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	05/01/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement adequate supervision, careˆplanned interventions and Interdisciplinary Team's (IDT- a mandated group of healthcare professional including physicians, nurses, social workers, and therapists who collaborate to create and manage a comprehensive, individualized care plan for resident) recommended safety measures for 1 of 3 sampled residents (Resident [Res] 1) who was at high risk for falls. Resident 1 had four falls between 4/19/26 and 4/25/26, including an initial fall resulting in a right hip fracture (partial or complete break in a bone, often caused by high-force impact or stress) on 4/19/26, and two additional falls within four hours of readmission to the facility on 4/23/26 and another fall on 4/25/26. These failures resulted in pain and suffering, requiring Res 1 to be transferred back to emergency room (ER) via ambulance for evaluation on 4/23/25 and 4/25/26 and placed Res 1 at increased risk for more injuries and worsening of right hip fracture.During a review of Res 1's History and Physical (H&P) dated, 4/19/26 from [Hospital A], the H&P indicated, Res 1 was a [AGE] year old male with a past medical history of dementia [a loss of brain function that happens with certain diseases and affects memory, thinking, language, judgment, and behavior, making it hard for a person to do daily activities on their own], cerebrovascular accident [CVA- medical emergency that happens when blood flow to part of the brain is suddenly blocked or a blood vessel in the brain break], gout [type of painful arthritis (joint disease) that happens when sharp, needle-like crystals build up in joints], sacral pressure ulcer [a wound on the skin and tissue over the sacrum, the triangular bone at the very bottom of the spine, just above the tailbone], bilateral upper and lower contractures [permanent or long-lasting tightening of muscles, tendons, or skin on both sides of the body, affecting both the arms and the legs, which makes it difficult to straighten joints fully], functional quadriplegia [complete inability to move due to severe, end-stage physical or mental disability without structural damage to the spinal cord or brain], left femur [the thighbone in the left leg, extending from the hip to the knee] fracture [broken bone] and epilepsy [a brain condition that causes a person to have recurring, unprovoked seizures]. Res 1 presented to ER after falling out of bed at his skilled nursing facility. Positive loss of consciousness and positive head strike post fall. Pelvic roentgenogram [a fast, painless imaging test that uses a small amount of radiation to create images of the bones in the hip and pelvic region] identified a right femoral fracture, avulsion fracture of the right greater trochanter [a rare injury where a piece of bone is pulled off by the hip muscles] and Res 1 was admitted to the hospital for Closed right hip fracture [a severe injury where the upper femur breaks but does not pierce the skin, usually causing extreme pain, inability to walk, and swelling].During a concurrent interview and record review on 5/1/26 at 12:20 p.m. with the Nurse consultant (NC) and Facility Administrator (ADM), Res 1's Electronic Medical Record (EMR) undated was reviewed. The review of Nursing Progress Note, by Licensed Vocational Nurse (LVN)1 dated 4/19/26 at 1:00 p.m. indicated that, Writer was passing patient room when writer heard a yelling help coming from room, writer found patient on the floor with gown and a brief, bed was place on the lowest position call light was attached to bed sheet, patient was laying down on left side near bed, immediate call for assist from (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff to help place patient back safe to bed, head to toe assessment was completed notice redness on right shoulder small abrasion, resident refused to move extremities stated he was in pain, and hit his head, when he fell towards the floor, Patient was asked what happened he stated he turned and fell toward the floor, and he hit his head on the floor, complain of back pain, MD was notified new order sent out to ER orders were carried out . NC stated that Res 1 was assessed per policy and had a high fall risk upon admission to the facility. NC stated that it was Res 1's first fall at the facility and care plan was updated based on IDT team's recommendations. NC stated that Res 1 was assessed for injuries and was sent to the [Hospital A] for further evaluation and Nursing Note, dated 4/19/26 at 5:09 p.m. indicated that facility was notified that Res 1 was admitted for right hip fracture (partial or complete break in a bone, often caused by high-force impact or stress). The review of document titled IDT fall review dated 4/20/26 indicated, . Once resident returns from acute IDT has recommendations . Offer fall mats bilaterally to decrease potential injury .During a concurrent interview and record review on 5/1/26 at 12:25 p.m. with the NC, Res 1's EMR undated was reviewed. NC stated that Nursing note dated 4/26/26 at 7:30 p.m. indicated that resident arrived back to the facility from [Hospital A] on 4/23/26 at 4:28 p.m. and was already restless upon admission to facility and experienced two more falls within four hours of readmission. The review of Nursing Note, by LVN 2 dated 4/23/26 at 8:50 p.m. indicated, At [6:35 p.m.] resident was found on the floor on his [left] side next to his bed. RN supervisor evaluated resident, resident assisted back to bed and placed on neuro checks. Resident's son [son's name] made aware via phone. At [8:20 p.m.], resident was again noted to be on the floor next to his bed on his left side again . Resident also placed on one to one for safety. NC stated she was unable to find any updated documented interventions after the initial fall on 4/23/26 at 6:35 p.m. in Res 1's EMR that could have potentially prevented the second the fall on 4/23/26. NC stated she was unable to find any documentation of whether fall prevention mats were placed for Res 1 as recommended during the IDT and care planned after the initial fall on 4/19/26. NC stated she was also not able to find any documentation indicating whether the 1:1 [one health care worker continuously observing one patient in person to prevent falls] companion sitter for safety was initiated after the first fall on 4/23/26. NC stated sitter should have been initiated after the first fall upon readmission to the facility and it would have potentially prevented the second fall on 4/23/26. NC stated that Res 1 was restless upon readmission to facility on 4/23/26, Res 1's fall risk score was high and Res 1 was returning to the facility from [Hospital A] after a right hip fracture that resulted from the fall at the facility on 4/19/26. NC stated she was unable to comment what interventions were in place and whether care planned interventions discussed after the fall on 4/19/26 were implemented upon readmission on [DATE]. During a concurrent interview and record review on 5/1/26 at 12:29 p.m. with the NC, Res 1's Care Plan for falls was reviewed. The review of Care plan for falls indicated it was initiated on 3/16/26 upon admission of Res 1 to facility and was updated on 4/19/26, 4/23/26 and 4/25/26. NC stated that offer floor mats bilaterally to decrease potential injury were care planned on 4/20/26 and 1:1 supervision was care planned on 4/24/26 and she would have expected staff to implement these interventions.During a review of Res 1's ED Physician Note, dated 4/24/26 from [Hospital A], the ED physician note indicated, admit date [DATE] 10:31 [a.m.] . Mode of Arrival: Ambulance . Chief Complaint ED: Fall . Subjective Nursing Assessment: [Brought in by ambulance (BIBA)] from [facility name] [diagnose] with recent hip [fracture] [discharged] last night and had 2 falls post return back to the facility.patient was not a surgical candidate . Discussed all results, diagnosis, treatment plan, prescriptions, and discharge back to [Skilled Nursing Facility (SNF)]. The patient verbalized understanding and agrees to be discharged at this time. They understand to return to the ED for worsening of symptoms or concern for their safety . Disposition Discharge .During a concurrent interview and record review on 5/1/26 at 12:30 p.m. with the NC, Res 1's electronic medical record (EMR) undated was reviewed. NC stated that Nursing Notes dated 4/24/26 indicated that Res 1 was sent out to Emergency Department (ED) for an evaluation on 4/24/26 around 9:10 a.m. after two falls on 4/23/26. NC stated Res 1 returned to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility on 4/24/26 at 3:10 p.m. The review of document titled IDT fall Review, dated 4/24/26 at 9:45 a.m. indicated . Describe new interventions to prevent future falls . 72 [hour] alert charting. Resident to have [Bilateral] floor mats to decrease risks of injury . 1:1 companion sitter in place. Wide mattress . NC stated that facility plan was to initiate 1:1 sitter to prevent any more falls. During a concurrent interview and record review on 5/1/26 at 12:28 p.m. with the NC, Res 1's Nursing Note, by LVN 1 dated 4/25/26 at 12:40 indicated, Staff reported to writer that patient was found on the floor, when writer arrive(d) patient was found laying on right side of body on a fetal position with his knees drawn towards his chest, on the safety floor mat, writer observe(d) bed in the lowest position and call light attach(ed) to the bed sheet, head was facing toward bed frame, and wearing a gown and clean dry brief and safety mat in place, immediate([NAME]) assist(ed) patient back to bed with staff help, RN was called to room and report was given, head to toe assessment completed no visible injuries noted , resident able to move all extremities without pain, mild red scratch noted on left hip measurement length 2.5 cm no drainage noted no bleeding or no warmth to touch, neurological assessment completed with no deficits noted, no other skin issues noted neruo check initiated and will continue per protocol . new order place(d) 1:1 with patient for safety, orders were carried out patient continues with [neuro] checks and with a 1: 1, orders were carried out for stat (urgent/immediate) right hip x-rays . NC stated Res 1 experienced another fall [4th fall at the facility since 4/19/26] on 4/25/26 and was sent out again to the ER for evaluation on 4/25/26 at 9:45 p.m. and returned to the facility on 4/26/26 at 4:00 a.m. NC stated she was not able to comment why Res 1 was not re-started on 1:1 for safety as care plan indicated and IDT recommendation on 4/24/26 after the two falls on 4/23/26. NC stated the nursing documentation does not reflect that patient had 1:1 companion sitter for safety when returned to the facility on 4/24/26 after evaluation in ER. NC stated documentation reflects Res 1 was with 1:1 for safety prior to leaving for evaluation in ER and it appears 1:1 was not restarted after Res 1 returned to the facility on 4/24/26. NC stated that documentation reflected 1:1 sitter was started by nurse after the fall on 4/25/26. NC stated Res 1 had a high fall risk, had a fall at the facility resulting in hip fracture on 4/19/26, had two more falls on 4/23/26 within four hours of returning to the facility, Res 1 was sent out for evaluation and returned to the facility and experienced another fall, total four falls since 4/19/26. NC stated that fall on 4/25/26 would have been prevented if the care plan and IDT recommendations were followed. NC stated she was unable to find any documentation that indicated Res 1 was with 1:1 companion sitter for safety at the time of fall on 4/25/26. During a review of Res 1's ED Physician Note, dated 4/25/26 from [Hospital A], the ED physician note indicated, . admit date : [DATE] [10:08 p.m.] . Mode of Arrival: Ambulance . Subjective Nursing Assessment: BIBA [brought in by ambulance] from [facility name] for [Right] HIP [Fracture], [Res 1] fell from bed this morning, XRAY [common, fast, and painless medical imaging technique to produce internal body images] CONFIRMED FROM FACILITY RT FEMORAL NECK FRACTURE [a serious hip injury, often caused by falls] . history of a right hip fracture diagnosed during a prior hospitalization on 4/19. The patient is bedridden . He was admitted to the care center in April has had multiple falls, including incidents on April 19 and April 24. The patient denies pain at present . Patient has a known history of a right hip fracture was seen on prior hospitalization for which orthopedics have determined that this is a nonoperative management. Patient not having any pain or tenderness on evaluation. I did repeat the x-ray which did show femoral neck fracture consistently with history. I did also compare images from priors and it appears there are no change in the fracture upon my independent review. No other injuries found on examination . Patient stable for discharge . During an interview on 5/1/26 at 2:15 p.m. with the ADM the ADM stated that he was familiar with Res 1 and was made aware of all falls. ADM stated that he expected facility staff to follow policies and procedures. ADM stated that sitter for safety should have been in place for Res 1 after the initial fall on 4/23 and it would have potentially prevented the subsequent falls on 4/23/26 and 4/25/26. ADM stated that he had approved the sitter and would have to review the documentation and staffing sheet to confirm whether sitter was present or not when Res 1 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experienced second fall on 4/23/26 and the fall on 4/25/26. ADM stated he expected the facility staff to follow up with IDT recommendations and care planned interventions.During a concurrent interview and record review on 5/1/26 at 1:38 p.m. with LVN 1, Res 1's Nursing Notes, dated 4/19/26 to 4/26/26 were reviewed. LVN 1 stated that she was the assigned nurse on 4/19/26 and 4/25/26 when Res 1 had fallen. LVN 1 validated that she had to call and get order for 1:1 safety sitter on 4/25/26 after the fall. LVN 1 stated she was not able to comment on why Res 1 did not have assigned sitter on 4/25/26 prior to the fall. LVN 1 stated that she was not the assigned nurse when Res 1 had two falls on 4/23/26, however, she did send out Res 1 for evaluation on 4/24/25 in the morning following the two falls due to Res 1 grimacing in pain. During a concurrent interview and record review on 5/1/26 at 2:00 p.m. with LVN 2, Res 1's Nursing Notes, dated 4/19/26 to 4/26/26 were reviewed. LVN 2 stated that he was the assigned nurse on 4/23/26 when Res 2 had a fall on 4/23/26 at 6:35 p.m. and 8:20 p.m. LVN 2 stated that he does not recall Res 1 having a safety sitter after the first fall. LVN 2 stated that supervisor assessed the Resident and safety sitter was started after the second fall. LVN 2 stated that Res 1 was assessed and physician was notified. LVN 2 stated Res 1 should have had 1:1 sitter after the first fall. LVN 2 stated he does not recall why the sitter was not initiated. LVN 2 reviewed the IDT notes for 4/24/26 and care plan for Res 1. LVN 2 stated that documentation does not reflect that Res 1 continued with 1:1 safety sitter after it was initiated on 4/23/26 and LVN 1 had to call and get order for the sitter on 4/25/26 after the fall. LVN 2 stated that having the sitter with Res 1 potentially would have prevented the fall on 4/25/26. During a concurrent phone interview and record review on 5/5/26 at 3:44 p.m. with the Assistant Director of Nursing (ADON) Res 1's EMR was reviewed for all Progress notes between 4/19/26 to 4/26/26. The DON stated she was familiar with Res 1. The ADON stated she had reviewed the care plan updates and IDT notes for all falls for Res 1. The ADON stated that she was contacted after the first fall on 4/23/26 and had asked the facility to start 1:1 sitter to ensure Res 1's safety. The ADON stated she was not able to find any documentation indicating that 1:1 sitter was initiated or the rationale for not starting 1:1 sitter for Res 1's safety. The ADON stated the documentation indicated that sitter was initiated after the second fall on 4/23/26 and patient was sent out to ER for evaluation in the morning of 4/24/26. The ADON stated that Res 1 returned in the afternoon on 4/24/26 and it was unclear from documentation that 1:1 sitter was restarted. The ADON stated she expected the facility staff to continue with 1:1 sitter upon Res 1's return on 4/24/26. The ADON stated Res 1 had another fall on 4/25/26 and documentation reflects patient was not placed with 1:1 sitter as care planned and recommended by IDT team. The ADON stated that 1:1 sitter was important to ensure resident safety and potentially would have prevented second fall on 4/23/26 and the fall on 4/25/26 requiring evaluation in ED. The ADON stated she would also like to check staffing sheets as the EMR does not reflect Res 1 had 1:1 sitter present on 4/23/25 until after the second fall and was not present at the time of fall on 4/25/26. The ADON stated the LVN 1's documentation clearly states that she had to call and get an order for 1:1 sitter after the fall on 4/25/26. The ADON stated she expected staff to follow care plan interventions and IDT recommendations. During a phone interview on 5/5/26 at 4:20 p.m. with the ADM, the ADM stated that he was unable to find any documentation to confirm that 1:1 safety sitter was started for Res 1 prior to second fall on 4/23/26. The ADM also stated he was unable to find documentation that indicated whether one to one sitter was present at the time of fall on 4/25/26 in accordance with documented care plan intervention and IDT recommendations. The ADM stated he expected staff to follow facility policies and procedures along with care planned interventions and IDT recommendations. The ADM stated documentation needs improvement and without documentation he was unable to confirm whether sitter was present in the room for Res 1.During a review of the facility's policy and procedure (P&P) titled, . Fall Management and Neurological Check . The center implements a fall management plan based on medical history review and resident evaluation . The LN updates care plans reflecting individualized intervention in an attempt to reduce or prevent falls . The residents care plan is reviewed quarterly and after a fall to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine effectiveness of current intervention and considers the residents goals, choices and preferences . A new intervention is not required with each fall, as not all falls require an intervention nor a change in intervention. A systematic review of current interventions is completed post fall and root cause is identified . Should a new intervention be implemented, previous interventions are reviewed for discontinuation to determine if they were ineffective .