

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055191	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2026
NAME OF PROVIDER OR SUPPLIER  Golden Madera Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide adequate supervision and failed to report an elopement (resident leaving a healthcare facility, hospital, or care setting without authorization, without being discharged, or without notifying staff.) to the State Survey Agency within the required timeframe for one of three residents (Resident 1), when Resident 1 was not reassessed for risk of elopement after repeatedly expressing the desire to leave the facility and return to the river. On 2/8/26, Resident 1 left the facility without staff knowledge or supervision. The State Agency was unaware of the elopement until it was reported by the Ombudsman (a neutral, independent advocate who investigates, and resolves issues between patients/residents and healthcare providers, insurers, and long term care facilities) on 2/26/26. This failure placed Resident 1 at risk for harm including injury from traffic, lack of access to food or medications, and exposure to the environmental elements, as temperatures on 2/8/26 were reported to be as low as 39 degrees. During a review of Resident 1's admission Record (AR- a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/27/26, the AR indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis of Wedge compression fracture of the second lumbar vertebra (the front part of that specific lower-back bone collapses due to pressure, taking on a wedge shape while the back part remains intact), Obstructive and reflux uropathy (blockage at any point in the urinary tract [kidneys, ureters, bladder, or urethra] that prevents urine from flowing out of the body), heart disease (condition that damages the heart or blood vessels), Acute kidney failure (the sudden, temporary loss of kidney function), urine retention (the inability to fully empty your bladder, resulting in urine building up and causing discomfort or pain), urinary tract infection (a common infection caused by bacteria entering and multiplying within the urinary system), and homelessness (the state of lacking a fixed, regular, and adequate nighttime residence. This includes living in places not meant for human habitation [cars, parks, streets], emergency shelters, or transitional housing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/17/26, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive [involving the process of thinking, learning and understanding] understanding on a scale of 1-15 ) score of 8 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 1 had moderate cognitive impairment. During a review of Resident 1's Nurses Progress Notes, dated 2/8/26, the nurses progress notes indicated, at approximately 3:15 p.m. today Certified Nursing Assistant (CNA) asked if I had seen resident. informed CNA last seen resident at 2:15 p.m. while doing initial rounds. CNA stated that she can't find resident. 3:30 p.m., entire building and perimeter</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  055191	Facility ID:  055191  If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>checked.patient was not located. Search was extended to the outside and surrounding buildings.again not located.notified Director of Nursing (DON) and Administrator at 3:40 p.m. via phone.contact PD (Police Department) at 3:48 p.m. gave all necessary information.has expressed the desire to go home in the past couple of days.PD arrived at 7:17 p.m. to do report with writer.reported at facility regarding patient elopement.During review of Resident 1's Summary of Care Provided Hospital course -Discharge Summary (DS), dated 1/12/26, the DS indicated, Resident 1 was admitted to the hospital on [DATE] and discharged from the hospital on 1/12/26.reason for hospital stay urinary retention.significant hospital diagnoses urinary retention, hypertension, substance use disorder risk (amphetamine positive), homelessness.During an interview on 2/27/26 at 9:55 a.m. with the Administrator, the Administrator stated after Resident 1 left the facility, staff reviewed his medical record and conducted interviews with staff. It was only following this review-after the resident's departure, the facility determined Resident 1 was alert and oriented times three (A&amp;Ox3 - a medical assessment indicating a patient is awake, responsive, and aware of three key spheres: person [their name], place [where they are], and time [date/day/year]. It signifies normal cognitive function and consciousness), and capable of making his own decisions. The Administrator stated as a result, the incident was processed as an Against Medical Advice (AMA) discharge rather than an elopement.During an interview on 2/27/26 at 10:05 a.m., the Social Services Director (SSD) reported on 2/8/26, nursing staff informed her Resident 1 had left the facility and could not be located. The SSD subsequently contacted Adult Protective Services (APS) and completed the necessary paperwork regarding Resident 1's departure on 2/9/26. When asked if staff saw Resident 1 leave, the SSD stated no one witnessed his departure.During a concurrent interview and record review on 2/27/26 at 10:33 a.m., with the Director of Staff Development (DSD), Resident 1's Electronic Medical Record (EMR), was reviewed. The EMR indicated Resident 1 was admitted on [DATE] with diagnoses including wedge compression fracture of the spine and urinary obstruction. The DSD confirmed a record review indicated Resident 1 had a BIMS score of 8. The DSD confirmed during record review Resident 1 had a history of homelessness. The DSD stated documentation indicated that a Certified Nursing Assistant (CNA) reported Resident 1 was missing and staff conducted a search of the facility and surrounding areas. The DSD stated documentation indicated Resident 1 had last been seen on 2/8/26 at 2:15 p.m. and reported missing at approximately 3:15 p.m. The DSD stated documentation initially identified the event as an elopement however after the elopement, documentation dated 2/9/26 from the Interdisciplinary Team (IDT) indicating Resident 1 had the mental capacity to choose to leave the facility AMA. The DSD stated the IDT came to this conclusion based on the post elopement staff interview and physician's H&amp;P documentation indicating resident 1 was A&amp;Ox3.The DSD stated there was no documentation of intervention or safety precautions for Resident 1 after verbal expression of desire to leave. The DSD stated Resident 1 had made no prior attempts to leave the facility, he would only say he wanted to leave. The DSD stated a care plan and safety plan with interventions such as frequents checks on Resident 1 should have been created for Resident 1.During an interview on 2/27/26 at 11:01 a.m., in the DSD office with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated she did recall reporting Resident 1 missing. LVN 1 stated she observed the resident earlier during medication pass. The LVN stated a Certified Nursing Assistant (CNA) later reported the resident could not be located, and staff conducted a search of the facility and surrounding area but were unable to locate him. The LVN stated the resident had previously expressed a desire to leave the facility but did not inform staff he was leaving at that time. LVN 1 stated she was not instructed to report the incident to the State Survey Agency at that time.During a concurrent interview and record review on 2/27/26, at 1:30 p.m., with the Administrator, the facility's policy and</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>procedure (P&amp;P) titled, Elopements and Wandering Residents, dated 12/19/22 was reviewed. The P&amp;P indicated .Definition:. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.DON or designee shall notify the physician.Appropriate reporting requirements to the State Survey agency shall be conducted. The Administrator confirmed the facility did not report the incident to the State Survey Agency. The Administrator stated after interviewing staff and reviewing the physicians H&amp;P, the incident was determined AMA and was not an elopement. The Administrator acknowledged that the facility did not report the incident to the State Survey Agency. She explained that, after reviewing staff interviews and the physician's H&amp;P, the facility concluded the event was an AMA discharge rather than an elopement. However, the Administrator recognized that Resident 1 left without staff awareness or supervision and had expressed a clear desire to leave. The Administrator stated for resident's safety, the incident should have been reported and confirmed that Resident 1 had still not been located at the time of the interview.During a phone interview on 3/5/26 at 3:00 p.m. with the Director of Nursing (DON), the DON confirmed Resident 1's assessment dated [DATE] documented a BIMS score of 8. The DON confirmed an elopement risk assessment completed on 1/12/26 indicated Resident 1 was not considered an elopement for risk. When asked about Resident 1's BIMS score of eight the DON stated Resident 1 appeared alert and oriented during interactions and a reassessment should have been initiated if there was a change in condition. The DON stated the physician's documentation indicated Resident 1 was alert and oriented however, confirmed no reassessment of BIMS had been completed. The DON confirmed Resident 1 went missing on 2/8/26 and nursing staff documentation initially indicated the incident was an elopement. The DON stated the facility did not report this incident to the State Survey Agency while the facility was conducting its investigation and stated she did not have a reason why the incident was not reported if it had been classified as an elopement.During a review of the facility's P&amp;P titled Elopement and Wandering Residents, dated 12/19/22, the P&amp;P indicated .The facility shall establish and utilize a systematic approach to monitoring residents at risk for elopement.Residents will be assessed for risk of elopement and unsafe wandering, when clinically appropriate.evaluate the unique factors contributing to risk.develop a person-centered care plan.Definition:. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.DON or designee shall notify the physician.Appropriate reporting requirements to the State Survey agency shall be conducted. increase staff awareness of resident's risk.,adequate supervision will be provided to help prevent accidents or elopements. During a review of the facility's P&amp;P titled Resident Assessment-RAI, dated 12/19/22, the P&amp;P indicated, . this facility makes a comprehensive assessment of each resident's needs, strengths, goals, life history and preferences.the facility will use the results of the assessment to develop, review and revise the resident's comprehensive care plan.During a review of the facility's P&amp;P titled Accidents and Supervision, dated 12/19/22, the P&amp;P indicated, .each resident will receive adequate supervision and assistive devices to prevent accidents.monitoring for effectiveness and modifying interventions when necessary.During a review of the facility's P&amp;P titled Transfer and Discharge (including AMA), dated 12/19/22, the P&amp;P indicated . transfer and discharge includes movement of a resident to a bed outside of the certified facility whether the bed is in the same physical place or not. Resident -initiated transfer or discharge means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment) .Discharge Against Medical Advice</p> <p>(continued on next page)</p>		

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