STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055271	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan (a personalized, written document that outlines a resident's health needs, goals, and the specific actions and services to be provided) for one of three sampled residents (Resident 1) when Resident 1 was a known elopement (a resident who leaves a nursing facility without authorization or staff knowledge) risk and did not have a care plan in place for elopement.This failure resulted in Resident 1 not having a care plan with interventions in place to prevent elopement and led to Resident 1 eloping from the facility on the evening of 11/16/25.During a review of Resident 1's admission Record (AR - a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included dementia (a decline in mental abilities that makes daily life difficult, affecting memory, thinking, and behavior) and severe intellectual disabilities (a person that has a serious difficulty with learning, communication, and daily living skills that requires ongoing, hands-on support from caregivers).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 9 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating moderate cognitive impairment.During a review of Resident 1's Admission/ readmission Data Tool, dated 10/21/25, the Admission/ readmission Data Tool indicated, XV. Elopement Risk Assessment . T. Evaluation of Resident Elopement Risk . 1. Is resident independently mobile? . b. Yes . If the ?yes' option is selected for one or more of the questions above, a resident may be considered as ?AT RISK' for elopement . 5. Based on the above criteria, is the resident at risk for elopement? . b. Yes . 5a. Has a care plan been initiated for elopement risk? . 1. Yes . Signed by [Licensed Vocational Nurse 2] . Signed Date 10/21/25.During an interview on 11/19/25 at 12:03 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had dementia and episodes of sundowning (a state of increased confusion, anxiety, agitation, and mood changes that occurs in the late afternoon and evening in people with cognitive impairment) and tended to wander around the facility, especially in the evenings. During an interview on 11/19/25 at 12:26 p.m. with Resident 1, Resident 1 stated nursing staff would get busy and would not always have time to take her outside. Resident 1 stated staff did not notice her when she eloped from the facility on 11/16/25.During an interview on 11/19/25 at 1:01 p.m. Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had a habit of wandering the facility since she was admitted on [DATE]. LVN 1 stated it was known to nursing staff that Resident 1 tended to wander the facility, especially in the evenings. LVN 1 stated Resident 1 frequently needed to be kept near the nurse's station (a central workspace in a healthcare facility where nurses and other staff coordinate patient care activities) for monitoring. LVN 1 stated that nursing staff were not following a care plan for Resident 1 for elopement. LVN 1 stated she did not think Resident 1 had a (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan for elopement in place prior to her elopement on 11/16/25. LVN 1 stated it was important for Resident 1 to have a care plan for elopement in place since she was known to wander the facility. LVN 1 stated a care plan for elopement for Resident 1 was important because it would guide her care and would provide nursing staff with interventions to prevent elopement from happening. During an interview on 11/19/25 at 1:10 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 had a habit of wandering the facility since she was admitted on [DATE]. RN 1 stated Resident 1's wandering behavior was worse in the evenings. RN 1 stated that prior to Resident 1 eloping, staff were just keeping an eye on her and redirecting her. RN 1 stated that nursing staff were not following a care plan for Resident 1 for elopement. RN 1 stated that care plans were important to ensure residents were getting individualized care. RN 1 stated that if Resident 1 did not have a care plan for elopement in place, nursing staff would not know which interventions to implement to prevent elopement. RN 1 stated Resident 1's elopement could have been prevented if there had been a care plan in place for elopement. During a concurrent interview and record review on 11/19/25 at 2:03 p.m. with the MDS/Licensed Vocational Nurse (MDS) nurse, Resident 1's Admission/ readmission Data Tool, dated 10/21/25, was reviewed. The Admission/ readmission Data Tool indicated Resident 1 was identified as an elopement risk and that a care plan for elopement had been initiated by LVN 2. The MDS nurse stated the Admission/ readmission Data Tool indicated Resident 1 was an elopement risk and a care plan for elopement had been initiated by LVN 2 on 10/21/25. During a concurrent interview and record review on 11/19/25 at 2:08 p.m. with the MDS nurse, Resident 1's Care Plan Report dated 10/21/25, was reviewed. The Care Plan Report indicated Resident 1's care plan for elopement was initiated on 11/16/25, after her elopement had occurred. The MDS nurse stated Resident 1's care plan for elopement was not initiated by LVN 2 on 10/21/25 when Resident 1 was admitted and identified as an elopement risk. The MDS nurse stated that LVN 2 should have initiated a care plan for elopement for Resident 1 once she identified that she was an elopement risk. The MDS nurse stated that it was important for Resident 1 to have a care plan in place for elopement so nursing staff could identify issues that might trigger the resident to elope. The MDS nurse stated that if a care plan for elopement had been initiated on admission for Resident 1, her elopement could have been prevented. During an interview on 11/19/25 at 2:51 p.m. with the DON, the DON stated LVN 2 should have initiated a care plan for elopement for Resident 1 on 10/21/25 when she was admitted and identified as an elopement risk. The DON stated it was important for Resident 1 to have a care plan for elopement in place to provide nursing staff with specific interventions . to help prevent the resident from eloping. The DON stated she expected nursing staff to implement care plans for elopement when they identify a resident as an elopement risk. The DON stated having a care plan for elopement in place for Resident 1 on admission could have potentially prevented her elopement. During an interview on 11/19/25 at 2:51 p.m. with the Administrator (ADM), the ADM stated that if Resident 1 was identified as an elopement risk on admission, a care plan for elopement should have been initiated. The ADM stated he expected nursing staff to follow facility policies and procedures in creating care plans and implementing interventions to prevent elopement. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopements, dated 2001, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 2001, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 9. Care plan interventions are chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes .