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	04/04/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat one of three residents (Resident 1) with dignity and respect when Resident 1 requested assistance from the Certified Nursing Assistant (CNA) to locate the footrest (a stationary hanger and footplate for the user's feet to rest on the wheelchair) to her wheelchair and the CNA told Resident 1 to shut up on 3/31/25. This failure resulted in Resident 1 to experience mental and emotional distress (anger and frustration) on 3/31/25. Findings: During a concurrent observation and interview on 4/3/25 at 9:47 a.m. with Resident 1 in Resident 1's room, Resident 1 was sitting in her wheelchair and Spanish speaking only. The Unit Manager (UM) interpreted. Resident 1 was alert and oriented to person, place, and time. Resident 1 stated on 3/31/25 at 3:30 a.m., the CNA came to assist her to get ready for dialysis (a medical treatment that removes waste products and excess fluid from the blood when the kidneys have failed). Resident 1 stated she requested the CNA to assist her with her shoes and the CNA said no. Resident 1 stated she asked the CNA to hurry because the dialysis transportation was waiting outside. Resident 1 stated the CNA replied by saying I don't know. Shut up. Resident 1 stated the CNA was on her phone. Resident 1 stated the CNA should not have treated her that way. Resident 1 stated staff were paid employees and were expected to treat residents with respect. During a review of Resident 1's admission Record (AR), dated 4/3/25, the AR indicated Resident 1 was admitted on [DATE] with a history of right femur fracture (broken upper leg bone) and End Stage Renal Disease (a medical condition where the kidneys have permanently lost the ability to function adequately, requiring dialysis or a kidney transplant to survive) During a review of Resident 1's Minimum Data Set (MDS- a federally mandated process for clinical assessment of all residents of long term care nursing facilities) , dated 3/3/25, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 12 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 required moderate assistance (Helper does less than half the effort) with transfer (unable to move without help from another person or persons) from bed to chair and required moderate assistance with dressing and personal hygiene (habits to maintain cleanliness). (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Interdisciplinary Team(a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) Post Incident Meeting (IDT) , dated 3/31/25, the IDT indicated, . Unit Manager informed [Administrator]/[Director of Nursing] today at [3:00 p.m.] that Resident 1 reported to her that she feels like going home and does not like it here . Resident 1 informed the UM that the [night] shift Registry (an individual licensed or certified by a regulatory agency who receives compensation from a third party to work at a nursing care facility) [name of CNA] was using her phone and told her to shut up when asked to be changed . DON interviewed Registry CNA [name of CNA] via phone who denied the allegation . For safety reasons, this facility has blocked this CNA to defer from situations like this . IDT RECOMMENDATIONS: DON blocked CNA from picking up more shifts on [name of Registry's website] . During an interview on 4/3/25 at 10:10 a.m. with Resident 2, Resident 2 stated on 3/31/25 the CNA came into the room to assist Resident 1 go to dialysis, but their roommate, Resident 3 was soaked and wet with urine. Resident 2 stated the CNA instructed Resident 3 to take her clothes and sheets off. Resident 2 stated Resident 3 was unable to do that, and Resident 2 informed the CNA Resident 3 required assistance. Resident 2 stated Resident 1 asked the CNA for the footrest to her wheelchair and the CNA told Resident 1 to wait and shut up. Resident 2 stated Resident 1 was Spanish speaking only and Resident 2 told the CNA not to talk to Resident 1 like that. Resident 2 stated the CNA no longer provided care at the facility. During an interview on 4/3/25 at 12:35 p.m. with the CNA, the CNA stated on 3/31/25 at 3:30 a.m. she went to Resident 1's room to assist her to go to dialysis. The CNA stated she assisted Resident 1 to the bathroom and Resident 3 complained of being cold. The CNA went to check Resident 3 and Resident 3 was wet with urine, and Resident 3 had soiled her clothes and linen. The CNA stated she changed Resident 3 while Resident 1 was in the bathroom brushing her teeth and hair. The CNA stated Resident 1 requested the footrest for her wheelchair and the CNA was unable to find the footrest. The CNA stated Resident 2 stated the blue footrest was hers, and Resident 1 started saying callate callate callate over and over again (meaning shut up in Spanish). The CNA stated she asked Resident 1 who she was saying callate to and Resident 2 stated Resident 1 wanted to go to the front for dialysis. The CNA denied telling Resident 1 to shut up. The CNA stated it was not acceptable to tell any residents to shut up for any reason. The CNA stated staff were required to treat residents with respect and dignity. During an interview on 4/3/25 at 10:31 a.m. with the Director of Staff Development (DSD), the DSD stated the CNA assisted Resident 1 on 3/31/25 and was not kind to Resident 1. The DSD stated staff and Registry staff were required to treat residents with dignity and respect. The DSD stated staff and Registry staff were required to abide by the residents privacy and residents rights policy and procedure. The DSD stated the CNA's behavior on 3/31/25 was unacceptable and the CNA was no longer allowed to work at the facility. During an interview on 4/3/25 at 10:33 a.m. with the DON, the DON stated Resident 1 alleged that the CNA told her to shut up on 3/31/25. The DON stated the allegation was investigated and was substantiated (confirmed) with Resident 2 as a witness. The DON stated the CNA was no longer allowed to work at the facility and would be reported to the Board (the agency that provides oversight for Certified Nursing Assistants). The DON stated staff and Registry staff were required to treat residents with kindness and respect. The DON stated the facility was the resident's home and should be treated with dignity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/25 at 11:35 a.m. with the Administrator (ADM), the ADM stated Resident 1 asked for assistance on 3/31/25 and was told to shut up. The ADM stated an investigation was conducted and the CNA's behavior was unacceptable. The ADM stated the CNA no longer provided care at the facility and would be reported to the Board. The ADM stated residents should be treated with dignity and respect by all staff. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 12/2021, the P&P indicated, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; .