

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Merced Nursing & Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident's medications regimen must be free from unnecessary medications and entire medication regimen was monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being (refers to the state of mental, emotional, and social health of an individual) for one of three sampled residents (Resident 1), when Resident 1's target behaviors were not accurately monitored and documented for the use of psychotropic medications (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). These failures had the potential for Resident 1 to be inaccurately assessed for the effectiveness of psychotropic medications and to receive inappropriate doses of psychotropic medications leading to ineffective treatment. Findings: During a concurrent interview and record review on 7/16/26 at 2:53 p.m. with Registered Nurse (RN)1, 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), undated, and Electronic Medication Administration Record (EMAR - a daily electronic documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 7/2026 were reviewed. The AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). The EMAR indicated, Monitor behaviors of auditory hallucination (when you hear voices or noises that don't exist in reality) every shift. Order Date 2/24/2025 .[check mark]. Monitor behaviors(s) of aggressive Behaviors towards others every shift Order Date 2/24/26. (number) 3-11 7/11/26 -0 - [check mark] by CH (initial of licensed nurse). Monitor episodes of self-talking with verbal aggression. number 3-11 7/11/26 -0 -[check mark] by CH. LVN 1 stated Resident 1 was admitted at the facility with psychiatric disorders such as schizophrenia and multiple behaviors such as physical and verbal aggression toward staff and other residents. LVN 1 stated Resident 1's behaviors were being monitored by nursing staff every shift and were documented in the EMAR. LVN 1 stated Resident 1's EMAR for behavior of auditory hallucinations showed check marks from 7/1/26 to 7/16/26 and were initialed by licensed nurses which indicated Resident 1 was being monitored for auditory hallucinations. RN 1 stated Resident 1's behavior monitoring should indicate a total number of episodes of auditory hallucinations per shift. RN 1 stated check marks were not specific for the targeted behaviors being observed by the licensed nurses. RN 1 stated Resident 1's EMAR was used to monitor aggressive behaviors towards others could be a (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring for physical and verbal aggression and there was additional monitoring specifically for verbal aggression. RN 1 stated Resident 1's behavior monitoring was repetitive and could cause confusion for the licensed nurses to appropriately document Resident 1's targeted behaviors. RN 1 stated the EMAR dated 7/11/26 on the p.m. (post meridiem -after noon) shift indicated Resident 1's behavior monitoring was zero, which meant Resident 1 had no physical or verbally aggressive behaviors. RN 1 stated Resident 1 had an episode of increased physical and verbal aggression on 7/11/26 towards his roommate (Resident 4). RN 1 stated p.m. shift licensed nurse should capture and document Resident 1's physical and verbal aggression on 7/11/26 when Resident 1 had a resident-to-resident altercation. RN 1 stated licensed nurses should document the number of episodes of observed behaviors in the EMAR at the end of their shift. RN 1 stated it was important for licensed nurses to accurately capture and document Resident 1's targeted behaviors related to the psychotropic medication use to evaluate the effectiveness of the medications. RN 1 stated Resident 1's aggressive behaviors had been increasing, and he could benefit from an admission to a behavioral facility to effectively manage his behaviors. RN 1 stated Resident 1 should not have a roommate for the safety of other residents. RN 1 stated Resident 1's roommate (Resident 4) was transferred to another room after the resident-to-resident altercation (an aggressive physical, verbal, or sexual interaction between people living in a care facility that causes physical injury or mental distress). During a concurrent observation and interview on 7/16/26 at 3:28 p.m. with Resident 1, in Resident 1's room, Resident 1 was sitting at the edge of his bed with his feet touching the floor. Resident 1 was calm, alert and oriented to names, places, and situations. Resident 1 was observed with a flaccid (limp) left hand. Resident 1 stated he had a stroke. Resident 1 recalled the resident-to-resident altercation with his roommate because his roommate had stolen his personal belongings. Resident 1 stated that his phone, tablet, hats, clothes and hairbrush were missing. Resident 1 stated he did not want a roommate and wanted to be by himself in the room. During a concurrent interview and record review on review 7/17/26 at 9:16 a.m. with the Minimum Data Set Nurse (MDSN), Resident 1's Order Summary Report, dated 7/2026 was reviewed. The Order Summary Report indicated, [Brand Name] Oral Tablet 2.5 MG (milligrams -metric unit of measurement, used for medication dosage and/or amount) Olanzapine (a psychotropic medication used to treat schizophrenia and bipolar disorder) Give 1 tablet by mouth at bedtime for Schizophrenia [manifested by (m/b)] calm to angry/combatative behavior with episodes of striking out at staff Start Date 4/15/26. [Brand Name] Oral Tablet Delayed Release 125 MG Divalproex Sodium (a mood stabilizer to treat and manage bipolar disorder) Give 1 tablet by mouth two times a day for mood disorder m/b uncontrolled calmer to aggressive verbal/physical aggression Start Date 2/26/26. The MDSN stated Resident 1 had an active order for psychotropic medications related to diagnosis of Schizophrenia and Mood Disorder (mental health conditions that cause severe mood changes). MDSN 1 stated the Order Summary Report did not indicate an order for psychiatric evaluation and follow-up. The MDSN stated Resident 1 should have a physician's order for psychiatric services related to psychotropic medication use and needed a psych re-evaluation related to the recent episode of resident-to-resident altercation. During a concurrent interview and record review on review on 7/17/26 at 9:30 a.m. with MDSN 1, Resident 1's IDT (Interdisciplinary Team) Behavior Management, dated 5/29/26 was reviewed. The IDT Behavior Management indicated, He can be physical aggressive towards staff, have decreased overtime. MDSN 1 stated she was part of the behavioral meeting quarterly (every three months). MDSN 1 stated Resident 1 had waves of verbal outburst and physical aggression towards others. MDSN 1 stated Resident 1 could be redirected occasionally. MDSN 1 stated the facility has a process in monitoring and documenting target behaviors of residents on psychotropic medications. MDSN 1 stated licensed (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, interview, and record review, the facility failed to ensure that all staff were aware of reporting all alleged violations of mistreatment, exploitation (taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion), neglect, or abuse, including injuries of unknown source, and misappropriation of resident property (the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent) for one of three sampled residents (Resident 3), when the Activity Director (AD) did not report Resident 3's allegation of abuse to the facility's Administrator on 7/7/26. This failure resulted in delayed reporting of Resident 3's allegation of abuse and had the potential for Resident 3 to experience unrecognized negative outcomes including mental, emotional, and psychosocial distress (an emotional state characterized by painful mental, physical, and behavioral symptoms triggered by overwhelming social or psychological stressors). Findings: During an interview on 7/16/26 at 4:12 p.m. with the AD, the AD stated Resident 2 and Resident 3 were sitting at the same table in the activity room on 7/7/26. The AD stated she heard a loud noise from Resident 2 and Resident 3's table. The AD stated Resident 3 was yelling, Don't do that to me. The AD stated she went to Resident 3's table and Resident 3 was pointing her finger to her stomach and forehead. The AD stated Resident 3 was upset and left the activity room. The AD stated she reported the incident to the licensed nurse and a certified nurse assistant but unable to remember their names. The AD stated she did not report the incident to the Administrator (ADM) and did not follow up after the incident happened. During an interview on 7/17/26 at 10:58 a.m. with Minimum Data Set Nurse (MDSN) 2, MDSN 2 stated Resident 3 spoke to him on 7/8/26 and reported an incident that happened on 7/7/26 with another resident (Resident 2). MDSN 2 stated Resident 3 informed him that Resident 2 placed her hand to her forehead and pushed her while they were in the activity room. MDSN 2 stated he reported the incident immediately to the facility's abuse coordinator, the Administrator on 7/8/26. During an interview on 7/17/26 at 11:06 a.m. with the Director of Staff and Development (DSD), the DSD stated she provided abuse training to all staff. The DSD stated it was her expectation to notify the facility's abuse coordinator, which was their ADM immediately for any type of abuse to keep residents safe. During a concurrent observation and interview on 7/17/26 at 11:12 a.m. with Resident 3, in Resident 3's room, Resident 3 was sitting at the edge of the bed with ongoing oxygen therapy. Resident 3 was pleasant, alert and oriented to people, places, time, and situations. Resident 3 stated she had respiratory problems. Resident stated she remembered when another resident (Resident 2) placed the palm of her hand to her forehead and pushed her twice, and stated, the second one was harder. Resident 3 stated she was pulled out from the table by the activity person. Resident 3 stated she had no injury. During an interview on 7/17/26 at 12 p.m. with the ADM, the ADM stated being the facility's abuse coordinator, it was his expectation for all staff to notify him immediately of any suspected case of abuse for residents' safety. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/29/26, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 3's cognition was moderately impaired. During a review of the facility's 5-day Summary Report, dated 7/13/26, the report indicated, . Conclusion: Upon completion of investigation, it is found that this (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegation of abuse is substantiated as both residents are alert and had admitted to the circumstances of the interaction. Residents both understand that this was a disagreement and unfortunately led to physical; contact. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, dated 7/2011, the P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Reporting. 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has no resulted in serious bodily injury . During a review of the facility's Lesson Plan/Education Program titled, Abuse Prevention and Mandated Reporting, undated, the Lesson Plan/Education Program indicated, . 2. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 5. All staff are Mandated Reporters and are required to report all instances of suspected abuse, actual abuse, and injuries of unknown origin immediately. The Administrator is the Abuse Coordinator. 6. All reports of suspicions of, or actual abuse should be reported immediately. Employees should ensure the residents safety from abuse situations.		

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan to maintain the resident's highest practicable physical, mental, and psychosocial well-being (refers to the state of mental, emotional, and social health of an individual) for one of three sampled residents (Resident 1), when Resident 1's care plan for the indications for use of psychotropic medications (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) did not include measurable and objective goals to meet Resident 1's mental and psychosocial needs. These failures had the potential for Resident 1 to not receive the necessary care and services related to the indications for use of psychotropic medications and placed Resident 1 at an increased risk of not having his mental and psychosocial needs met. Findings: During a concurrent interview and record review on 7/16/26 at 2:53 p.m. with the Registered Nurse (RN) 1, 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), undated was reviewed. The AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), depression, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs). RN 1 stated Resident 1's aggressive behaviors had been increasing, and he could benefit with an admission to a behavioral facility to effectively manage his behaviors. RN 1 stated Resident 1 should not have a roommate for the safety of other residents. During a concurrent observation and interview on 7/16/26 at 3:28 p.m. with Resident 1, in Resident 1's room, Resident 1 was sitting at the edge of his bed with feet touching the floor. Resident 1 was calm, alert, and oriented to names, places, and situations. Resident 1 was observed with a flaccid (limp) left hand. Resident 1 stated he had a stroke. Resident 1 stated he recalled the resident-to-resident altercation (an aggressive physical, verbal, or sexual interaction between people living in a care facility that causes physical injury or mental distress) with his roommate because his roommate had stolen his personal belongings. Resident 1 stated he did not want a roommate and wanted to be by himself in the room. During a concurrent interview and record review on review 7/17/26 at 9:16 a.m. with Minimum Data Set Nurse (MDSN) 1, Resident 1's Order Summary Report, dated 7/2026 was reviewed. The Order Summary Report indicated, [Brand Name] Oral Tablet 2.5 (milligrams (MG) -metric unit of measurement, used for medication dosage and/or amount) Olanzapine (a psychotropic medication used to treat schizophrenia and bipolar disorder) Give 1 tablet by mouth at bedtime for Schizophrenia manifested by [m/b] calm to angry/combative behavior with episodes of striking out at staff Start Date 4/15/26. [Brand Name] Oral Tablet Delayed Release 125 MG Divalproex Sodium (a mood stabilizer to treat and manage bipolar disorder) Give 1 tablet by mouth two times a day for mood disorder m/b uncontrolled calmer to aggressive verbal/physical aggression Start Date 2/26/26. MDSN 1 stated Resident 1 had an active order for psychotropic medications related to diagnosis of (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Schizophrenia and Mood Disorder (mental health conditions that cause severe mood changes). MDSN 1 stated the Order Summary Report did not indicate there was an order for a psychiatric evaluation and follow-up. MDSN 1 stated Resident 1 should have a physician's order for psychiatric services related to his psychotropic medication use and needed a psych re-evaluation related to the recent episode of resident-to-resident altercation. During a concurrent interview and record review on 7/17/26 at 9:45 a.m. with MSDN 1, Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/9/26 was reviewed. The MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact). MDSN 1 stated a score of 12, indicated that Resident 1's cognition was moderately impaired. During a concurrent interview and record review on 7/17/26 at 9:50 a.m. with MDSN 1, Resident 1's care plan for psychotropic medications use, undated were reviewed. The care plan indicated, Focus: . has behaviors of talking to self in a mumbling tone with episodes verbal aggression . can display verbal aggression at bystanders but not with intent directed towards any specific individual Date Initiated: 3/4/25 Revision on 3/25/26. Goal: The resident will be free from complications related behavior. Focus: .has a behavioral problem: Physically & verbally aggressive related to : Bipolar disorder with Dementia. Attention seeking behaviors. will throw himself on the floor purposely. Behavior of agitation and striking out at staff with any utensil available. Throwing food tray and cups on the floor. Date Initiated: 03/23/2025 Revision on: 03/25/2026. Goal: will have fewer episodes of physical and verbal aggression by review date. Focus: .uses psychotropic medications [related to (r/t)] Schizophrenia and bipolar free of drug related disorder m/b calmer to anger/combatative behavior [with (w/)] episodes of striking at staff. Date Initiated: 02/28/2025 Revision on: 03/18/2026. Goal: The resident will be/remain free of drug related complications. Interventions: Will be seen by the psychiatrist [a medical doctor who diagnoses, treats, and prevents mental, emotional, and behavioral disorders] as needed. Monitor/document for side effects and effectiveness. Monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and documents per facility protocol. Date Initiated: 02/28/2025 Revision on: 02/28/2025. MDSN 1 stated Resident 1's care plan goals for targeted behaviors were not objective, measurable or attainable. MDSN 1 stated care plan should be person-centered with measurable objective goals to ensure what was being done for the residents was appropriate according to their assessment and needs. MDSN 1 stated residents' care plan should be reviewed and updated by the interdisciplinary team (IDT) as needed. MDSN 1 stated residents' care plan should reflect a measurable and objective goal which was developed specific to the residents and positively impacting the residents' care. During an interview on 7/17/26 at 12:15 p.m. with the Director of Nursing (DON), the DON stated it was her expectation that a resident's care plan should be person-centered with objective and measurable goals. The DON stated it was important for the residents to have measurable and objective goals to evaluate if the prescribed psychotropic medications were effective for the resident's symptoms and diagnosis. The DON stated if the care plan goal was not measurable or attainable, the physician and qualified staff were not able to re-evaluate the resident's progress and effectiveness of their plan of care. The DON stated care plans direct the care of the residents. During a review of Resident 1's Psychiatry Progress Note, dated 2/26/26, the Psychiatry Progress Note indicated, .Assessment/Plan: BIPOLAR DISORDER, UNSPECIFIED Plan: Monitor for effectiveness and side effects of medications. Encourage staff to report any changes in behavior or (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication efficacy. SCHIZOPHRENIA, UNSPECIFIED No medication changes made during this visit. Continue monitoring the behaviors. During a review of the facility's policy and procedures (P&P) titled, Care Plans, Comprehensive Person Centered, dated 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develop and implements a comprehensive person-centered care plan for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions; 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change; 12. The interdisciplinary team reviews and updates the care plan: b. when the desired outcome is not met; d. at least quarterly.		