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	06/11/2025

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 - Few	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** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) had elopement (when a resident leaves the facility, or a designated safe area within the facility, without proper authorization or supervision, which potentially endangers themselves) risk factors assessed when he was admitted to the facility. This failure resulted in Resident 1 eloping from the facility. Findings: During a review of Resident 1 ' s admission Record (AR), dated 6/11/25, the AR indicated he was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (also known as a type of ' stroke ' which occurs when blood flow to a part of the brain is interrupted, leading to lack of blood supply and subsequent brain tissue death; symptoms can include sudden weakness or numbness on one side of the body, difficulty speaking or understanding speech, vision problems, dizziness, and loss of coordination), problems relate to life management difficulty, need for assistance with personal care, and alcohol abuse. During a review of Resident 1 ' s Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool), dated 5/1/25, the MDS indicated at Question C0500 a score of 4 out of a possible 15, which indicated Resident 1 ' s cognition (having sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the resident ' s environment) was severely impaired. During a review of Resident 1 ' s Progress Notes (PN), dated 5/29/25, at 5:13 p.m., the PN indicated, Writer was on his way home when writer noticed an individual in a wheelchair heading towards [nearby street]. Writer pulled over and noticed that individual was actually [Resident 1]. Writer got out of vehicle and approached [Resident 1]. Writer asked resident where [sic] he was attempting to go and he stated ' I have family that lives around here. ' [Resident 1] currently in bed resting. The PN was written by Licensed Vocational Nurse (LVN) 1. (continued on next page)

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

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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 - Few	During an interview on 6/11/25, at 11:50 a.m., with LVN 1, LVN 1 stated, I was leaving work in my car and I noticed [Resident 1] in his wheelchair [on a nearby sidewalk about 1,000 feet from the front door of facility, per Google Maps]. [Resident 1] stated, ' I have family near here. ' I got out of my car and wheeled him back to facility with no further incident. We applied a Wander guard [an electronic security bracelet, that sets off alarm when it activates a sensor, often placed by exit doors to alert staff that a resident may be attempting to leave the building without supervision] to him upon his return. There ' s been no further episodes of elopement. If I had to guess, he left the building via the front doors. During a review of Resident 1 ' s Order Summary Report (OSR), dated 6/11/25, the OSR indicated Resident 1 had a physician ' s order dated 5/29/25 for a Wander Guard to right ankle to prevent resident from wandering outside attended area. During an interview on 6/11/25, at 12:45 p.m., with LVN 2, LVN 2 stated she performs new admission paperwork for residents when they are admitted to the facility. LVN 2 stated, elopement risk assessments are usually done by the 2nd shift after the resident arrives in the facility. LVN 2 stated they are to be done certainly by 24 hours after admission. During a review of Resident 1 ' s admission – readmission Nursing Evaluation ([NAME]), the [NAME] indicated it was completed on 6/5/25. During a concurrent record review and interview on 6/11/25, at 12:50 p.m., with the Administrator, Resident 1 ' s clinical record was reviewed. The Administrator stated all residents admitted to the facility are to have a Nursing admission Evaluation done at admission. The Administrator stated Resident 1 ' s Nursing admission Evaluation was not done until 6/5/25 (41 days after Resident 1 ' s admission to the facility). The Administrator stated, This assessment captures his elopement risk, which was not done. I don ' t know why it was not done. This should have been done at admission. During a review of the facility ' s policy and procedure (P&P) titled, Nursing admission Evaluation, dated 7/14, the P&P indicated, The nurse completes the Nursing admission Evaluation at admission. Members of the IDT [Interdisciplinary Team, made up of representatives of different departments such as Nursing, Dietary, Activities, Social Services] review the Nursing admission Evaluation upon completion to facilitate a complete evaluation and plan of care for the resident. During a review of the facility ' s P&P titled, Elopement/Wandering, dated 2/25, the P&P indicated, The Center evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions as indicated via the evaluation process. At admission, the licensed nurse (LN) completes the Nursing admission Evaluation, to determine the resident ' s risk for wandering/elopement. The LN gathers as much information as possible at the time of admission from the family, significant other, or responsible party regarding previous elopement attempts or desire to leave the premises.