

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055988	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Golden Merced Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3170 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137</p> <p>Based on observation, interview, and record review, the facility failed to implement physical interventions to reduce hazards and risks identified in their fall prevention program for 2 of 3 sampled residents (Resident 1 and Resident 2), and failed to ensure three of three sampled staff could not describe other key interventions of the fall prevention program when:</p> <ol style="list-style-type: none"> 1. Resident 1 did not have non-skid socks (socks that have grips to prevent slipping when standing and walking) that were ordered by her physician as a fall prevention intervention. 2. Resident 2 had one transfer bar (bed rails attached to bed to aid resident when getting in and out of bed) attached to her bed when two transfer bars were ordered by her physician as a fall prevention intervention. 3. Three of three staff could not define what the 4 P's (1. Pain [address pain management] 2. Personal belongings [assure personal belongings are kept close to resident] 3. Personal care [assure residents ADL care is addressed] 4. Positioning [assure residents is positioned safe and comfortable]. were, indicated as interventions in the facility's fall prevention program.) <p>These failures had the potential to result in falls for Resident 1 and Resident 2 when interventions of the facility's fall prevention program were not implemented, which increased their risk for serious injury, including bone fracture, pain, and reduced mobility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 1's Admission Record (AR) , dated 11/8/24, the AR indicated diagnoses of dorsalgia (pain in the back that can affect the muscles, ligaments, bones, joints, and nerves of the spine), unspecified dementia (a general term for dementia, a decline in mental function that causes interference with daily life, mood disturbance (mental health condition that primarily affects emotional state) and anxiety (feeling of fear, dread, and uneasiness), muscle weakness, postural kyphosis (rounding or hunching of the back), and age-related osteoporosis (condition when bones become less dense and more likely to break). The AR indicated Resident 1 was admitted to the facility on [DATE]. <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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility document titled, Monthly Fall Report - October (MFR) , dated 10/24, the MFR indicated Resident 1 had fallen in the facility nine times since she was admitted (on 4/25/24).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a comprehensive, standardized assessment tool) , dated 9/16/24, the MDS indicated Resident 1 was assessed at Question C0500 a score of 3 on a scale of 1 to 15 , which indicated Resident 1 was severely cognitively impaired (difficulty with thinking, learning, remembering, and making decisions).</p> <p>During a review of Resident 1's Care Plan (CP) (undated), the CP indicated Resident 1 was on the facility's Fall Program, due to being high fall risk and fall with major injury. Date Initiated 8/1/24. Interventions, Fall Program .Non-skid socks if indicated, Blue information sheet above the bed.</p> <p>During a review of Resident 1's Order Summary Report (OSR, a recap of Physician Orders) , dated 11/8/24, the OSR indicated a Physician's Order for Fall Interventions in place: .non skid socks, blue information sheet above bed. The Physician's Order was written on 8/6/24.</p> <p>During a review of EVG- IDT Post Fall Meeting, dated 10/21/2024, the EVG- IDT Post Fall Meeting indicated, .IDT [Interdisciplinary Team, comprised of health care professionals from different disciplines such as Nursing, Activities, Dietary and Social Services] Recommendations 2. IDT identified the root cause of the fall [Resident 1 had fallen on 10/19/24] as residents' cognitive impairment, poor safety awareness. Previous IDT recommendation for falls included: . - resident to be placed on the Fall Program . - 4P's monitoring .</p> <p>During an observation on 11/7/24 at 10:40 a.m., in Resident 1's room, Resident 1 was observed to be lying in bed, with eyes closed and no non-skid socks on her bare feet. A blue sheet of paper was attached to the wall behind resident's bed that indicated, Resident 1] - Fall Program Interventions: Non-skid socks.4 P's.</p> <p>During a concurrent observation and interview on 11/7/24 at 12:09 p.m., in Resident 1's room, Resident 1 was awake and alone, sitting on the edge of the bed with her bare feet resting on the fall mat. Certified Nursing Assistant (CNA) 1 walked into the resident's room and stated Resident 1 should always have non-skid socks on. CNA 1 looked throughout Resident 1's room and stated she was unable to locate any non-skid socks for the resident.</p> <p>During an observation on 11/7/24 at 1:20 p.m., Resident 1 was in the dining room. Resident 1 showed confusion when her son approached for a visit and the resident did not recognize who he was. Resident 1 then grabbed her son's walking stick and would not let go after provided direction several times by staff to remove her hand from the walking stick.</p> <p>During interview on 11/7/24 at 2:09 p.m., with the Director of Nursing (DON), the DON stated Resident 1 does not require one to one staff monitoring (when one designated staff person monitors one resident closely, at all times, in an effort to prevent certain behaviors such as those likely to result in injury to self or others) because she is not always anxious and there are times she is resting and does not require close monitoring. The DON stated Resident 1 should have been wearing non-skid socks.</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 - Some</p>	<p>2. During a review of Resident 2's AR , dated 11/8/24, the AR indicated diagnoses of epilepsy (chronic brain disorder that causes seizures, which are episodes of abnormal electrical activity in the brain), muscle weakness, other abnormalities of gait and mobility, other specified disorders of bone density and structure, unspecified convulsions (when body's muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking), anxiety, and age related osteoporosis.</p> <p>During a review of Resident 2's Progress Notes (PN) dated 10/17/24, at 1:27 p.m., the PN indicated, . resident was calling for help CN [Certified Nurse] went to room. Found resident hanging off the bed c/o [complaining of] dizziness. Resident was placed back in the bed .</p> <p>During a review of Resident 2's PN dated 10/17/24, at 9:17 p.m., the PN indicated, .Resident worried about her bed's side rails. CNA notified writer resident stated I need bed's side rails. I might go to fall again .</p> <p>During review of Resident 2's Order Summary Report (OSR) dated 11/8/24, the OSR indicated a Physician's Order for Transfer bars x 2 for assistance with bed mobility and transfer. The Physican's Order were written on 10/18/24.</p> <p>During review of Resident 2's CP (undated) , the CP indicated, Focus, [Resident 2] is at risk for falls [related to] impaired safety awareness. Date initiated 01/29/2024 . Interventions . Transfer rails x2 for assistance with bed mobility and transfers. Date initiated: 10/18/2024.</p> <p>During an observation on 11/7/24 at 1:32 p.m., in Resident 2's room, her bed was observed to have one transfer bar in place on the right side of the bed. There was no transfer bar on left side of the bed.</p> <p>During a concurrent interview, observation, and record review on 11/7/24 at 1:34 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 2's physician orders were reviewed. LVN 1 stated Resident 2's physician's orders indicated Resident 2 was ordered to have two transfers bars on her bed. Upon entering Resident 2's room, LVN 1 stated there was only one transfer bar on Resident 2's bed but there should be two.</p> <p>During an interview on 11/7/24, at 2:09 p.m., with the DON, the DON was informed Resident 2 did not have two transfer bars on her bed that were ordered by her physician, and this was confirmed with LVN 1. The DON stated Resident 2 was moved to a different bed overnight and both transfers bars were not taken and placed on the Resident 2's new bed, and this will be corrected.</p> <p>3. During an interview on 11/7/24, at 1:25 p.m., with CNA 3, CNA 3 stated she was unsure what the 4 P's , as indicated in the fall prevention program, stood for. CNA 3 stated she would have to ask a colleague to find out what that stood for.</p> <p>During an interview on 11/7/24 at 1:34 p.m., with LVN 1, LVN 1 stated the 4 P's stood for positioning and proximity but did not know what the additional 2 P's stood for.</p> <p>During an interview on 11/7/24 at 1:50 p.m., with LVN 2, LVN 2 did not know what the 4 P's stood for. LVN 2 stated that each resident's fall interventions are individualized but she did not know what the 4 P's within the fall prevention program meant.</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 - Some</p>	<p>During an interview on 11/7/24 at 2:09 p.m., with the DON, the DON stated it was her expectation that staff were aware of what the 4 P's were.</p> <p>During a review of the facility document titled 4 P's, (undated), the 4 P's indicated, 1. Pain (address pain management) 2. Personal belongings (assure personal belongings are kept close to resident) 3. Personal care (assure residents ADL care is addressed) 4. Positioning (assure residents is positioned safe and comfortable).</p> <p>During a review of the facility's Policy & Procedure (P&P), titled Falls and Fall Risk, Managing, dated 9/23, the P&P indicated . 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .8. The Fall Program identifies high fall risk residents by Blue arm bands, non-skid socks, Blue door tag, Blue information sheet . 11. The facility can use the following interventions but not limited to these interventions for the resident. Falling Star, 1:1 . Monitoring Subsequent Falls and Fall Risk . 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions .</p>		