

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  03/19/2026
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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to report to the state agency two episodes of alleged or suspected abuse violations when; 1. An unknown intruder entered the facility without staff knowledge and interacted with Resident 1, Resident 2, Resident 3, and Resident 4. 2. One resident (Resident 6) struck another resident (Resident 5) across the face with a walker, causing a laceration (cut in the skin) on his left eyebrow. These failures resulted in delayed investigations, potential for delayed protection and continued harm for the five sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, and Resident 5). During a review of the document titled On-Line Health Facility Complaint (OLHFC), dated 3/12/26, at 10:38 a.m., from the [NAME] County Department of Social Services, the OLHFC indicated, On March 12, 2026, the [[NAME] County Department of Social Services] received a written report of suspected elder abuse from [NAME] Police Department (case # 26M-00810). It was reported that the officer was dispatched to the [facility] on 02/06/26 to a report of an unidentified male, [NAME] Doe, bothering elderly females. The following was reported in summary: The original reporting party (ORP), [Administrator], who is an employee of the [facility] was contacted. ORP said on 2/3/26, at approximately [7:30 p.m.], an unknown male entered the facility and was acting strangely with the tenants. During a review of the document titled On-Line Health Facility Complaint (OLHFC), dated 3/13/26, at 11:03 a.m., from the [NAME] County Department of Social Services, the OLHFC indicated, On March 12, 2026, the [[NAME] County Department of Social Services] received a written report (Case #26M-01530) of suspected elder abuse from [NAME] Police Department for an incident on 3/9/26 [that occurred at the facility]. It was reported while the nurse was helping [Resident 6] out of his bed for a therapy walk, [Resident 6] grabbed his walker and struck Resident 5] on the left side of his head causing approximately a one-inch laceration on the left side of [Resident 5's] head, above his left eyebrow. During an interview on 3/18/26, at 10:25 a.m., with the Director of Staff Development (DSD), the DSD stated she was the primary facility educator regarding abuse and abuse prevention policy and procedures. The DSD stated, I cover this information for new hires, about mandated reporting, annual competencies. If abuse occurs, we report the appropriate agencies, which [include the Department]. The incident between Resident 5 and Resident 6 on 3/9/26 was resident-to-resident abuse, with injury, and that should have been reported to the Department. I educate everyone to this. When asked if the incident with the intruder on 2/3/26 should also have been reported to the Department, the DSD stated, I feel nauseous. I need some fresh air. During an interview on 3/18/26, at 11:17 a.m., with Resident 1, Resident 1 stated she recalled the evening of 2/3/26, when an unwanted and unknown visitor entered her room before 8 p.m., while she was in her bed. Resident 1 stated the unknown and unwanted visitor was wearing a sweatshirt hoodie and spoke to her roommate, Resident 2, first, then turned his attention to her and stated if she wanted to 'follow the word of God' and if she wanted to 'follow him'. Resident 1 stated, I told him he'd better get out of here. We called the nurse [Licensed Vocational Nurse, or LVN, 1] but she didn't come right away. We were both scared, we both have had sleepless nights [since then]. Every time I hear the exit doors at the end of the hallway open, I think (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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>it could be him again or another intruder. I don't feel safe here. It could happen again. During a review of Resident 1's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool), dated 1/22/26, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact (having sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the resident's environment). During an interview on 3/18/26, at 11:30 a.m., with Resident 2, Resident 2 stated she recalled the evening of 2/3/26, when an unwanted and unknown visitor entered her room before 8 p.m., while she was in her bed. Resident 2 stated, I was sleeping and I awoke to see this man inches from my face, he was leaning forward as if he was going to kiss me. I put my hands up to stop him, he put his hands up, and our hands met. I said to him: Listen - what is your name? He answered: A good citizen. I said to him: You need to get out of here. He finally left the room. Looking back on it, I should have stabbed him with my scissors. I was scared, I felt the need to protect myself from him. During a review of Resident 2's MDS, dated 2/23/26, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 2 was cognitively intact. During an interview on 3/18/26, at 11:10 a.m., with Resident 3, Resident 3 stated she recalled the evening of 2/3/26, when an unwanted and unknown visitor entered her room before 8 p.m. Resident 3 stated she was sitting in her bedside chair when the unwanted visitor walked in and went to her roommate's (Resident 4) bed and attempted to lift her roommate out of her bed. Resident 3 stated, He tried to pick her up out of her bed. Like he was on dope or something. I was scared, I didn't know if he had a gun or what. He tried to take [Resident 4] out of this building, that's what it looked like to me he was trying to do. I raised my voice to him, and in that commotion, that's when a nurse came into the room and got him to leave. The nurse was [LVN 1]. During a review of Resident 3's MDS, dated 2/16/26, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 3 was cognitively intact. During an interview on 3/18/26, at 11:15 a.m., with Resident 4, Resident 4 recalled an event where an unwanted and unknown visitor entered her room and tried to lift her up. Resident 4 stated, I was scared. He was so rough with me. He made me mad. During a review of Resident 4's MDS, dated 2/2/26, the MDS indicated at Question C0500 a score of 9 out of a possible 15, which indicated Resident 4's cognition was moderately impaired. During an observation on 3/18/26, at 11:45 a.m., Resident 5 was noted seated in wheelchair in the dining room. Over Resident 5's left eyebrow, a small bandage was noted. During a review of Resident 5's clinical record, the document titled Order Summary Report (OSR), dated 3/9/26, the OSR indicated he had a physician's order for Monitor steri-strips [small adhesive bandages] on skin tear to left eyebrow. During a review of Resident 5's clinical record, the document titled Progress Notes (PN), dated 3/10/26, at 11:19 a.m., the PN indicated, This resident was involved in a resident to resident altercation. This resident was the receiver. [Resident 6] threw his walker at [Resident 5] and made contact with his left eyebrow. Appropriate entities notified of event by sending SOC 341 [Report of Suspected Dependent Adult/Elder Abuse, an official document used by mandated reporters] faxed out to Ombudsman [a trained advocate who investigates complaints, protects rights, and improves the quality of life for residents in nursing homes, assisted living, and similar adult care facilities] . and [NAME] [Police Department]. The Department was not included in the PN as an entity notified. During an interview on 3/18/26, at 3:05 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she recalled the evening of 2/3/26. LVN 1 stated she had just returned from her evening meal break about 7 p.m. LVN 1 stated I noticed a gentleman at the nurses' station. Visiting Hours are from 8 a.m. to 8 p.m., and I lock the front doors at 8 p.m. He was already in the building when I returned from break, I did not see him walk through the front door. At about 7:15 p.m., I began passing my medications. I was at room [ROOM NUMBER], I saw him go into room [ROOM NUMBER]. I did not think anything about it at the time, I thought he was a visitor. Then, later, I heard [Resident 3, who resides in room [ROOM NUMBER]] saying 'I don't know you, get out of my room' or words to that effect. That got my attention. I went to the doorway of room [ROOM NUMBER] and confronted him. He was standing in front of [Resident (continued on next page)</p>		

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