STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055249	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merced Nursing & Rehabilitation Ctr	510 West 26th 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 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 observation, interview, and record review, the facility failed to ensure one of five residents (Resident 1), was free from physical and verbal abuse when on [DATE] Certified Nursing Assistant (CNA) 1 was witnessed grabbing Residents 1's left arm forcefully and escorting Resident 1 back to her room. Resident 1 was instructed by CNA 1 to then remain in her room with the door closed.This failure resulted in Resident 1 experiencing witnessed physical abuse by CNA 1 and isolation.During a concurrent observation and interview on [DATE] at 10:53 a.m. with Resident 1, Resident 1 was sitting on a chair in the lobby with a staff member. Resident 1 was pleasant, easily redirected, compliant and cooperative. The Registered Nurse Supervisor (RNS) escorted Resident 1 to her room for an interview. Resident 1 had a wander guard (a device designed to automatically alarm to prevent residents from leaving a designated safe area) on her left ankle. Resident 1 was Spanish speaking only and the RNS interpreted. Resident 1 was oriented (aware) of self only and answered simple questions. Resident 1 was unable to recall the incident on [DATE]. Resident 1 stated staff treated her well and stated she felt safe. During a record review of Resident 1's admission Record, dated [DATE], the AR indicated, Resident 1 was admitted on [DATE] with a history of Alzheimer's disease (a progressive neurological disorder that causes brain cells to degenerate [a gradual worsening or deterioration of the function or structure of cells, tissues, or organs over time, leading to a lower or less effective state], leading to memory loss, cognitive decline, and impaired daily functioning), Delusional disorders (a mental illness characterized by persistent, non-bizarre delusions lasting at least one month, without other symptoms of psychosis [a mental health condition characterized by a loss of contact with reality] and Bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, alternating between periods of elevated mood and periods of depression). During a review of Resident 1's Brief Interview for Mental Status (BIMS- an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life), dated [DATE], the BIMS score was 3 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment).During a record review of Resident 1's Post-Event Review (PER), dated [DATE], the PER indicated, . 5. IDT [Interdisciplinary Team - a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff] Review: IDT met to review incident that occurred [DATE]. Per staff, they witnessed the CNA assigned to [Resident 1] grab her arm aggressively to pull her back into her room. Upon witnessing this, the CNA assigned was sent home immediately and suspended pending investigation. Upon investigation, it was determined that he did grab her in an aggressive manner and staff member will be terminated and not allowed back to work. [Resident 1] is not able to recall incident due to her [diagnosis] dementia (a medical condition characterized by a progressive decline in cognitive abilities, such as memory, thinking, language, and judgment, that interferes with daily functioning and social interactions). Body assessment was completed and no injuries noted. [Resident 1] continues to get up daily and ambulate around the facility per her normal routine. She was pleasant during interview. No signs of emotional distress noted. Staff will continue to monitor and address any changes if they occur.During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated, The resident has impaired cognitive function/dementia or impaired thought processes [related to (r/t)] Alzheimer's, Dementia; Constantly pacing/wandering with no purpose. Interventions: Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. During a review of Resident 1's CPR, dated [DATE], the CPR indicated, Resident allegedly received physical aggression to her left arm from a staff member on [DATE]. Interventions: Monitor for emotional distress [every (Q)] shift [times (x)] 72 [hours (H)]. Monitor left upper arm for any redness, pain, swelling, or new skin discoloration x 72H. Notify [Medical Doctor (MD)] of any changes with resident.During an interview on [DATE] at 11:04 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on [DATE] she and CNA 3 witnessed CNA 1 grab Resident 1's left arm in the hallway and escorted Resident 1 back to her room. LVN 1 stated CNA 1 was forceful and agitated with Resident 1. LVN 1 stated CNA 3 informed the Administrator (ADM) immediately and the ADM instructed CNA 1 to leave the facility. LVN 1 stated Resident 1 was assessed with no physical or psychosocial harm. LVN 1 stated Resident 1 was ambulatory (able to walk