

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 07/16/2025
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)
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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a safe environment and adequate supervision to prevent elopement (a person left a place without anyone knowing or without permission) for 1 of 3 sampled residents (Resident 1), when the Wander Guard alarm system failed to activate when Resident 1 exited through a secured door and staff were not immediately alerted to the resident's departure. This failure resulted in Resident 1 leaving the facility unsupervised, placing Resident 1 at risk for serious injury, harm or death due to potential environmental hazards, including vehicular traffic. During a review of Resident 1's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and abnormalities of gait (walking) and mobility (how easily a person could move their body when sitting, standing or using a wheelchair). During a review of Resident 1's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 5/20/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 8 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had moderate cognitive impairment. During an interview on 7/16/25 at 12:11 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she heard Resident 1's Wander Guard did not sound when she left the facility, but was not on shift the day the incident happened. CNA 1 explained when a resident wearing a Wander Guard approaches an exit door, the system is supposed to trigger an alarm. CNA 1 stated it was important for the system to be working, because that was how they knew everyone was in the facility. During an observation on 7/16/25 at 12:18 p.m. in Resident 1's room, Resident 1 was observed sitting up in her bed. She was well groomed and dressed for the day. Resident 1 was oriented (person knew basic information such as who they are, the day, and what was happening around them) to self but displayed confusion regarding the day and the current situation. Resident 1's demeanor was calm. A Wander Guard device was observed on her left wrist. During an interview on 7/16/25 at 12:38 p.m. with CNA 2, CNA 2 stated there had been a recent elopement and they heard there was a possible malfunction of a Wander Guard. CNA 2 explained it was important for the alarm to sound, as it alerts staff when a high-risk resident is attempting to leave the facility. CNA 2 stated residents who wear a Wander Guard typically have dementia and stated the alarm has a distinct sound that differs from the call light. During an interview on 7/16/25 at 12:45 p.m. with Registered Nurse (RN) 1, RN 1 stated the alarm system notifies staff immediately when a resident wearing a Wander Guard attempt to leave the facility. RN 1 stated the system is a very important safety precaution, as elopements can result in falls, serious injuries and even death. During an interview on 7/16/25 at 1:19 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Wander Guards helped ensure resident safety, so it's important that the system functions properly. The LVN shared Resident 1 can be difficult to redirect. During a concurrent interview and review of Wander Guard Daily Functioning Log dated for month July 2025 with the Activities Director (AD), The AD stated Wander Guards system is checked daily, typically in the morning. The AD explained that the facility uses an approved system device that displays the Wander Guard number if it is active. If the number does not appear, the device is not active. The device only tests the Wander Guard that is placed on the resident wrist or ankle. The July 2025 log indicated on July 10, the day of the incident, Resident 1's Wander Guard was documented as active and had passed the daily check. During an interview on 7/16/25 at 2:24 p.m. with the Administrator (ADMIN), the ADMIN stated on the day of the incident, Resident 1 requested her medication around 10:35p.m. The nurse informed Resident 1 it was too early to administer her medication but assured her it would be given at the earliest appropriate time. Resident 1 then returned to her room. At 11:00p.m. the nurse went to administer the medication; Resident 1 was not there. Approximately thirty minutes later Resident 1 was found down the street in front of a Farmers Insurance building. Resident 1 was returned to the facility by staff. Upon reentry, Resident 1's Wander Guard alarm sounded. However, staff reported the alarm did not activate when Resident 1 initially exited the facility and they were not alerted to her departure. The ADMIN stated this may have been a potential system malfunction and emphasized that it is important to keep residents safe. During a review of Resident 1's Care Plan Report (CP), revised 1/3/25, the CP indicated Resident 1 was identified as an elopement risk/wanderer and a fall risk. The goal was for</p>		