

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 04/03/2025
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45645</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) for 1 (Resident #7) of 1 sampled resident reviewed for dialysis.</p> <p>Findings included:</p> <p>A facility policy titled, Enhanced Barrier Precautions, revised 08/2024, indicated, Enhanced barrier precautions (EBP's) are utilized to reduce the transmission of multi-drug-resistant organisms (MDROs) to residents. The policy revealed the section titled Policy Interpretation and Implementation, included, 5. EBPs are indicated (when contact precautions do not otherwise apply) for resident with wounds and/or indwelling medical device regardless of MDRO colonization. Further review revealed, b. Indwelling medical devices include central lines, urinary catheters, feeding tubes and tracheostomies. The policy revealed, 6. EBP's remain in place for the duration of the resident's stay or until the resolution of the wound or discontinuation of the indwelling medical device that places them at risk. Per the policy, 11. Signs are posted in [sic] the door or wall outside the resident room indicating the type of precautions and PPE required.</p> <p>An Admission Record revealed the facility admitted Resident #7 on 09/13/2024. According to the Admission Record, the resident had a medical history that included diagnoses of dependence on renal dialysis and acquired arteriovenous fistula.</p> <p>A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated Resident #7 received hemodialysis.</p> <p>Resident #7's Care Plan Report included a focus area, revised 03/27/2025, that indicated the resident had an arteriovenous fistula to the left arm. Interventions directed staff to monitor for thrill and bruit every shift and notify the medical doctor of any complications.</p> <p>Resident #7's Order Summary Report, with active orders as of 04/01/2025, contained an order dated 11/08/2024, that instructed staff to monitor dialysis fistula every shift for potential complications and signs and symptoms of infection. The Order Summary Report contained an order dated 11/08/2024, that instructed staff to monitor dialysis fistula every shift for thrill and bruit. Further review of the resident's Order Summary Report did not reveal an order for EBP.</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:	Facility ID: 055191
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/31/2025 at 10:07 AM, Resident #7 stated that upon returning to dialysis, the nurse checked their dialysis access site, removed the dressing, and took vital signs. Resident #7 stated that the nurses did not wear gowns when checking the resident's arteriovenous fistula site. During a concurrent observation there were no EBP postings for Resident #7. Resident #7 stated that they did not think they were on precautions.</p> <p>A document titled Enhanced Barrier Precautions provided by the facility and dated 04/01/2025 revealed a list of residents at the facility on EBP. Further review revealed Resident #7 was not listed as being on EBP.</p> <p>On 04/01/2025 at 1:03 PM, Licensed Vocational Nurse (LVN) #1 stated that Resident #7 received dialysis but was not on EBP. LVN #1 said that nurses performed a post-assessment after dialysis, including checking vital signs, the dialysis access site for bruit and thrill, and disposing of the dialysis access site dressing. LVN #1 could not explain why the resident was not on EBP and recommended asking the Infection Preventionist (IP). LVN #7 stated that residents on dialysis had EBP signs posted on their door, but Resident #7 did not.</p> <p>On 04/01/2025 at 1:56 PM, the Unit Manager (UM) stated the facility posted EBP signage to alert staff when extra precautions were needed for residents with indwelling devices, like a fistula. She said Resident #7 had a fistula that required EBP. The UM stated the IP reviewed orders and the resident's condition to decide if EBP was needed. The UM stated the IP would tell the nurse to get an order from the medical doctor for EBP and that it was missed for Resident #7.</p> <p>On 04/02/2025 at 7:50 AM, the IP stated that the goal of EBP was to prevent the spread of MDROs between residents, especially those with indwelling devices or wounds. The IP said Resident #7 met the EBP requirements, but the precaution was not implemented, and the resident did not have an order for EBP.</p> <p>On 04/02/2025 at 1:14 PM, the Director of Nursing (DON) stated that the facility's expectation was for the IP to recognize when a resident required EBP and implement it immediately. According to the DON, EBP was intended for residents with a point of entry, with the goal of protecting them from infection. The DON stated Resident #7's condition met the criteria for EBP, but it was not implemented.</p> <p>On 04/03/2025 at 7:45 AM, the Executive Director stated residents needing EBP should be placed on the program to ensure safety protocols are followed. The Executive Director stated Resident #7, who was on dialysis, should have been on EBP but was not. The Executive Director stated he expected staff to follow the facility's EBP policy for residents' safety.</p>		