameters as ordered on blood pressure medications and to obtain a HR reading within 30 minutes prior to administering the medication. DON stated nursing staff were expected to follow those orders closely because, "There's a reason." During a review of the facility's P&P titled, "Medication Administration- General Guidelines," dated March 2018, the P&P indicated, "Procedures... B. Administration... 2) Medications are administered in accordance with written orders of the attending physician... 10) Medications are administered within 60 minutes of scheduled time... Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility."	F 759		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 13) was free of a significant medication error when tramadol (opioid medicine used for the short-term relief of moderate to severe pain) was not available for routine administration. This failure resulted in Resident 13 experiencing pain and psychosocial (the combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) harm when pain was left untreated. Findings: A review of Resident 13's Admission Record indicated she was admitted to the facility on 8/11/23 with diagnoses which included vertebral wedge compression fractures (a type of crush or break of the spine) of thoracic vertebrae 5 (T5) to T10 (the middle section of the spine), fracture of fourth lumbar vertebra (the lower back section of the spine), neuropathy (nerve damage which leads to pain), lung cancer, osteoporosis (a condition in which the bones become brittle) and complete rotator cuff tear or rupture of left shoulder. During a review of Resident 13's Pain Interview, dated 8/11/23, the Pain Interview indicated Resident 13 experienced frequent pain that limited her day-to-day activities and made it difficult to sleep at night. The document indicated Resident 13's pain was severe, rated at a level 7	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 43	F 760		

(pain scale of 0 to 10, with 10 being the highest level of pain), and staff assessment for pain was to include, "1. Non-verbal sounds... 2. Vocal complaints of pain... 3. Facial expressions (e.g... winces...) ..."

During a medication pass observation on 8/21/23 at approximately 8:50 a.m. with Licensed Nurse 2 (LN 2), LN 2 was observed preparing twelve medications for Resident 13. LN 2 stated she would not be able to administer Resident 13's tramadol (a medication to treat severe pain) 50 milligrams (mg, a unit of measurement) scheduled for 8 a.m. because they had run out of her medication on 8/20/23.

A review of Resident 13's medical record indicated the following active physician's orders:

- Tramadol 100 mg: 1 tablet at bedtime for chronic pain, dated 8/11/23;
- Tramadol 50 mg: 1 tablet every 6 hours as needed for pain for 30 days, dated 8/13/23; and,
- Tramadol 50 mg: 1 tablet two times a day for chronic pain at 0800 (8 a.m.) and 1400 (2 p.m.), dated 8/11/23

During an observation on 8/21/23 at 8:57 a.m., LN 2 entered Resident 13's room to administer her medications. Resident 13 was observed sitting upright in her wheelchair, shaky, pale, and tearful. LN 2 told her she did not have her pain medication available for administration. LN 2 asked Resident 13 if she had the physician's cell phone number to contact the doctor herself to request another tramadol order be sent to the pharmacy. Resident 13 quietly replied, "No."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 44	F 760		

During the same medication pass observation, LN 2 was observed applying a Lidoderm (a medication to treat pain) 5% patch to Resident 13's back. As the patch contacted Resident 13's skin, she winced.

During a concurrent observation and interview on 8/21/23 at 2:59 p.m. with Resident 13, Resident 13 was observed tense, lying still in her bed on her back. When asked how she was doing she stated, "Not very good." Resident 13 stated she did not receive her tramadol dose scheduled for 8 a.m. that morning until 10 a.m. and reported her pain level was now at a 7. She stated when she did receive her tramadol on time, it brought her pain level down to a 4 or 5, which was tolerable for her.

A review of Resident 13's Medication Administration Record (MAR), dated August 2023, indicated a pain level of 6 for both day and evening (assessed day, evening, and night) on 8/21/23.

During an interview on 8/21/23 at 3:12 p.m. with Registered Nurse (RN), RN stated an acceptable pain level for a resident was 1 to 3, which was treated with mild pain medication such as acetaminophen.

During a review of Resident 13's Care Plan, dated 8/11/23, the Care Plan indicated, "Focus: Resident is at risk for pain... Goal: Will be relieved of pain 30 to 45 minutes after intervention is given daily... Interventions/Tasks: Administer medication as ordered..."

During a review of the facility's policy and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 45 procedure (P&P) titled, "Pain Assessment and Management," dated March 2020, indicated, "General Guidelines: 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain... the comprehensive care plan, and the resident's choices related to pain management. 2. 'Pain management' is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals... Implementing Pain Management Strategies... 5. Implement the medication regimen as ordered..." During a review of the facility's P&P titled, "Medication Administration- General Guidelines," dated March 2018, indicated, "B. Administration... 10. Medications are administered within 60 minutes of scheduled time..." According to The Clinical Journal of Pain, in an article titled, "The Multimodal Assessment Model of Pain: A Novel Framework for Further Integrating the Subjective Pain Experience Within Research and Practice," dated March 2019, the article indicated, "Although quantitative pain measures are vital to understanding and targeting mechanisms and benchmarking management, they often overlook important attributes of the subjective experience, such as personal context and meaning, which can profoundly shape the experience of pain." (https://journals.lww.com/clinicalpain/fulltext/2019/03000/the_multimodal_assessment_model_of_pain__a_novel.2.aspx; accessed 8/28/23)	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 46 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure: - Medication carts were kept securely locked when left unattended; - Opened biologicals, multi-dose inhalers, and inhalation solutions were dated with an open and discard date to ensure they were not used beyond the discard date; - Medication was appropriately labeled with a pharmacy label or name to correctly identify	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 47 which resident they were for; and - Expired and discontinued medications were not available for resident use. The deficient practices had the potential for residents to receive medications with unsafe or reduced potency from being used past their discard date or improper storage, and diversion or misuse of medications from not being securely stored in medication carts. Findings: During an observation on 8/21/23 at 8:29 a.m., the medication cart (med cart) was observed unlocked and unattended facing a resident's room. During a second observation on 8/21/23 at 8:34 a.m. with Licensed Nurse 2 (LN 2), LN 2 left the med cart unlocked, unattended, angled away from the resident's room, and walked into the room to administer medications. During an interview on 8/21/23 at 12:07 p.m. with LN 2, LN 2 stated nursing staff were expected to lock the med cart if they walked away. She confirmed she had left it unlocked and unattended earlier and stated, "But it was a quick situation I came out for." During an interview on 8/22/23 at 10:20 a.m. with Director of Nursing (DON), DON stated, "If you walk away from the cart, you lock it, every time." During a concurrent observation and interview on 8/23/23 at 9:21 a.m., Med Cart 2 was in the hallway unlock and unattended. LN 5 was	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 48 assisting the resident in the lobby. There were other residents in the lobby and staff in the hallways. LN 5 confirmed the medication cart should be locked at all times when not present. During an interview on 8/24/23 at 9:25 a.m., the DON stated she expected nurses to lock the medication cart when unattended. During a review of the facility's policy and procedure titled, "Medication Administration," dated March 2018, the P&P indicated, "During administration of medication, the medication cart is kept closed and locked when out of sight of the medication nurse." During a concurrent observation and interview on 8/21/23 at 9:39 a.m. with DON, an inspection of the medication storage room identified one vial Tubersol (an injectable solution used to aid diagnosis of tuberculosis infection) expired 8/12/23, three pouches ipratropium/albuterol (a medication to treat asthma) 0.5 milligrams/3 milligrams (mg, a unit of measurement) per 3 milliliters (ml, a unit of measurement) inhalation solution, three unlabeled weekly pill boxes containing various tablets, one box Piston Irrigation Syringes (a solution used for wound care) expired 7/15/23, and one sharps container filled with broken tablets and plastic packaging without a lid on it. DON confirmed the finding and stated the identified items should have been removed from the facility's medication supply. DON stated discontinued medications were to be placed in a separate cabinet designated for that purpose, and the sharps container should not have been open and left on the countertop in the medication storage room.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 49 During a concurrent observation and interview on 8/21/23 at 1:04 p.m. with LN 6, an inspection of Med Cart 2 identified one bottle melatonin (a supplement to aid with sleep) 3 mg tablet, two omeprazole (a medication to treat acid reflux) 20 mg capsules, and one bottle diphenhydramine (a medication to treat allergies) 25 mg tablets, all expired. An unlabeled amber vial containing one white capsule was observed in the cart along with one vial EvenCare G3 test strips (used to test blood sugar), one box budesonide (a medication to treat asthma) 1 mg/2 ml inhalation solution, and one fluticasone/salmeterol (a medication to treat asthma) 250/50 microgram (mcg, a unit of measurement) inhaler opened and unlabeled with an open date. One vial heparin (a medication to prevent blood clots) 5000 units/ml was also identified without a label indicating which resident it was for. LN 6 confirmed the findings and stated medications that were resident specific should have had a label on them to identify who they were for. She stated the EvenCare G3 test strips expired 30 days once opened and should have been labeled with an open date, "at bare minimum." LN 6 reviewed the manufacturer's specifications on the outside of the budesonide inhalation solution and fluticasone/salmeterol inhaler and confirmed both had shorter expiration after first use and should have been labeled with an open date. During an interview on 8/22/23 at 10:05 a.m. with DON, DON stated nursing staff were expected to label medications with an open date if they had shorter expiration dates after first use. During a review of the facility's policy and	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 50	F 761		

procedure (P&P) titled, "Medication Storage in the Facility," dated March 2018, the P&P indicated, "Procedures... M. Outdated, contaminated, or deteriorated medications... are immediately removed from stock, disposed of according to procedures for medication disposal... and reordered from the pharmacy... if a current order exists."

During a review of the facility's P&P titled, "Medication Labels," dated March 2018, the P&P indicated, "Procedure A. Labels are permanently affixed to the outside of the prescription container... the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container."

During a review of the facility's P&P titled, "Dating of Containers When Opened," dated March 2018, the P&P indicated, "Procedures... C. Medication in Multi-dose (injection) vials: are to be dated when opened and discarded after 28 days... E. Inhalers: Some inhalers require a shortened expiration date when first put in use... 1) Inhalers dispense by [supplier pharmacy] will either have a 'date opened' sticker place on the inhaler container or a shortened expiration date placed on the prescription label if once in use there is a shortened expiration date... F. Glucose Meter Test Strips: Glucose meter test strips need to be dated when opened..."

During a review of the facility's P&P titled, "Medication Destruction," dated March 2018, the P&P indicated, "Procedures... C. All non-controlled drugs that are eligible for disposal are placed in an approved waste container

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 51 properly labeled as medication waste..."	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the menu was followed for the therapeutic diets (a modification of a regular diet, to fit the residents nutritional needs) during the lunch meal on 8/22/2023 when nine residents (Residents 9, 18,20,23,31,43,203,	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 52 205 and 305) did not receive the correct dessert. These failures had the potential to result in compromising the medical and nutritional status of nine residents for a census of 52. Findings: During an observation of lunch meal service on 8/22/23, beginning at 12:15 p.m., it was noted seven residents (Residents 18,20,23,31,43,203, and 205) received fresh fruit as a substitute for the diet apple square for dessert on the menu. Resident 305 received fresh fruit instead of the regular glazed apple square for dessert. Resident 9 received puree regular apple square instead of puree diet apple square. A review of residents' meal tickets on 8/22/23 for lunch indicated eight residents (Residents 9, 18, 20, 23, 31, 43, 203, and 205) were on therapeutic diets of CCHO (controlled carbohydrate diet, a diet to give the same amount of sugar each day, to keep blood sugar levels stable). The meal ticket for Resident 305 indicated her therapeutic diet was low fat and low cholesterol (a diet to control or prevent heart disease). A review of the facility document titled, "Summer Menus, Week 4, Tuesday, 8/22/23," indicated, dessert for the regular lunch trays was an apple square. The document further indicated, diet apple square for the CCHO lunch tray. During an interview on 8/22/23, at 11:01 a.m., with the Certified Dietary Manager (CDM), CDM stated she was not aware the staff did not prepare the diet apple square for lunch and the	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 53 dessert was substituted with fresh fruit for CCHO lunch trays. The CDM further stated the Registered Dietitian (RD) was not aware of the substitution and the expectation was for the RD to be made aware. In a concurrent interview and record review on 8/23/23 at 1:50 p.m. with the CDM, CDM stated changes to the menu were supposed to be marked on the large spreadsheet. The CDM confirmed the large spreadsheet dated 8/22/23, titled "Summer Menus" did not indicated a change to the CCHO dessert. An interview on 8/23/23 at 1:55 p.m., with Cook (CK 2), CK 2 stated she did not review the menu spreadsheet on Monday to prepare the correct dessert for Tuesday. CK 2 stated she followed the resident's menu to prepare the tuesday's lunch dessert. CK 2 stated she assumed the dessert could be used because when she makes cake, the CCHO residents get the regular dessert but a smaller portion. CK 2 further stated, she did not notify the CDM of the change. CK 2 stated the expectation was to follow menu spreadsheet, not the resident menu. A review of the facility document titled, "Job Description (JD) Position: FNS [Food and Nutrition Service] Director" dated 2023, the JD indicated, "Is responsible for the preparation and service of all food and ensures that approved menus and accompanying recipes are followed ... Make menu adjustments as needed ...with final approval of the Dietitian".	F 803		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 54 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to honor food preferences during the lunch meal on 8/22/23 for two sampled residents (Resident 12 and Resident 8) out of a census of 53 when; 1. Resident 12 was served a whole slice of turkey even though ground meats was documented on Resident 12's meal card; and, 2. Resident 8 was served fresh fruit as a dessert instead of the regular dessert which was documented on Resident 8's meal card. This failure increased the potential for Resident 12 and Resident 8 to have an unpleasant dining experience and had the potential to result in altered nutrition. Findings: A review of Resident 12's "Admission Record" indicated, Resident 12 was admitted in Summer 2023 with multiple diagnoses which included dysphagia (difficulty swallowing).	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 806	Continued From page 55	F 806		

An observation of lunch tray line, Resident 12 was served a whole slice of turkey by the dietary aide (DA 1). DA 1 was then observed plating the next resident's tray.

A review of Resident 12's meal ticket (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) for 8/22/23 indicated preferences of ground meats.

A concurrent observation and interview on 8/22/23 at 11:55 a.m., in the kitchen with the Certified Dietary Manager (CDM), CDM confirmed Resident 12 was given a whole slice of turkey. CDM confirmed Resident 12's tray ticket indicated "preferences ... ground meats" and the plate was not correct.

A review of the facility's policy and procedure titled, "Resident Food Preferences" (Revised July 2017), indicated, "... individual preferences will be assessed upon admission ...The dietitian and nursing staff, assisted by the Physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident 's food preferences ..."

2. A review of Resident 8's "Admission Record" indicated she was admitted in Summer 2023 with multiple diagnoses which included type 2 diabetes mellitus (a condition when the body cannot control blood sugar levels).

A concurrent observation of lunch tray line on 8/22/23 at 11:55 a.m., Resident 8 received fresh fruit for dessert, not the glazed apple square on the menu.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 56 A review of Resident 8's meal ticket for lunch services on 8/22/23, indicated, "preferences regular desserts". An interview on 8/23/23 at 12:35 p.m., with Registered Dietician (RD 2), stated that residents' preferences should be acknowledged and followed. RD 2 stated it is the right of residents to have their preferences followed by the facility. A review of the facility's policy and procedure titled, "Resident Food Preferences" (Revised July 2017), indicated, "... individual preferences will be assessed upon admission ... The resident has the right not to comply with therapeutic diets."	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, when: 1) One dietary aide did not use appropriate handwashing during food handling; 2) The ice machine was not cleaned and sanitized correctly; 3) Two kitchen staff did not wear hair restraints in the food prep area; 4) Nineteen various size metal pans were found wet or dirty, stacked in the ready to use shelves; 5) Nine dry goods were not sealed or dated in the dry storage area; 6) Eleven cartons of supplement shakes (drinks that provide additional nutrients) were not dated with the correct use by date; and 7) The microwave in the resident's nutrition room was dirty. These failures had the potential to lead to food-borne illnesses. Findings: 1) During the initial kitchen tour on 8/21/23 at 8:52 a.m. Dietary Aide (DA 1) was observed not washing hands in between tasks multiple times when she touched dirty dishes with bare hands, then touched clean dishes, and placed clean gloves on when: a. At 8:52 a.m., DA 1 touched dirty dishes with her bare hands, then touched the clean	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 58 dishes when doing the dishwashing task; b. At 8:58 a.m., DA 1 used same unwashed bared hands to touch the clean dishes at the clean side of the dishwashing machine after she touched the drawers; c. At 9:03 a.m., DA 1 placed clean gloves without washing hands and touched the cleaned dishes at the clean side of dishwasher machine after she touched the dirty dishes at the dirty side; and, d. At 9:09 a.m., DA 1 with her unwashed bared hands touched the clean dishes at the clean side after she touched the refrigerator door and the juice dispenser. A follow up observation and interview on 8/22/23 at 12:19 p.m., in the kitchen, DA 1 was observed during lunch tray line. DA 1 was observed pushing the food delivery cart from the kitchen into the dining room. DA 1 returned to the kitchen, touched her eyeglasses and placed them on her face. DA 1 grabbed a clean plate and prepare lunch plates, with out hand hygiene and changing gloves. An interview with the certified dietary manager (CDM), CDM stated the expectation for all staff was to wash hands and change gloves between tasks. During an interview with Registered Dietician (RD 1) on 8/23/23 at 2:54 p.m., the RD stated the expectation was for kitchen staff to wash hands at the beginning of their shift, touching their face, touching non-clean items, and in between dirty and clean tasks. RD stated hand washing prevents residents from catching food borne illnesses. A review of a facility policy and procedure (P&P)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 59 titled "Hand Washing Procedure" (undated), indicated "when hands need to be washed ... after touching your hair or face". 2) During a concurrent observation and interview on 8/21/23 at 9:25 a.m. with the Director of Plant Operations (DPO), the ice machine was inspected. An orange slimy substance was observed on the top of the ice evaporator panel (where ice is made) and was easily wiped off with a paper towel. A blackish substance was observed in the bottle of the ice unit and the ice trough (a piece that is located in the evaporator unit and holds the water before it is frozen during the ice-making process). DPO confirmed the orange and blackish substances were found. DPO stated the deep clean (the process of cleaning and sanitizing in ice maker and the ice storage bin interior and exterior of the ice machine) of the ice machine was performed quarterly by an outside vendor. DPO further stated he would have the outside vendor come clean the ice machine. During a concurrent observation and interview on 8/21/23 at 2:05 p.m., the ice machine was observed with Vendor Technician (VT). The VT confirmed the ice machine was not clean when he inspected. The VT stated his process to clean the ice machine was to mix a couple cups of cleaner solution, and ran the sanitizing cyle. The VT stated once the ice machine cycle is complete, he sprayed the ice storage bin with sanitizer, rinsed with the hottest water and wiped it down with a clean rag. During a concurrent interview and record review on 8/21/23 at 2:15 p.m. with the Administrator	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 60	F 812		

(ADM), the ADM stated, he heard the VT say sprayed sanitizer in the ice machine, rinsed it with the hottest water and wiped it with a clean rag. A manufacture policy titled, "Maintenance" (undated), "use 1/2 (one half) of the sanitizer/water solution to sanitize ... surfaces of the ice machine ... do not rinse the sanitized areas ... wait 30 minutes ..." The ADM confirmed the process by the VT was not correct.

A review of the ice machine manufacture policy titled, "Maintenance," (undated), it indicated the cleaning procedure with cleaning solution, and the sanitizing procedure with sanitizing solution separately by running cleaning and sanitizing cycles, but not mix the cleaning and sanitizing together to run the cycle.

3) A concurrent observation and interview on 8/21/23 at 9:31 a.m. in the food prep area of the kitchen, the cook (CK) was observed cutting hamburger patties. CK was observed picking up hamburger patties with gloved hands and no beard guard on. CDM confirmed the CK did not have a beard cover on. CDM further stated the expectation was always for beards to be covered. CDM further stated if a beard is not covered, hair can drop in food "and can be hazardous" to residents.

During an observation on 8/22/23 at 9:47 a.m. in the kitchen, the RD 1 was observed in the kitchen without a hair covering on and her hair loose and unsecured. In a concurrent interview with RD 1, she confirmed she did not have the hair covering on.

During an interview on 8/23/23 at 12:35 p.m. with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 61	F 812		

the RD 2, RD 2 stated the expectation for everyone entering the kitchen was to fully cover hair with a net. RD 2 further stated, if men have a beard longer than one-fourth inch they have to use a beard cover. RD 2 further stated beard and hair net covering prevent hair from falling in the resident's food.

A review of a facility P&P titled "Dress Code" (undated), indicated, "PROPER DRESS ... appropriate dress in the Food & Nutrition Services Department ... is very important in maintaining a high standard of food service. ...hair net for hair, if hair is long ... beards and mustaches (any facial hair) must wear a beard restraint [covering]."

4) During the initial kitchen tour on 8/22/23 at 9:58 a.m., 17 various sized steel pans were observed to be stacked wet (wet nesting) and stored on the clean shelves in the food prep area, which indicated they were ready to use.

During an interview on 8/22/2023, at 9:58 a.m., with the CDM, the CDM confirmed there the pans were wet. CDM stated pans are supposed to be "air dried and put away when no water is seen."

During an interview on 8/23/23 at 12:35 p.m. with the RD 2, RD 2 stated steel pans should be fully dried by air prior to being stacked and stored. RD 2 stated steel pans stored wet, it can lead to bacteria growth.

A review of the Food and Drug Administration (FDA) Food Code 2022, the food code indicated, "Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 62	F 812		

items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. (FDA Food Code Annex 4-901.11)."

During the initial kitchen tour on 8/21/23 at 10:06 a.m., two metal pans were found with dried white substance on their sides. A subsequent interview with the CDM, the CDM concurred there was "dried food particles on the side" of the pans. CMD stated metal pans are supposed to be cleaned and inspected prior to storing away.

During a review of the US FDA 2022 Food Code, section 4-601.11, titled, "Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils," 1/18/23 version, the food code indicated, "...(C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris."

5) During a concurrent observation and interview with the CDM on 8/21/23 at 10:15 a.m., in the dry storage area several dry goods were observed unsealed and undated; three boxes of grains, two dry cereals and one gravy mix were opened and not sealed, and one box of grains was undated and not sealed. The CDM confirmed the packages were not stored and dated correctly. CDM further stated all opened dry goods should be dated when opened, resealed, and tightly covered.

During an interview on 8/23/23 at 12:35 p.m. with the RD 2, RD 2 stated dry goods should be sealed tightly with no exposure from the outside. RD 2 further stated if food packages are not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 63	F 812		

sealed tightly pests can get inside and contaminate the food. RD 2 further stated the food should be thrown away if not sealed tightly.

A review of a facility document titled "Dry Goods Storage guidelines," (undated), indicated "keep them [dry goods] dry & [and] tightly covered."

A review of a facility's P&P titled "Storage of Food and Supplies" (undated), the P&P indicated, "dry foods ... dry beans ... should be stored in seamless metal or plastic container with tight covers ... which are easily sanitized. If using plastic bags ... food grade bags must be used ... All food will be dated - month, day, year."

6) During a concurrent observation and interview on 8/21/23 at 10:47 a.m., the walk-in refrigerator was inspected with the CDM, two clear plastic bins with cartons of supplement shakes on the top shelf. Observed on the outside of the clear bins were labels with prep date of 8/12/23 and a use by date of 8/29/23. The dates indicated the nutrition shakes had to be used in 17 days. The CDM indicated she was not sure how the date was calculated after the shakes were pulled out of the freezer. The CDM further indicated there was no dating system on the "refrigerated storage guide." CDM confirmed the instructions on the carton indicated, 14 days after thawing, and the date written on the clear bin was not correct. CDM stated the staff "should have read off the carton, if the carton says 14 days you have to go with the carton."

During an interview on 8/23, at 12:35 p.m., RD 2 stated nutritional shakes should be used within 14 days after being pulled from the freezer and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 64 staff should follow the manufacture guidelines. A review of instructions located on the carton of the supplement shake showed the supplement shakes had to be stored frozen and, once thawed in the refrigerator, used within 14 days. A review of a facility document titled, "Refrigerated Storage Guide," (undated) indicated, "Supplemental shakes taken from the frozen state and thawed in the refrigerator will be dated as soon as they are placed in the refrigerator. Follow the manufacture's recommendations ... for shelf life." 7) During a concurrent observation and interview on 8/22/23 at 3:28 p.m. with the DOP, the microwave in the resident's nourishment room was observed. The interior of the microwave was observed with food debris and dry sauce splashed on the top, right and left side. DOP stated he was responsible for the maintenance of the microwave. DOP further stated the microwave should be clean and sanitized weekly. During an interview on 8/23/23 at 12:30 p.m. with RD 2, RD 2 stated, she was not aware of the microwave in the resident's nourishment room. RD 2 stated microwaves for resident's use must be clean. A review of a facility policy titled "Sanitation," dated 2023, indicated "equipment shall be kept clean."	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 65 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

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F 842	Continued From page 66 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to document and communicate the necessary information for a hospital transfer for one resident (Resident 29) of 19 sampled residents, when Resident 29's Interact SBAR [Situation-Background-Assessment-Recommendation] Communication Form was not completed. This failure decreased the facility's potential to prevent delayed care for transferred residents.	F 842		

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	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 842	Continued From page 67	F 842		

Findings:

A review of an admission record indicated Resident 29 was initially admitted to the facility on 5/26/23, transferred to the hospital on 7/6/23, and was readmitted to the facility on 7/12/23 with diagnoses including sepsis (blood infection; a life-threatening medical emergency), hypotension (low blood pressure), pneumonitis (lung inflammation) due to inhalation of food and vomit, acute kidney failure, and urinary tract infection (UTI).

A review of Resident 29's Minimum Data Set (MDS; an assessment tool), dated 7/18/23, indicated the Brief Interview of Mental Status (BIMS) score was 10 with some memory problems.

A review of Resident 29's "Nursing Daily Skilled Charting," dated 7/4/23, indicated a severe increase in Resident 29's impaired cognition, lack of safety awareness, and attempt to ambulate without assistance.

During an interview on 8/21/23 at 11:52 a.m. with Resident 29, Resident 29 stated weeks ago she was transferred to the hospital for low blood pressure and she figured out from her daughter that she was admitted for UTI and lung infection.

During an interview on 8/24/23 at 11:18 a.m. with the infection preventionist (IP), IP stated, on 7/6/23 a certified nursing assistant notified her that Resident 29 had a low blood pressure (BP). IP asked Resident 29 to drink a salted soup to raise her BP. Resident 29 choked and gurgled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 842	Continued From page 68	F 842		

Resident 29 was able to cough and vomited some fluids. IP verbally notified the physician, charge nurse, supervisor, and director of nursing (DON), and transferred Resident 29 to the hospital. IP further stated, she did not document what happened with Resident 29 and the charge nurse was supposed to complete the change in condition SBAR form.

A review of Resident 29's progress notes, dated 7/6/23, indicated Resident 29 was sent to the emergency room (ER) for change in respiratory status.

A review of a document titled, "History and Physical," dated 7/6/23, indicated Resident 29 was admitted to the ER for aspirated food versus vomitus while eating at the facility associated with low blood pressure. Resident 29 was admitted to the hospital with UTI, pneumonitis, choking episode, hypotension, and acute kidney injury.

A review of Resident 29's "Weights and Vitals Summary," dated 8/24/23, indicated no vitals were documented when Resident 29 was transferred to the hospital on 7/6/23.

During an interview on 8/24/23 at 10:07 a.m. with Licensed Nurse 3 (LN 3), LN 3 stated, when a resident's condition have changed such as hypotension or confusion (inability to think clearly), then the charge nurse should have notified the doctor and the resident's responsible party (RP), made a progress note, and completed the SBAR form. LN 3 further stated she was not trained on how to complete the SBAR form and she could not find it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 842	Continued From page 69 During an interview on 8/24/23 at 10:18 a.m. with LN 4, LN 4 stated when a resident's condition changed such as hypotension or increased confusion, then the charge nurse would notify the physician and the resident's emergency contact, make a progress note, and complete the SBAR form. During an interview on 8/24/23 at 10:25 a.m. with DON, DON stated, Resident 29's progress note, dated 7/6/23, was "vague and incomplete," and there was no documentation for vital signs, nursing assessment, and Interact (SBAR) form when she was transferred to the hospital, and that was "unacceptable." DON further stated, the charge nurses should have followed and completed the Interact (SBAR) form when there was a change in Resident 29's condition on 7/6/23, otherwise; it could have delayed the provision of care, assessment, and proper communication with the provider. A review of the facility's policy titled, "Change in a Resident's Condition or Status," dated 02/21, indicated, " ...the nurse will make detailed observations and gather relevant and pertinent information for the provider, including ...information prompted by the Interact SBAR Communication Form ...The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status."	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 880	Continued From page 70 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 880	Continued From page 71 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to establish and maintain infection control practices designed to provide a safe and sanitary environment and help prevent the transmission of diseases and infections for a census of 52 when: 1. Hand hygiene (HH) was not practiced when assisting with meal; 2. HH was not practiced between residents' care, and before and after gloves usage; 3. A blood pressure cuff was not sanitized	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 880	Continued From page 72	F 880		

between use on residents; and,
4. HH was not practiced during medication administration.

These failures had the potential to result in transmission of infection in the facility and cause illness.

Findings:

1. During an observation on 8/21/23 at 12:38 p.m., the Certified Nursing Assistant 4 (CNA 4) was assisting a resident to eat in the dining hall. He washed his hands, then he touched his long beard and his nose before assisting the resident with meal. He was holding the straw and spoon and placed in the resident's mouth. There was no HH observed after touching his beard and nose.

During an interview on 8/21/23 at 12:55 p.m., CNA 4 confirmed touching the body is breaking hand hygiene and needed to use hand hygiene again.

During an interview on 8/23/23 at 1:16 p.m., the Infection Preventionist (IP) confirmed whenever staff touched their face or hair, then he/she needed to use hand sanitizer.

2. During an observation on 8/22/23 at 8:25 a.m., the CNA 2 exited a resident room (the first room) after assisting the resident with toileting. There was no hand hygiene observed after exiting the room.

During an observation on 8/22/23 at 8:27 a.m., CNA 2 went into the second resident room without using hand hygiene. Next CNA 2 left that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 73	F 880		

room and went to the kitchen without hand hygiene observed. CNA 2 came back to the second room with cereal and a spoon. Her hand was directly on the spoon. Then, CNA 2 left the second room without using hand hygiene. Afterward, CNA 2 went to a third room to assist the resident in the bathroom. She grabbed the gloves and walked into the room. There was no hand hygiene observed before donning gloves.

During a concurrent observation and interview on 8/22/23 at 8:35 a.m., CNA 2 was carrying the food tray from a resident room using gloved hands and put the food tray inside the food cart. She removed the gloves and placed inside her hand. There was no hand hygiene observed after removing gloves. CNA 2 confirmed hand hygiene practice should be done before entering a resident room, after exiting the room, in between resident care, and before putting on and after removing gloves.

During an observation on 8/23/23 at 10:16 a.m., the Director of Rehab (DOR) was assisting the resident to the bathroom in an enhanced standard precaution room (required to use gown and gloves) using only gloves. There was no gown usage as directed on signage at the door.

During an interview on 8/23/23 at 10:22 a.m., the DOR confirmed she did not put on gown before assisting the resident.

During an interview on 8/23/23 at 1:17 p.m., the IP confirmed she expected staff to use hand hygiene before and after resident care and before putting on and removing gloves. The IP expected staff to follow the enhanced standard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 74	F 880		

precaution signage in front of the door.

Review of a facility's undated policy titled, "Enhanced Standard Precautions," indicated anyone participating in any of these six moments including toileting and changing incontinence briefs must also: don gown and gloves.

Review of the facility's policy titled, "Handwashing/Hand Hygiene," revised 8/2019, indicated, "Use an alcohol-based hand rub ... soap .... and water for the following situations: before and after coming on duty; before and after direct contact with residents ... After removing gloves ... Before and after eating or handling food ... Before and after assisting a resident with meals; and after ... personal hygiene."

3. During an observation on 8/21/23 at 8:33 a.m. with Licensed Nurse 2 (LN 2), LN 2 used a blood pressure cuff to measure Resident 47's blood pressure. After the resident's blood pressure was taken, LN 2 removed the cuff and placed it on the top of the medication cart without sanitizing and disinfecting it. LN 2 was observed taking the blood pressure of Resident 3 and Resident 13 without sanitizing or disinfecting in-between uses.

4. During a medication pass observation on 8/21/23 at 9 a.m. with LN 2, LN 2 was observed administering medications to Resident 13. LN 2 placed Resident 13's medication cup on her bedside table then touched her own hair and glasses. LN 2 left the room to prepare applesauce for Resident 13 and returned to the resident without performing hand hygiene.

During an interview on 8/21/23 at 12:09 p.m. with LN 2, LN 2 confirmed she did not sanitize and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 75 disinfect the blood pressure cuff that was used earlier on multiple residents. When asked if she performed hand hygiene after touching her hair or glasses in the middle of performing direct resident care she stated, "No I would not wash my hands, that's just something [touching hair and glasses] we don't think about. We just do it." During an interview on 8/22/23 at 10:18 a.m. with Director of Nursing (DON), DON stated nursing staff were expected to perform hand hygiene before and after medication administration, and if any part of the face or hair was touched during the process. She confirmed nursing staff should sanitize and disinfect blood pressure cuffs between each use. During a review of the facility's policy and procedure (P&P) titled, "Handwashing/Hand Hygiene," dated August 2019, the P&P indicated, "7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: a. Before and after coming on duty; b. Before and after direct contact with residents; c. Before preparing or handling medications... q. After... conducting your personal hygiene."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 76 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555180	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

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F 883	Continued From page 77	F 883		

was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a pneumococcal vaccine (a vaccine to prevent infection of one or both lungs) for one of 19 sampled residents (Resident 32) when Resident 32 did not receive a pneumococcal vaccine when it was due.

This failure had the potential to increase the chance of Resident 32 getting a lung infection.

Findings:

Review of the Admission Record, Resident 32 was over 65 years old and admitted to facility on 2/13/23, with diagnoses including pneumonia (infection of the lung) and respiratory failure.

During a concurrent interview and record review on 8/23/23 at 1:42 p.m., the Infection Preventionist (IP) confirmed Resident 32 gotten a previous pneumococcal in 2020 and stated the next dose is due. The IP further stated the family member verbally consented for the vaccination and confirmed there was no documentation requesting an order from the physician.

Review of the facility's document titled, "Pneumococcal and Annual Vaccine Information and Request," dated 2/14/23, indicated Resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLD COUNTRY HEALTH CENTER	4301 GOLDEN CENTER DRIVE PLACERVILLE, CA 95667

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 78 32 received a pneumococcal vaccination in 2020. Review of the facility's document titled, "Pneumococcal Vaccine," dated 10/2019, indicated, "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections."	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff	F 887		

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F 887	Continued From page 79 member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide education regarding risks and benefits associated with COVID-19 (Coronavirus Disease, an infection affecting the lungs) vaccination for one of 19 sampled residents (Resident 35) when Resident 35 did not receive the risks and benefits education upon refusal of a COVID-19 vaccination. This failure had the potential to decrease the	F 887		

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F 887	Continued From page 80 chance of Resident 35 getting a COVID-19 vaccination. Findings: On review of the Admission Record, Resident 35 was admitted to facility on 3/28/23, with diagnoses including COVID-19. During a concurrent interview and record review on 8/23/23 at 1:59 p.m., the Infection Preventionist (IP) confirmed there was no documentation of education on the risks and benefits of COVID-19 when Resident 35 refused the vaccination. There was no documentation of COVID-19 consent upon request from the IP. Review of the facility's policy titled, "Coronavirus Disease (COVID-19) - Vaccination of Residents," dated 11/2021, indicated, "...The resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine ... The resident's medical record includes documentation that indicates ... the benefit and potential risks associated with COVID-19 vaccine ..."	F 887		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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555183 CA030000229	A. BUILDING _____ B. WING _____	08/25/2023

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F 558	Reasonable Accommodations Needs/Preferences CFR(s): 483.10 (e)(3)	F558	"Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth on this Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Health and Safety Code Section 1280 and 42 CFR 483 Et seq." 1. During the survey it was identified that resident #31 and resident #22 call lights had fallen on the floor. Immediate correction was made for these 2 residents ie: call lights were put within reach, preferences/requests were reviewed with residents. 2. An all facility round was completed, no other residents were identified. All call lights are verified within reach and preferences/request given. 3. Staff have been inserviced at a minimum on 8/30/23 and 9/07/23 and #### for call light accessibility. 4. Department managers will round on call-light preferences, Monday through Friday to ensure compliance with call lights and any changes will be reported to the QA&A for review.	09/22/2023

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Doug Hawkins	Administrator	09/21/2023

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F 578	Request/Refuse/Discontinue Treatment/Advanced Directive CFR(s): 483.10 (c)(6)(8)(g)(12)(i)-(v)	F578	1. During the survey it was identified that resident #29's POLST for DNR did not match the current physician orders for full code. This was clarified during the survey to match the priginal POLST order for DNR. The medical record was updated to reflect the original POLST. 2. An all facility review of medical records indicated that ALL patients POLST did match their physician orders, no other reisdents were indentiifed. 3. Licensed nurse staff have been inserviced on 08/30/2023, 09/07/23 and 09/21/2023. The training completed was on the POLST and the MD orders matching. a. A daily IDT review on new admissions to include verification of the POLST order matching the MD order. b. Medical records prior to scanning POLST into the electronic medical records will also ensure the POLST matches the MD order. c. During care conferences the SSD will review the POLST with the patient and responsible party to verify the current POLST matches the MD order. 4. Track and trending reults will be reported to the QA&A for review.	09/22/2023

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F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F640	1. During the survey it was indentified that one resident discharge MDS had been completed but NOT transmitted to CMS. This was transmitted during the survey. 2. An all facility audit for discharge MDS was completed during the survey and all patients are in compliance. 3. The licensed nurse staff have been inserviced on 08/30/23, 09/07/23, 09/21/2023 including the MDS licensed nurses on proper transmission of discharged patients to MDS to CMS. a. A quarterly audit will be conducted to include discharge tracking and CMS submission compliance. 4. Track and trending results and any changes will be reported to the QA&A for review.	09/21/2023

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F 656 SS=E	Develop/Implement Comprehensive Care Plans CFR(s): 483.21(b)(1)(3)	F656	1. During the survey it was identified that resident #19 did not have a comprehensive care plan written to match the manifested behavior componenet on the medical health record. This was completed during the time of survey. 2. An all facility review of others with the potential to be affected has been completed and all updates have been made to their comprehensive care plans. 3. Licensed nurse staff and IDT have been inserviced on 08/30/23, 09/07/23 and 09/21/23. a. A comprehensive care plan will be developed upon admission and compleed and verified by the assistant direcotr of nursing daily. b. An "Admission checklist and Audit" tool will be used to review new admissions within 3 days. c. The MDS department during their completion of the admission comprehensive assessment will validate and update the comprehensive careplan. d. A monthly comprehensive audit will be completed and submitted to the director of nursing or designee for review. 4. Track and trending results will be reported to the QA&A for review.	09/22/2023

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F657	1. During the survey it was identified that resident #31 did NOT have an upated "date" associate with an accurate careplan. This was resolved prior to her discharge. 2. An all facility review of careplans was completed and ALL careplans have been reviewed with a current date of review posted in the medical health record. 3. Licensed nurse staff and IDT have been inserviced on 8/30/23, 09/07/23 and 09/21/23 on ensuring careplans are reviewed quarterly and revised and dated appropriately. a. MDS will review careplans during the quarterly MDS assessment. b. Medical records will audit the patient careplanning when the quarterly MDS has been completed to ensure that the careplan has been reviewed. 4. Results of the routnie audits will be reported to the QA&A for review.	09/22/2023

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F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F676	1. During the survey it was identified that resident #16 and #13 did NOT have proper documentation for their shower. This was corrected during the survey and the documentation matched the shower care. 2. An all facility round on showers was completed and inconsistencies with shower type documentation was completed. 3. All licensed nurses and CNA have been inserviced at a minimum on 8/30/23, 9/07/23 and 09/21/2023 on shower documentation. a. The Director of Staff Development will monitor the shower documentation weekly to ensure that documentation is improving. 4. Fldnigs will be reported to the QA&A for review.	09/21/2023

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F686	1. During the survey it was identified that resident #31 a. Had a missing updated "date" for careplan re-evaluation. b. Documentation failed to match the shower care provided. c. Missing direct weekly observation documentation d. Turning and repositioning documentation not matching visual. 2. An all facility audit on potentilly affected patients were conducted to include: a. All careplans reviewed and updated as needed. All are current. b. All shower sheets have been reviewed and audited. c. Audits of the weekly summary schedule. d. Audits and visualization of the turning/repositioning schedule. 3. Licensed nurse and CNA staff have been inserviced on 8/30/23, 09/07/23, 09/21/23. a. Shower schedules with policy of checking of skin. b. Licensed nurse to check and document a weekly full body assessment. c. DSD to audit the weekly the CNA shower protocols for documentation and follow-thru. d. DSD will spot check weekly the turning and repositioning and ensure documentation matches. e. IDT will verify during review meetings the at risk for skin breakdown careplans are accurate and current. 4. Audits will be submitted and reported to the QA&A for review.	09/22/2023

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F 755 SS=E	Pharmacy Services/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F755	1. During the survey it was identified that: a. Resident #21 eMAR and Narc count sheet not matching. b. Medication storage revealed 2 E-kits without unsealing/opening proper documentation. c. A discontinued medication not stored away properly. d. 1 medication administration left unattended by the LN. 2. All resdients have the potential to be affected. 3. Staff have been inserviced at a minimum on 8/30/23, 09/07/23 and 09/21/23. Listed below a facility review that was conducted: a. Further review and audits of eMAR and narc count sheets weekly by the diirector of nurses or designee to verify accuracy. b. Ongoing weekly inspections to include inspection of the E-kits are sealed and documented appropriately. c. Night nurse daily will verify E-kit's usage and order replacement PRN. d. Rountine rounds by nursing to verify no medications left unattended. 4. All reviews and changes will be reported to the QA&A for review.	09/22/2023

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F 758 SS=E	Free from Unnessary Pyschotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F758	1. During the survey it was identified that resident #202 and resident #19 were identified with psychotropic medication usage prescribed by their physician lacking the proper documentation for manifested behavior montoring, consent documentation and side effects. All this was corrected during the survey. 2. An enitre facility audit for all patients with the potential to be affected was completed, no other residents were identified. All pyschotropic orders in place with proper documentation of, behavior monitoring, consent documentation and side effects. 3. Licensed nurses and IDT staff have been inserviced 8/30/23, 09/07/23 and 09/21/2023 on proper documentation to include; manifested behavior monitoring, consent documentation and side effects. a. All new pyschotropic orders to be audited to ensure consents, side effects, behavior monitoring and PRN stop dates. 4. Medical records to report compliance and any changes to the QA&A for review.	09/22/2023

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F 759 SS=E	Free of Medication Errors CFR(s): 483.45(f)(1)	F759	1. During the survey it was identified that resident #3, #13 and #47 received medication administration not following the manufacturers recommendations for dispensing of medication. LN2 was immediately counceled and reeducated on medication pass and the 6 rights. 2. All residents have the potential to be affected. AN immediae inservice was given to licensed nurse to ensure proper dispaensing of medications. No other residents identified as being affected. 3. Licensed nurse staff have been inserviced on 8/30/23, 09/07/23 and 09/21/2023. a. All licensed nurse training on the 6 rights of medication pass. b. Medication skill check with licensed nurses with 100% pass rate. c. Director of nursing or designee will spot check medication pass and make recommendations as needed. d. Pharmacist or designee to rountinely spot check medication pass and report on the quartely QA&A. 4. Tracks and trendind will be reported to the QA&A for review.	09/22/2023

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555183 CA030000229	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760 SS=G	Free of Significant Medication Errors CFR(s): 483.45(f)(2)	F760	1. During the survey it was identified that resident #13 was medicated outside the parameters prescribed by the physiciain. LN2 was counseled and educated immediately on the medication 6 rights for med pass. 2. An all facility round was completed immediately, no other residents were identified. All nurses on duty were immedaitely counseled. 3. Licensed nurse staff have been inserviced on 8/30/23, 09/07/2023, 09/21/2023. a. All licensed nurse training on the 6 rights of medication pass. b. Licensed nurse inserviced on protocols on ordering of medicaitons/narcotics and on availability with E-kit usage. MD to be notified immediately of medication unavailibilites and of E-kit alternative pain medication choices. c. Director of nursing or designee will spot check weekly on medication pass observation and make recommendations as needed. d. Pharmacist or designee to rountinely spot check medication pass and report on the quartely QA&A. 4. Tracks and trendind will be reported to the QA&A for review.	09/22/2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F 761 SS=E	Label/Storage Drugs and Biologicals CFR(s): 483.45(f)(2)	F761	1. During the survey it was identified that medication cart storage was improper. LN2 was counseled immediately and inserviced on proper medication cart storage while on the floor. 2. An all facility round during survey was completed, no other residents were identified. Licensed nurses were immediately inserviced on medication cart storage. The medciation room was immediately corrected with removal of expired medcialtons and all labeling brought current. 3. Licensed nurse staff have been inserviced on 8/30/23, 09/07/2023. a. Proper monitoring and storage of medication carts. b. Proper Labeling of medication upon opening. c. Expired medication storage and distruction. Director of nursing or designee to round weekly: a. Ensure medication carts are secure, b. Proper labeling of medications and distruction of expired medications. 4. Department managers will round on call-light preferences, Monday through Friday to ensure compliance with call lights and any changes will be reported to the QA&A for review.	09/22/2023

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F 803 SS=E	Menus Meet Resident Needs/Prep in Adv/followed CFR(s): 483.60(c)(1)-(7)	F803	1. During the survey it was identified that resident #9, 18, 20,23, 31, 43, 203. 205 and resident #22 received meal substitution of dessert not following the spread sheet production menu . 2. An all facility round was completed, no other residents were identified. The reistered dietician and dietary service manager validated all prescribed diets match production menus are in accordance to the recommendations. 3. Dietary staff have been inserviced at a minimum on 08/26/23 and 8/30/23. a. Usage of the production menu. b. Any variant to be reviewed and approved by the registered dietician, 4. Trending and any changes will be reported to the QA&A for review.	09/22/2023

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F 806 SS=D	Resident Allergies, Preferences, Substitues CFR(s): 483.60(c)(1)-(7)	F806	1. During the survey it was identified that resident #8 and 12 lunch meal did not honor food preferences. This was immediately corrected and resolved on the residents indivual menu plan. 2. An immediate all facility round was completed by the registered dietician and dietary service manager and no other residents were identified. All resident food choices and preferences/request given. 3. Dietary staff have been inserviced on 8/30/23 and #### on following food choice menu plan preferences. 4. Trending reports will be reported to the QA&A for review.	09/22/2023

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F 812 SS=F	Food Procurement, Store, Prepare/Serve - Santitary CFR(s): 483.60(i)(1)(2)	F812	1. During the survey it was identified: a. Improper hand-washing b. Ice machine with scaly build-up internal freezer. c. Improper hairnet usage. d. Metal pans stores improperly. e. Food items not dated correctly. f. Nutrition room microwave not cleaned properly. 2. An all facility round/correction was completed and issues resolved, no other residents were identified. 3. Staff have been inserviced at a minimum on 8/30/23 and #### on a. Hand-washing and hairnet usage , ice machine and microwave cleaning schedule, metal pan storage, dating of food items. b. Spot rounds by the dietary service manager to ensure proper hand-washing and hairnet usage, metal pan storage, ice machine and microwave cleaning scheules 4. Results and tred=ndings will be reported to the QA&A for review.	09/22/2023

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5, 483.70 (i)(1)-(5)	F842	1. During the survey it was identified that resident #29 was missing some documentation in the medical health record. 2. An all facility round was completed and updates and clarification have been made to other residents identified. 3. Licensed nurses and IDT staff have been inserviced on 8/30/23 and ####. a. SBAR completion with change of condition. Medical records to audit transfers to ensure the SBAR completion weekly and reported to the director of nursing or designee. 4. FIndings and trendings will be reported to the QA&A for review.	09/22/2023

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80 (a)(1)(2)(4)(e)(f)	F880	1. During the survey it was identified hygeine practices were not followed properly as well as disinfecting of medical equipment 2. An all facility round was completed with emphasis on spot observation and inservcing on hand hygeine and disinfecting practices of medical equipmet. No other residents potentially affected. 3. Staff have been inserviced at a minimum on 8/30/23 and #### on hand hygeine and disinfecting of medical equipment. a. Director of nursing or designee will observe hand hygeine practices along with sanitation of medical records weekly. 4. track and trending will be reported to the QA&A for review.	09/22/2023

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F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80 (d)(1)(2)	F883	1. During the survey it was identified that resident #32 lacked the documentation for the consent of the pneumoncoccal vacciantion. This vacciantion has been given. 2. An all facility round was completed, other residents who have the potential to be indentified plans of care have been updated. 3. Licensed nurse staff have been inserviced 8/30/23, 09/18/23 and 09/21/23. a. IP will follow-up within 5 days of admission and provide education, consent if requested for pneumococcal vaccination. b. Medical records will audit the pneumonia censent/declinations weekly after admission and provide this information to the director of nursing or designee. 4. any changes will be reported to the QA&A for review.	09/22/2023

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F 887 SS=D	COVID-19 Immunization CFR(s): 483.80 (d)(3)(i)-(vii)	F887	1. During the survey it was identified that resident #35 lacked the documentation for the consent of the covid-19 vacciantion. This vacciantion has been given. 2. An all facility round was completed, other residents who have the potential to be indentified plans of care have been updated. 3. Licensed nurse staff have been inserviced 8/30/23, 09/18/2023 a. IP will follow-up within 5 days of admission and provide education, consent if requested and vaccination for covid-19. b. Medical records will audit the pneumonia censent/declinations weekly after admission and provide this information to the director of nursing or designee. 4. any changes will be reported to the QA&A for review.	09/22/2023

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