STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055988	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Merced Care Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27137 Based on observation, interview, and record review, the facility failed to ensure the safety and security of the residents when 15 of 15 sliding glass doors (located in resident rooms that exited to the exterior of the building) were noted to be unsecured, with no system to alert staff if a person entered or exited the facility via these 15 doors. This failure resulted in one resident (Resident 1) eloping (the act of leaving facility premises, or enters an unsafe area, without facility knowledge and/or supervision) via one of the 15 unsecured sliding glass doors twice in one day, and after the second elopement was found by staff 0.6 miles from the facility in a confused state. This placed Resident 1 at significant risk for injury, including trauma from a traffic collision; and, resulted in the potential for other ambulatory residents to elope via the 15 unsecured doors in the facility, and the potential for unknown visitors to enter the facility via the 15 unsecured doors. Findings: During a review of Resident 1 Admission Record (AR) , dated [DATE], the AR indicated Resident 1 had diagnoses that included dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and disorientation (the condition of having lost one's sense of direction). During a review of Resident 1's Progress Notes (PN) , dated [DATE], at 4:04 p.m., the PN indicated, Resident [1] was spotted entering the building through the front door. Receptionist asked how she got out and she said through the back door. Writer walked around the side of the building where resident room has a sliding door. The door opens to a walkway that is open on both ends. A woman approached writer as I was examining the gate that leads to the front parking lot and was told that she saw a lady coming through the gate 10 minutes prior. (continued on next page)

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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NAME OF PROVIDER OR SUPPLIER: Golden Merced Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 3170 M Street Merced, CA 95340	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 PN dated [DATE], at 6:02 p.m., the PN indicated, Writer was notified by [Registered Nurse 1] that resident [1] was last seen at about 5:50 p.m. [Staff including Registered Nurse 1] were seen leaving the facility to look for resident and writer went through the back door in search of resident as well. Resident was found by [Registered Nurse 1] at . grocery store at 6:15 p.m. and redirected back to the facility at about 6:20 p.m. Resident [1] had the sliding back door of her room open and went out from there. Resident [1] was asked why she left the facility, resident stated, I am tired of being here, I want to go home, I was taking a walk to my house, my house is on the 16thstreet, I don't want to be here anymore, please allow me to go home. Writer educated resident [1] on the risks of leaving facility without a proper way of discharge, counselled on being hurt/injured/getting lost without the knowledge of the facility staff and family members. During a review of Resident 1 PN dated [DATE], at 6:32 p.m., the PN indicated, Resident [1] found by [Registered Nurse 1] and returned to facility around 6:30 p.m. Resident [1] ambulates independently with no problems. When resident asked why she left resident [1] stated, I wanted to go home so I left. Resident reports she left through her glass door in her room. Residents' doors don't have alarms. Gate outside doors don't have locks. During a review of Resident 1's Care Plan Report (CPR) dated [DATE], the CPR indicated Resident 1 is an elopement risk/wanderer related to History of attempts to leave facility unattended. During a concurrent observation and interview on [DATE] at 11:55 a.m., with Maintenance Supervisor, (MS), a tour of the 15 rooms on the North facing hall (rooms 27, 29, 31, 33, 35,37, 39, 40, 41, 43, 44, 45, 47,49, and 51), each room was noted to have a sliding glass door leading to a sidewalk on the exterior of the facility. Both ends of the sidewalk led to a wooden gate which could be opened by pulling on a string. Each gate opened to a parking lot and city streets beyond. The MS confirmed that the 15 sliding glass doors provide 15 exits from the facility that residents have access to. The MS stated that there are no alarms or system to alert staff when any one of the 15 doors are opened and there are no alarms or system to alert staff when the two wooden gates are opened. The MS also stated that there are no alarms or system to alert staff when any one of the 15 doors are opened to gain entry into the building. The MS stated, I feel handcuffed, because I feel like I can't do anything to keep my residents safe. During an interview on [DATE] at 2:06 p.m., with the Administrator, the Administrator nodded her head in agreement that there were 15 sliding glass doors that ambulatory residents could leave the building without staff knowledge and that unknown visitors could enter the building without staff knowledge through the same 15 sliding glass doors. Administrator stated, I probably have less than five ambulatory residents right now. During an interview on [DATE] at 3:15 p.m. with Registered Nurse [RN] 1, RN 1 stated that on [DATE], that she went looking for Resident 1 in her car and found her in front of a store 0.6 miles from the facility. RN 1 stated she watched Resident 1 cross multiple lanes of traffic with busy streets. The address of the store was verified with RN 1 using Google Maps, and RN 1 agreed Google Maps indicated the walking distance between the facility and the store was 0.6 miles. RN 1 stated she spoke with Resident 1 and convinced her to return with her to the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Elopement/Wandering , dated ,d+[DATE], the P&P indicated, The [facility] evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process. Definitions: Elopement: The resident/patient exits the [facility] without staff knowledge or the resident/patient enters an unsafe area without staff knowledge or presence. During a review of the Facility Assessment (FA), dated [DATE], the FA indicated the Resident Profile as having an average daily census as 102 residents. The FA indicated the facility averages 7 to 8 admissions and discharges per week. The FA indicated the facility admits and provides services to residents with Impaired cognition, Memory Loss, and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and other dementias .