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	07/11/2025

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. (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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(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	Based on interview and record review, the facility failed to ensure the facility was free from accidents or hazards when one of three sampled residents (Resident 1) eloped (exited the facility without supervision or staff knowledge) from the facility when staff did not respond to a security alarm timely. This failure had the potential for Resident 1 to become lost, disoriented, physically injured from a fall or traffic collision, when he was found approximately 350 feet away from the facility. Findings: During a review of the facility document titled Subject: Unusual Occurrence, dated 7/9/25, the document indicated, On 7/8/25 at approximately 5:10 PM, [Resident 1] was seen ambulating in the south hallway. Approximately 10 minutes later he was reported to be in the [fast food restaurant] parking lot across the street from the back of the facility. Staff immediately responded and were able to guide [Resident 1] back to the facility. Nursing staff assessed [Resident 1] for any injuries and no injuries noted to him. [Security Alarm] system at the back door was in place and functioning. Nurse reported to hear alarm and responded at time of the event. During a review of Resident 1's admission Record (AR), dated 7/17/25, the AR indicated Resident 1 had been in the facility over one year. During a review of Resident 1's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool), dated 4/21/25, the MDS indicated at Question C0500 a score of 3 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) had severe impairment. During a review of Resident 1's Care Plan Report (CPR), dated 7/9/25, the CPR indicated Resident 1 had an episode of elopement on 7/8/25 [related to] impaired cognition. The CPR dated 4/5/24 indicted Resident 1 is an elopement risk/wanderer. Intervention/Tasks: [electronic security bracelet that activates an alarm whenever the bracelet comes near a sensor, usually installed next to exit doors] to left wrist to prevent resident from wandering outside unattended area. During a review of Resident 1's Elopement Risk Assessment (ERA), dated 4/2/25, the ERA indicated, Yes the resident is at risk for elopement. During an interview on 7/11/25, at 10:30 a.m., with the Administrator, the Administrator stated Resident 1 can walk and does not need the use of a wheelchair. The Administrator stated the staff person who first responded to the Security System alarm from Resident 1 on 7/8/25, was Licensed Vocational Nurse (LVN) 3. The Administrator stated, She is reporting that she didn't see [Resident 1] when she checked the alarm and opened the door to look for him. Ten minutes later, a former employee recognized him at [the nearby fast-food restaurant] and called an employee here and informed us of [Resident 1's] location. During an interview on 7/11/25, at 11:10 a.m., with the Administrator, the Administrator stated it is her expectation that, when a door alarm goes off, it gets checked by staff in one minute or less, as soon as they hear it. We have 15 residents with [security alarm bracelets]. During an interview on 7/23/25, at 8:55 p.m., with LVN 3, LVN 3 stated she recalled responding to a door alarm on 7/8/25. LVN 3 stated, I responded to one of the alarms at the back door on the south station [of the facility]. The alarm was going off, I was there within five minutes. I went outside and didn't see anyone, the alarm was going off. Then I went to the front door and looked there. I don't know why I went to the front door to look, the front door alarm was not going off. During a review of Google Maps, the distance from the South Station exit of the facility, to the fast-food restaurant, was measured to be approximately 350 feet (a standard football field is 300 feet). During a review of the facility's policy and procedure (P&P) titled, Elopement/Wandering, dated 2/25, the P&P indicated, Definitions: Elopement: The resident/patient exits the [facility] without staff knowledge.