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	04/09/2026

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 a safe environment for one of four residents (Resident 3) when a Certified Nursing Assistant (CNA 2) failed to get the help and assistance of a second caregiver for a bed bath and linen change, as required by Resident 3's clinical documentation, and instead performed this activity without help. This failure resulted in Resident 3 falling from her bed to the floor, causing pain, anxiety, and a skin tear to her right wrist.During a review of the document titled SOC 341 dated, 3/30/26, the SOC 341 indicated that on 3/30/26, a charge nurse was called into [Resident 3's] room by CNA [2] at approximately 10 am related to a fall related to a bed bath. [Charge Nurse] assessed resident. Resident reported right arm skin tear on [top of] wrist. [Resident 3] was sent to the [Emergency Department] for further evaluation at 10:15 [a.m. CNA 2] immediately suspended pending investigation.During a review of the document titled 5 Day Summary, dated 4/3/26, the 5 Day Summary Report indicated following the incident on 3/30/26, Resident 3 was alert and able to state yes when asked if she had pain. Upon staff interview, CNA [2] stated that I turned resident [3] on her side to put new bed sheet on when she rolled all the way over onto the floor. [Resident 3] depends on staff for ADL [Activities of Daily Living] care. The interdisciplinary team [IDT, a group of healthcare professionals from different disciplines, such as dietary, activities, and nursing, who work together to improving resident health outcomes] reviewed the incident and determined that [Resident 3] fall is to be caused by CNA [2] not following Kardex appropriately.During an interview on 4/9/26, at 1:30 p.m., with the Director of Nursing (DON), the DON stated, A Kardex is like a CNA care plan, it's in PCC [Point Click Care, the facility's electronic documentation system] and explains how to care for the patient in the safest manner. The Kardex says [Resident 3] was supposed to have another person present for the bath & linen change. When I interviewed [CNA 2], she said she knew how to use the Kardex. I asked her if she was aware [Resident 3] was a 2-person assist . [CNA 2] answered that she didn't ask for help.During a review of Resident 3's admission Record (AR) dated 4/10/26, the AR indicated, Resident 3 was [AGE] years old and had medical diagnoses that included the inability to move her right arm and leg due to a previous stroke (a medical emergency occurring when blood flow to part of the brain is interrupted or a blood vessel bursts, depriving brain tissue of oxygen and causing cells to die; common symptoms include sudden numbness/weakness (often one-sided), confusion, trouble speaking, vision problems, and dizziness).During a review of Resident 3's Progress Notes (PN), dated 3/30/26, at 10:44 a.m., the PN indicated, Writer was called to resident's room around 10 am related to fall sustained during bed bath. Writer found resident unclothed, laying on her back. There was blood on the floor under her right arm. resident said her shoulder hurt, right arm had L shaped skin tear on [top of] wrist measuring 3-4 cm [centimeters] During a review of Resident 3's PN, dated 3/30/26, at 2:36 p.m., the PN indicated, IDT met regarding resident had a fall on 3/30/26, approx. [10 a.m.] resident was found on the floor in her room, [Registered Nurse] reports she observed resident unclothed, on her back, blood under and besides her R[ight] arm. resident complained of shoulder pain and skin tear noted to [top of] wrist measuring 3-4 inches [sic] on each side . observed CNA [2] standing on L[eft] side of resident's (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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Golden Merced Care Center	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 - Few	bed, bed observed to be approx. 3 feet above ground level. resident was alert, and able to state yes when asked if she had pain. Per CNA [2] she was performing a bed bath and resident rolled too far on the bed and landed on the floor, resident has a diagnosis of [stroke causing inability to use right side of her body].During a review of Resident 3's PN, dated 3/30/26, at 9:58 p.m., the PN indicated, Resident appeared anxious when head of bed was elevated during brief changes / taking medication. Writer and CNA assured resident that she is in a safe place and had bed in lowest position upon exiting room.During a review of Resident 3's PN, dated 3/31/26, at 11:17 p.m., the PN indicated, Observed to have some anxiety when bed is adjusted. Ensured resident that she is in a safe place and staff will make sure her bed is in lowest position before leaving the room.During a review of Resident 3's Kardex Report, dated 3/30/26, the Kardex Report indicated, Bed Mobility: Assistance by 2 staff to turn and reposition in bed. Ensure / provide a safe environment.During a review of Resident 3's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool), dated 4/2/26, the MDS indicated at Question GG0100 - A, that Resident 3 was assessed to be Dependent - a helper completed all the activities of Self-Care. the resident's need for assistance with bathing.During a review of Resident 3's MDS, dated 4/2/26, the MDS indicated at Question GG0115 that she had Impairment on one side of her Upper extremity (shoulder, elbow, wrist, hand), and Impairment on both sides of her Lower extremity (hip, knee, ankle, foot).During a review of Resident 3's MDS, dated 4/2/26, the MDS indicated at Question GG0170 A - Roll left and right: The ability [of the resident] to roll from lying on back to left and right side, and return to lying on back on the bed an answer of 1, indicating Resident 3 was assessed to be Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.During a review of a document (statement) written by CNA 2, undated, the statement indicated, I [CNA 2] was given [Resident 3] a bed bath I turned resident on her side to put new sheets on when I was putting the sheet on she rolled all the way over on to the Floor. That's when I went to get the nurse. It happened So Fast. During an interview on 4/15/26, at 11:18 a.m., with CNA 2, CNA 2 stated she recalled the incident with Resident 3 on 3/30/26. CNA 2 stated she recalled her written statement and stated it was accurate. CNA 2 stated, I was working with [Resident 3] alone. I don't check the Kardex all the time. I don't check it as much as I should.