STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055191	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Madera Care Center	1700 Howard Road Madera, CA 93637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137 Based on interview and record review, the facility failed to ensure one of three residents (Resident 1) received supplemental oxygen (from a portable tank which delivers oxygen through a tube inserted into the nostrils), as ordered by her physician, when she left the facility to go to a medical appointment. This failure resulted in Resident 1 going approximately 7 hours without her physician-ordered supplemental oxygen, which has the potential to cause respiratory distress such as shortness of breath, elevated heart rate, anxiety, and confusion. Findings: During a review of Resident 1's Admission Record (AR) dated 7/3/24, the AR indicated Resident 1 was a [AGE] year-old female admitted to the facility with diagnoses that included Acute and Chronic Respiratory Failure with Hypercapnia (a condition where there is too much carbon dioxide, a waste product, in the body), and Dependence on Supplemental Oxygen. During a review of Resident 1's Order Summary Report (OSR), dated 7/3/24, the OSR indicated Resident 1 had a physician's order for Oxygen administered continuous [at all times] at 2 Liters, every shift for oxygen, dated as beginning on 4/17/24. During a review of Resident 1's Care Plan (CP), dated 4/18/24, the CP indicated Resident 1 has oxygen therapy. Resident is on oxygen. During a review of Resident 1's Progress Notes (PN), dated 5/28/24, at 3:44 PM, the PN indicated that earlier that day, at 1:45 PM, Resident 1 had returned from a medical appointment outside the facility. A PN dated 5/28/24, at 3:50 PM, indicated Resident 1 was at the appointment for most of AM shift. Both Progress Notes were written by Licensed Vocational Nurse (LVN) 1. During an interview with the Administrator, on 7/3/24, at 10:50 AM, the Administrator stated Resident 1 had gone to this appointment without her ordered supplemental oxygen. The Administrator stated this incident was investigated by the facility, found it to be substantiated , and LVN 1 had been assigned to Resident 1's care when she left for her appointmen.t (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24, at 11:45 AM, with LVN 1, LVN 1 stated he recalled Resident 1 going to a medical appointment outside the facility that day. LVN 1 stated he was assigned to Resident 1's care and transportation had arrived early that morning at about 6:30 AM to take her to the appointment. LVN 1 stated he assigned Certified Nursing Assistants to get her up out of bed and ready for her appointment, and he did not notice she was to have oxygen, and subsequently Resident 1 left the facility with no supplemental oxygen. LVN 1 stated Resident 1 returned to the facility later that day about 1 or 1:30 PM in no respiratory distress but was notified by her accompanying family she was to be on supplemental oxygen. During a review of the facility document titled Verification of Investigation Report (VOIR), dated 6/20/24, the VOIR indicated .facility identified that the nurse was [LVN 1] and he admitted to forgetting to send [Resident 1] out with [oxygen] tank. Employee was in-serviced by the Director of Nursing and Director of Staff Development. During a review of the facility document titled Employee Correction Notice (ECR), dated 6/20/24, the ECR indicated that on 5/28/24, LVN 1 Failed to follow MD [Medical Doctor] order for Resident 1 on that date, and failed to ensure [Resident 1] was wearing and receiving oxygen via nasal cannula [flexible tubing that is inserted into the nostrils] prior to leaving for a doctor appointment as per MD order. The ECR was signed by LVN 1. During a review of the facility Policy and Procedure (P&P) titled, Oxygen Administration, dated 10/10, the P&P indicated, in part, Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed.