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	11/19/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately identify and document all wounds present on readmission when the facility did not document the sacral wound identified in the hospital discharge summary and this wound was not reported to the wound care provider.This failure resulted in the resident's sacral wound not being identified, assessed, communicated, or treated following re-admission from the hospital.During a review of Resident 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 10/28/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes (T2DM-high blood sugar), anemia (lack of health red blood cells to transport oxygen, leading to fatigue and weakness), Chronic Atrial Fibrillation (the heart's irregular and rapid rhythm is continuous), Chronic Kidney disease, stage 3 (CKD- kidney disease where damage reduced function), Heart failure (the heart is not pumping blood efficiently), Pressure ulcer of unspecified site, unspecified stage (localized damage to the skin and/or underlying tissue usually over a bony prominence) and Pancytopenia (medical condition deficiency of all three types of blood cells: red blood cells, white blood cells, and platelets, can increase risk of infection, and bleeding problems.)During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 8/5/25, the MDS indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) score 10 out of 15, which indicated Resident 1 was moderately impaired. During a review of Resident 1's MDS, dated 8/5/25, the MDS indicated Resident 1 had Section M- Skin conditions (a resident assessment tool used to identify resident's risk for skin breakdown focusing on pressure ulcers/wound, documenting wounds and lesion, detailing the treatments being used) assessment completed indicated Resident 1 was at risk of developing pressure ulcers/injures. During a review of resident 1's hospital History and Physical (H&P), dated 10/6/25, the H&P indicated, Resident 1 had two pressure wounds on the sacrum and right heel,During a review of Resident 1's hospital Physician Note- Discharge Summary Note (Discharge Summary- a comprehensive report that summarizes a resident's hospitalization, including their diagnoses, and care they received), dated 10/13/25, the Discharge Summary indicated Resident 1 was diagnosed with infected pressure sore right heel and sacrum.During an interview on 10/27/25 at 1:18 p.m. with the Director of Nurses (DON), the DON stated Resident 1 was admitted to the hospital on [DATE] and returned to the facility on [DATE]. DON stated Resident 1 returned with intravenous (IV) antibiotics (medication used to treat bacterial infection given directly into the blood stream). The DON further indicated Resident 1 was admitted again to the hospital on [DATE] for sepsis. During a concurrent interview and record review on 11/19/25 at 9:15 am with Licensed Vocational Nurse (LVN) 1, Resident 1's long term weekly skin evaluation (skin eval), dated 10/18/25, was reviewed. The skin eval indicated that the admission nurse only identified the right heel as having a pressure ulcer. LVN 1, who also serves as the wound nurse for the facility, stated that it is the responsibility of the admission nurse (the nurse who is receiving the resident returning to the facility) to obtain the report, take vitals, conduct a full body skin assessment, document findings, update care plans, and place orders for proper care. LVN 1 further indicated that the nurses should review the hospital discharge summary, and if there were any discrepancies during the assessment of Resident 1, the nurse should have used all available resources for clarification. LVN 1 noted on 10/13/25 Resident 1 was readmitted from the hospital without wound treatment orders. LVN 1 clarified that if the discharge summary had been reviewed, it would have indicated that Resident 1 had two wounds: one on the right heel and one on the sacrum.During a concurrent interview and record review on 11/19/25 at 10:00 a.m., with LVN 1 Resident 1's Treatment Administration Record (TAR), dated Oct. 2025 was reviewed. The TAR indicated treatment orders to the right heel did not start until 10/16/25. LVN 1 confirmed Resident 1 returned to the facility on [DATE] and became aware of Resident 1 not having treatment orders after returning to work. LVN 1 stated when Resident 1 returned on 10/13/25 the nurse admitting Resident 1 back to the facility should have ensured treatment orders to the identified wounds of Resident 1. During an interview on 11/19/25 at 10:27 am, LVN 2 stated that it had been the responsibility of the receiving nurse to accurately assess the resident from head to toe and verify all treatment and medication orders. LVN 2 further stated if a resident had been admitted with wounds and no treatment