

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  07/12/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure dignity was provided for one of 26 sampled residents (Resident 4) when Resident 4's nephrostomy catheter (a tube that is inserted into the kidneys, allowing the urine to drain freely into a connected bag) bag was uncovered leaving the urine visible.</p> <p>This failure resulted in Resident 4 not being provided her right to have a dignified existence while in the facility.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), dated 7/11/24, the AR indicated Resident 4 had been admitted on [DATE]. Resident 4's admitting diagnoses included: a urinary tract infection (UTI- an infection in any part of the urinary system), hydronephrosis (swelling of one or both kidneys), and calculus of ureter (stone in the tubes responsible for the passage of urine).</p> <p>During an observation on 7/9/24 at 9:51 a.m. in Resident 4's room, Resident 4 was seen in a wheelchair with her nephrostomy catheter bag uncovered and, on her lap, leaving the urine visible.</p> <p>During a concurrent observation and interview on 7/9/24 at 3:40 p.m. with Certified Nursing Assistant (CNA) 3 in Resident 4's room, Resident 4's nephrostomy catheter bag was seen uncovered hanging on her bed. CNA 3 stated nephrostomy bags are treated like foley catheter (a tube that is inserted into the bladder, allowing the urine to drain freely into a connected bag) bags and they need to be covered. CNA 3 stated it was important to cover catheter bags because it provided dignity and privacy to resident. CNA 3 stated Resident 4 may have felt embarrassed or uncomfortable having her urine easily visible for people to see.</p> <p>During an interview on 7/11/24 at 9:48 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 4 should have had a separate bag over her catheter bag to provide privacy. LVN 2 stated CNA's and LVN's can both apply a privacy bag. LVN 2 stated not having a bag could have caused Resident 4 to not feel respected while living in the facility.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/12/24 at 10:08 a.m. with the director of staff development (DSD), the DSD stated Resident 4's nephrostomy bag should have been covered by a privacy bag. The DSD stated it was the expectation of staff to always place catheter bags into a privacy bag to protect the dignity of the residents.</p> <p>During an interview on 7/12/24 at 10:38 a.m. with the director of nursing (DON), the DON stated Resident 4's nephrostomy bag should not have been exposed. The DON stated having the urine exposed did not provide Resident 4 with privacy or dignity.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P), titled, Dignity dated 02/2021, the P&amp;P indicated, . Each resident shall be cared for in a manner that promotes and enhances his or her sense of wellbeing, level of satisfaction with life, and a feeling of self-worth and self-esteem . 1. Residents are treated with dignity and respect at all times . 12 Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered .</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424</b></p> <p>Based on observation, interview, and record review the facility failed to implement a clean, comfortable, homelike environment for 7 of 29 sampled residents (Residents 1, 9,16, 18, 26, 27, 47) when:</p> <ol style="list-style-type: none"> <li>Residents 1, 16, 26, and 47's room and privacy curtains were not properly hung on the hooks.</li> </ol> <p>This failure had the potential to result in Residents 1, 16, 26, and 47 not being provided their right to have privacy or a comfortable homelike environment.</p> <ol style="list-style-type: none"> <li>The facility failed to honor the right of three of 23 sampled residents (9, 18, and 27), when the wall of residents 9,18 and 23's room had paint that missing, chipped and peeling.</li> </ol> <p>Findings:</p> <ol style="list-style-type: none"> <li>During an observation on 7/9/24 at 10:39 a.m. in Resident 1, 16, and 26's room, the middle section of the window curtain was not properly hung on the hooks.</li> </ol> <p>During an observation on 7/9/24 at 10:44 a.m. in Resident 47's room, the end of Resident 47's privacy curtain was not properly hung on the hooks.</p> <p>During a concurrent observation and interview on 7/12/24 at 9:20 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 1,16, and 26's room, the middle section of window curtain was not properly hung on the hooks. CNA 1 stated having the middle section of the window curtains not hanging on the hooks looked ugly and may not provide adequate light blocking. CNA 1 stated the curtain did not provide a homelike environment in its condition.</p> <p>During a concurrent observation and interview on 7/12/24 at 9:33 a.m. with CNA 1 in Residents 47's room, the end of Resident 47's privacy curtain was not hung properly on the hooks. CNA 1 stated the hooks on the curtains were missing and the curtain did not slide smoothly. CNA 1 stated the condition of the curtains in Resident 47's room was not homelike. CNA 1 stated the curtain may not be able to fully provide privacy to the resident. CNA 1 stated she would not have curtains in the same condition in her own home.</p> <p>During an interview on 7/12/24 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated all the curtains in every resident room should be hung correctly. LVN 4 the curtains in Residents 1,16, 26 and 47's room did not provide a homelike environment. LVN 4 stated it was the responsibility of all staff to ensure the curtains were hung correctly. LVN 4 stated if curtains were not properly hung or don't function as they should it could have made the residents sad whenever they go back to their rooms.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/12/23 at 9:45 a.m. with the Maintenance Supervisor (MAINS), The MAINS stated he was aware of the condition of the Residents 1,16, 26, and 47's curtains and they should have been hung properly. The MAINS stated the curtains may have had damaged or missing hooks and it was important for the curtains to be in proper working order because it helped create a homelike environment. The MAINS stated the rooms were the residents' homes and things like appealing curtains help the residents feel better.</p> <p>During an interview on 7/12/24 at 9:54 a.m. with the Housekeeping Supervisor (HS), the HS stated all the curtains in each residents' room should have been hung properly on the hooks. The HS stated properly hanging the curtains was the responsibility of housekeeping staff and having proper working hooks was the responsibility of the maintenance department. The HS stated both departments should have fixed the problem when it was noticed. The HS stated if curtains weren't hung correctly, they would not provide privacy or a homelike environment to the residents.</p> <p>During an interview on 7/12/24 at 10:08 a.m. with the director of staff development (DSD), the DSD stated certified nursing staff should have reported the loose curtains to the maintenance or housekeeping department. The DSD stated properly hung curtains was important because it provides privacy and makes the room more homelike.</p> <p>During an interview on 7/12/24 at 10:38 a.m. with the director of nursing (DON), the DON stated privacy curtains in the residents' rooms should be hung correctly on the hooks. The DON stated it was important to have proper hanging curtains to provide a homelike environment for the residents. The DON stated the condition of Residents 1,16, 26, and 47's curtains was not homelike.</p> <p>During an interview on 7/12/24 at 11:41 am with the Administrator (ADM), the ADM stated residents should have been provided properly hanging curtains in their rooms. THE ADM stated properly hung curtains was important because it provided privacy to the residents.</p> <p>During a review of the facility's Housekeeper job description, (undated), the job description indicated, . the purpose of your job position is to maintain a clean and safe environment in accordance with the current federal, state and local standards that govern the facility, and as directed by housekeeping department and/ or the Administrator .</p> <p>During a review of the facility's Maintenance Supervisor job description, (undated), the job description indicated, The purpose of your job is to assist in supervising the day-today activities (installing, repairing, and upkeep) of the facility in accordance with current applicable federal, state, and local standards and regulations to ensure the safety if all residents and personal as directed . Essential duties and responsibilities . Performing regular inspections of resident rooms for order safety and proper performance of equipment. Providing or scheduling facility repairs as needed .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Homelike environment, dated 2/21, the P&amp;P indicated, . The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary, orderly environment .</p> <p>41608</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 9's Admission Record (AR), dated 7/12/24, the AR indicated Resident 9 was admitted on [DATE] from an acute care facility with the following diagnoses, Type 2 Diabetes Mellitus (DM - a disease where the blood sugar is high), benign prostate cancer (not cancer, the prostate gland is larger than usual, can slow or block the flow of urine from the bladder), difficulty walking, oral phase dysphagia (difficulty swallowing food or liquid), Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities), Viral Hepatitis (infection that causes liver inflammation and damage), and Chronic Obstructive Pulmonary Disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/23/24, the MDS section C indicated, Resident 9 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 6 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 9 had severe cognitive impairment.</p> <p>During a review of Resident 18's AR dated 7/12/24, the AR indicated, Resident 18 was admitted from an acute care facility with the diagnoses of Dysphagia, Respiratory Failure (not enough oxygen in the body for survival, Pneumonia (infection of one or both lungs), DM, Dementia, and Anxiety (a chronic inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>During a review of Resident 18's MDS section C dated 4/19/24, the MDS section C indicated Resident 18 had a BIMS score of 0 which indicated Resident 18 had severe cognitive impairment.</p> <p>During a review of Resident 27's AR dated 7/12/24, the AR indicated, Resident 27 was admitted on [DATE] from an acute care facility with the diagnoses of Pyelonephritis (kidney infection), Dysphagia, muscle weakness, pressure ulcer to the right hip, anemia (low number of red blood cells), Peripheral Vascular Disease (PVD - the reduced circulation of blood to a body part other than the brain or heart), COPD, and Hemiplegia (total paralysis) of right side.</p> <p>During a review of Resident 27's MDS section C dated 4/23/24, the MDS section C indicated Resident 27 had a BIMS score of 9 which indicated Resident 27 had moderate cognitive impairment.</p> <p>During a concurrent observation and interview on 7/9/24 at 11:07 a.m. with Resident 27 in Resident 9,18, and 27's room, the walls were painted light green. On the wall closest to the door, there was an approximately 3 foot (unit of measure), by 2 foot section with chipped and missing paint exposing the white surfacepaint under the green paint. Resident 27 stated, if he was at his house, he would have painted the wall a long time ago.</p> <p>During an interview on 7/10/12 at 9:12 am with the Maintenance Supervisor (MAINS), the MAINS stated the missing paint from the bedroom wall did not provide a homelike environment for the residents, and the wall should have been painted and the peeling paint removed.</p> <p>During an interview on 7/12/24 at 2:36 p.m. with the Administrator (ADM), the ADM stated, the missing paint on the wall did not provide a homelike environment for the three residents in the room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled Homelike Environment, dated 1/2018, indicated . 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, home like setting. These characteristics include: a period clean, sanitary, and orderly environment .</p> <p>During a review of the facility's Maintenance Director job description, dated 10/19/2015, the job description indicated, . the maintenance director is responsible for the overall maintenance operation of the center, and he/she is responsible for performing repairs and maintenance on equipment .</p> <p>Responsibilities/Accountabilities 1. Performs overall supervision of the maintenance department including hands on performance of maintenance and repair work . 3. maintains the building and grounds in compliance with federal, state, and local laws . 15. performs other responsibilities, as may be required, and as directed by the administrator . 20. performs other duties as requested .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899</b></p> <p>Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for 5 of 16 sampled residents (Residents 1, 16, 26, 69, and 127) when:</p> <ol style="list-style-type: none"> <li>Residents 69 and 127's care plan did not have an individualized care plan developed and implemented for Activities of Daily Living (ADL).</li> </ol> <p>This failure had the potential for Residents 69 and 127 ADL needs to not be met.</p> <ol style="list-style-type: none"> <li>Residents 1, 16, and 26 did not have an individualized care plan developed and implemented to ensure they got out of bed.</li> </ol> <p>This failure had the potential to cause Residents 1, 16, and 26 to develop pressure ulcers (areas of damaged skin and tissue caused by sustained pressure that reduces blood flow to areas of the body).</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>During a review of Resident 69's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 7/11/24, the AR indicated, Resident 69 was admitted from acute hospital on 4/16/24 to the facility, with diagnoses that included Cerebrovascular Disease (CVA, stroke), Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), Anemia (low in iron), Muscle Weakness, Hemiplegia (weakness on one side of the body), Difficulty in Walking, and Dependence on Supplemental Oxygen.</li> </ol> <p>During a review of Resident 69's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 4/19/24, the MDS indicated Resident 69's Cognitive Skills for Daily Decision Making score was 3, indicating his cognitive ability was severely impaired (0 - Independent, 1 - Modified Independence, 2 - Moderately Impaired, and 3 - Severely Impaired).</p> <p>During an observation, on 7/9/24, at 3:25 p.m., inside Resident 69's room, Resident 69 was observed in bed, awake, and receiving continuous supplemental oxygen at 2 Liters per minute. One female direct care staff was observed providing personal care to Resident 69.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/10/24, at 9:52 a.m., with Registered Nurse (RN) 1, Resident 69's care plan was reviewed. Resident 69's care plan stated, . The resident has an Activities of Daily Living (ADL) Self Care Performance Deficit related to hemiplegia, Stroke . date initiated:4/17/24 . RN 1 reviewed Resident 69's ADL care plan interventions and stated there was no specific interventions created to address Resident 69's transfer assistance needs. RN 1 stated Resident 69 is not independent with ADLs and requires one staff to assist during transfer from bed to chair and vice versa. RN 1 stated the facility failed to follow the policy on care planning, and potentially placed Resident 69 at risk for fall or injury.</p> <p>During a review of Resident 127's AR, dated 7/11/24, the AR indicated, Resident 127 was admitted from acute hospital on 6/26/24 to the facility, with diagnoses that included Osteomyelitis, Type 2 Diabetes Mellitus, Hypertension, Cerebrovascular Disease, Anemia, Muscle Weakness, Dependence on Supplemental Oxygen, and Pressure Ulcer of Sacral Ulcer Stage 4 (open sore to the coccyx area, loss of skin tissue with exposed bone or muscle tissues).</p> <p>During a review of Resident 127's MDS, dated [DATE], the MDS indicated Resident 127's Cognitive Skills for Daily Decision Making score was 3, indicating her cognitive ability was severely impaired.</p> <p>During an observation, on 7/9/24, at 10:22 a.m., inside Resident 127's room, Resident 127 was observed in bed, with both eyes open, and receiving continuous supplemental oxygen at 2 Liters per minute. Resident 127 was unable to respond to simple questions and unable to follow simple commands.</p> <p>During an interview on 7/10/24, at 9:00 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 127 was bed bound and requires two staff to use a hoier lift and to transfer Resident 127, from bed to a chair and vice versa.</p> <p>During a concurrent interview and record review on 7/10/24, at 9:54 a.m., with RN 1, Resident 127's care plan was reviewed. Resident 69's care plan stated, . The resident has an Activities of Daily Living (ADL) Self Care Performance Deficit related to confusion, impaired balance . date initiated: 6/26/24 . RN 1 reviewed Resident 127's care plan interventions and stated there was no specific interventions created to address Resident 69's transfer assistance needs. RN 1 stated Resident 127 requires total assistance with ADLs and requires two staff to assist during transfer, from bed to chair and vice versa. RN 1 stated the facility failed to follow the policy on care planning, and potentially placed Resident 127 at risk for fall or injury.</p> <p>During a concurrent interview and record review on 7/12/24, at 11:40 a.m., with the DON, Residents 69 and 127's nursing care plans were reviewed. The DON stated Residents 69 and 127's ADL care plan should have been resident-specific and it was not. The DON stated the care plan drove resident care to ensure resident's care and wishes were being met. The DON stated the facility failed to follow the facility's policy and procedures related to care planning process. The DON stated the failure could potentially result to injury.</p> <p>During a review of the facility's document titled, Job Description: Registered Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Assessment and development of resident care plans .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered, dated 3/23, the P&amp;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 . The comprehensive, person-centered care plan will:</p> <p>a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain or maintain resident's highest practicable physical, mental, and psychosocial well-being . c. includes the resident's stated goals upon admission and desired outcomes .</p> <p>48424</p> <p>2. During a review of Resident 1's admission record (AR), dated 7/11/24, the AR indicated Resident 1 was admitted on [DATE]. Resident 1's diagnoses included: Alzheimer's (a brain disorder that slowly destroys memory and thinking skills), dysphagia (difficulty swallowing), and bipolar disorder (condition which causes extreme mood swings)</p> <p>During a review of Resident 16's AR, dated 7/11/24, the AR indicated Resident 16 was admitted on [DATE]. Resident 16's diagnoses included: chronic obstructive pulmonary disease (condition which makes it difficult to breathe), dementia (condition characterized by loss of memory, language, problem-solving and other thinking abilities), dysphagia, and bipolar disorder.</p> <p>During a review of Resident 26's AR dated 7/11/24, the AR indicated Resident 26 was admitted on [DATE]. Resident 26's diagnoses included: dementia, schizoaffective disorder (a mental health condition that is marked symptoms such as hallucinations and delusions), muscle weakness, and contractures (a permanent tightening of the muscles, tendons, or skin) of left and right knees.</p> <p>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 6/25/24, the MDS indicated Resident 1's Cognitive Skills for Daily Decision-Making score was 3, indicating her cognitive ability was severely impaired.</p> <p>During a review of Resident 16 MDS, dated [DATE], the MDS indicated Resident 16's Cognitive Skills for Daily Decision-Making score was 3, indicating her cognitive ability was severely impaired.</p> <p>During a review of Resident 26's MDS, dated [DATE], the MDS indicated Resident 26's BIMS score was 2 out of 15, indicating severe cognitive impairment.</p> <p>During an observation on 7/9/24 at 10:38 a.m. in Residents 1, 16 and 24's room, Residents 1, 16 and 24's were observed lying in bed.</p> <p>During a concurrent observation and interview on 7/11/24 at 2:24 p.m. with Certified Nursing Assistant (CNA) 2, in Residents 1, 16, and 26 room, Residents 1, 16, and 26 were observed laying in their beds. CNA 2 stated staff had not gotten Residents 1,16, and 26 out of bed all day. CNA 2 stated the residents also did not get up the day before on 7/10/24. CNA 2 stated she does not know why Residents 1, 16, and 26 have not gotten up out of bed. CNA 2 stated there were no nursing instructions or directions to get the residents up out of bed. CNA 2 stated the residents should get up because it's important to socialize with other residents and so they don't develop pressure sores.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 7/11/24 at 2:37 p.m. with Licensed Vocational Nurse (LVN) 3 in Residents 1, 16, and 26's room, Residents 1, 16, and 26 were observed laying in their beds. LVN 3 stated Residents 1, 16, and 26 don't get up every day. LVN 2 stated the residents get up to be showered twice a week but there was nothing care planned to get them up beyond that. LVN 3 stated Residents 1, 16, and 26 should be out of bed more so they don't develop pressure ulcers and can have a better quality of life.</p> <p>During a concurrent interview and record review on 7/11/24 at 2:34 p.m. with LVN 3, Resident 1's Clinical Record (CR) was reviewed. LVN 3 stated there was no documentation of attempts to get Resident 1 out of bed. LVN 3 stated there has never been communication or a plan to get Resident 1 out of bed. LVN 3 stated there was no care plan developed or implemented to ensure Resident 1 got out of bed. LVN 3 stated having an individualized care plan was important, so staff know the resident goals and what interventions were needed to reach those goals.</p> <p>During a concurrent interview and record review on 7/11/24 at 2:44 p.m. with LVN 3, Resident 16's CR was reviewed. LVN 3 stated there was no documentation of attempts to get Resident 16 out of bed. LVN 3 stated there has never been communication or a plan to get Resident 16 out of bed. LVN 3 reviewed Resident 16's care plan and stated there was no care plan developed or implemented to ensure Resident 16 got out of bed. LVN 3 stated a care plan should have been implemented to get Resident 16 out of bed so she would not develop pressure sores. LVN 3 stated having an individualized care plan was important, so staff know the resident goals and what interventions were needed to reach those goals.</p> <p>During a concurrent interview and record review on 7/11/24 at 2:50 p.m. with LVN 3, Resident 26's CR, undated, was reviewed. LVN 3 stated there was no documentation of attempts to try to get Resident 26 out of bed. LVN 3 stated there has never been communication or a plan to get Resident 26 out of bed. LVN 2 reviewed Resident 26's care plan and stated there was no care plan developed or implemented to ensure Resident 26 got out of bed. LVN 3 stated a care plan should have been implemented to try to get Resident 26 out of bed, so she does not develop pressure sores.</p> <p>During an interview on 7/11/24 at 3:29 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated nursing staff should have gotten Residents 1, 16, and 26 out of bed more often. The MDSC stated Resident 26 had violent behaviors and if it was too hard to get her up staff should have documented it. The MDSC stated Residents 1 and 16 did not have violent behaviors and should have been out of bed regularly. The MDSC stated getting resident out of bed was important because staying in bed could have caused skin breakdown.</p> <p>During an interview on 7/11/24 at 3:57 p.m. with the Activities Coordinator (AC), the AC stated Residents 1, 16 and 24 received room visits regularly but no efforts were in place to ensure they got out of bed. The AC stated Residents 1, 16, and 24 should be getting out of bed. The AC stated if the residents stayed in bed all day it could have ruined their mood and led to pressure ulcers. The AC stated individualized care plans would allow staff to be aware of what goals they need to work on for each resident. The AC stated it was important to have the residents out of bed because they would have been able to socialize with others and prevent pressure ulcers.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/12/24 at 10:08 a.m. with the Director of Staff Development (DSD), the DSD stated nursing staff should have gotten Residents 1, 16, and 26 out of bed more frequently. The DSD stated getting out of bed was important, so the residents do not get pressure ulcers and because it was important for their mental health.</p> <p>During an interview on 7/12/24 at 10:38 a.m. with the DON, the DON stated nursing staff should have attempted to get residents 1, 16, and 26 out of bed. The DON stated there should have been documentation on the attempts to get the residents out of bed in the progress notes. The DON stated there should have been a care plan implemented to ensure staff were getting the residents out of bed. The DON stated getting out of bed was important because Residents 1, 16, and 26 would have been able to get range of motion (activity aimed at improving movement in the arms or legs) exercises and it would help the lungs to not build up fluids and breathe better.</p> <p>During an interview on 7/12/24 at 11:41 a.m. with the Administrator (ADM), the ADM stated staff were not capturing or monitoring the trends of getting out of bed for Residents 1, 16, and 26. The ADM stated if nursing staff did get the residents out of bed it was not reflected in the documentation. The ADM stated Residents 1, 16 and 26 should have had interventions or goals in place to ensure staff get them out of bed.</p> <p>During a review of the facility's Certified Nursing Assistant job description, (undated), the job description indicated, the purpose of your job position is to provide each resident with routine daily nursing care in accordance with the residents assessment plan along with federal state, and local standards that govern the facility, and as directed by your supervisors . essential duties and responsibilities . proper lifting and transitioning residence from wheelchair to bed, bed to chair, etc . helping residents, sit, stand and walk . transporting residents to dining area parenthesis for meals and activities parentheses and returning them to their room . documentation/charting .</p> <p>During a review of the facility's Licensed Vocational Nurse job description, (undated), the job description indicated, the purpose of your job position is to provide each resident with routine daily nursing care in accordance with current federal, state, and local standards that govern the facility, and as directed by your supervisors . Essential duties and responsibilities accurate and detailed charting of resident progress notes .</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered, dated 3/23, the P&amp;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 . The comprehensive, person-centered care plan will: a. include measurable objectives and timeframes; b. describe the services that are to be furnished to attain or maintain resident's highest practicable physical, mental, and psychosocial well-being . c. includes the resident's stated goals upon admission and desired outcomes .</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424</b></p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards of practice for two of 26 sampled residents (Residents 4 and 16) when:</p> <ol style="list-style-type: none"> <li>1.No physician orders for oxygen were in place for Resident 4</li> <li>2.The physician orders for oxygen delivery rate were not followed for Resident 16</li> </ol> <p>These failures had the potential to cause Residents 4 and 16 to receive the incorrect amount of oxygen required for their individual needs.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 4's Admission Record (AR), dated 7/11/24, the AR indicated Resident 4 had been admitted on [DATE]. Resident 4's diagnoses included: chronic obstructive pulmonary disease (COPD-condition which makes it harder to breathe) and dependence on supplemental oxygen.</li> </ol> <p>During an observation on 7/9/24 at 9:51 a.m. Resident 4 was seen with an oxygen concentrator next to her bed.</p> <p>During a concurrent observation and interview on 7/10/24 at 8:32 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 4's room, Resident 4 was seen receiving oxygen via nasal cannula (tube which goes in the nose to deliver oxygen). CNA 3 stated Resident 4 received supplemental oxygen continuously. CNA 3 stated Licensed Vocational Nurses (LVN) were responsible for handling and providing the supplemental oxygen. CNA 3 stated an order was needed for a resident to receive oxygen. CNA 3 stated if an order was not present than the LVN would not be able to provide oxygen to a resident. CNA 3 stated It was important to have a doctor's orders in place for Resident 4 because she has COPD and may not get all the oxygen she medically needs.</p> <p>During a concurrent interview and record review on 7/11/24 at 9:48 a.m. with LVN 2, Resident 4's clinical record (CR) was reviewed. LVN 2 stated Resident 4 needed oxygen continuously due to her COPD. LVN 2 stated there were no physician orders in place for Resident 4's supplemental oxygen. LVN 2 stated there should have been a physician's order present for Resident 4's oxygen use. LVN 2 stated it was important to have proper physician orders in place so staff can deliver the correct amount of oxygen to Resident 4 and so no harm comes to her if she gets too much or too little.</p> <p>During an interview on 7/12/24 at 10:38 a.m. with the director of nursing (DON), the DON stated oxygen orders should have been in place before nursing staff administered oxygen. The DON stated the nurses should have checked the oxygen orders every shift. The DON stated it was important to verify if physician orders were in place because if the wrong amount of oxygen was delivered Resident 4 could have become dependent on the wrong amount of oxygen.</p> <p>During a review of the facilities policy and procedure (P&amp;P) titled, Oxygen Administration, dated 2/24, the P&amp;P indicated, . Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facilities policy and P&amp;P titled, Physician Orders, dated 11/23, the P&amp;P indicated, 1. Each resident must be under the care of a Licensed Physician . 2. A current list of orders must be maintained in chronological order . 3 . When recording orders for oxygen, specify, the rate of flow, route, and rationale .</p> <p>2. During a review of Resident 16's AR, dated 7/11/2016, the AR indicated Resident 16 was admitted on [DATE]. Resident 16 was admitted with a primary diagnosis of COPD.</p> <p>During an observation on 7/9/24 at 10:38 a.m. in Resident 16's room, Resident 16 was observed receiving three liters of oxygen per minute via a nasal cannula.</p> <p>During a concurrent observation and interview on 7/11/24 at 2:24 p.m. with CNA 2 in Resident 16's room, Resident 16 was receiving oxygen via nasal cannula at three liters per minute. CNA 2 stated LVN's were responsible for setting the oxygen at the appropriate rate. CNA 2 stated LVN's have to verify what the doctor's order states before they place oxygen on any resident. CNA 2 stated Resident 16 had COPD and she needed oxygen continuously to help her breath. CNA 2 stated it was important to follow the physicians order, so residents receive the correct amount of oxygen they need for their condition.</p> <p>During a concurrent interview and record review on 7/11/24 at 2:37 p.m. with LVN 3, Resident 16's CR was reviewed. The CR indicated, apply oxygen at two liters per minute. LVN 3 reviewed Resident 16's care plan, the care plan indicated to apply two liters of oxygen per minute per doctor's orders. LVN 3 stated Resident 16 was receiving three liters per minute and the doctor's orders for oxygen delivery rate were not followed. LVN 3 stated it was important to follow the doctor's order, so residents did not receive the incorrect amount of oxygen. LVN 3 stated since Resident 16 had COPD, delivering the wrong amount of oxygen could have caused her to retain carbon dioxide (waste product made by the body which needs to be released) and lead to her not being able to breathe.</p> <p>During an interview on 7/12/24 at 10:38 a.m. with the DON, the DON stated nursing staff did not follow the doctors order for the proper rate of oxygen delivery. The DON stated it was important to verify the physician orders every shift because the wrong amount of oxygen delivered could have made Resident 16 dependent on the incorrect amount. The DON stated if higher levels of oxygen were needed, staff should have contacted the doctor for an updated order.</p> <p>During a review of the facilities policy and procedure (P&amp;P) titled, Oxygen Administration, dated 2/24, the P&amp;P indicated, . Preparation 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration .</p> <p>During a review of the facilities policy and P&amp;P titled, Physician Orders, dated 11/23, the P&amp;P indicated, 1. Each resident must be under the care of a Licensed Physician . 2. A current list of orders must be maintained in chronological order . 3 . When recording orders for oxygen, specify, the rate of flow, route, and rationale .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41608</p> <p>Based on observation, interview, and record review, the facility failed to ensure food was stored and/or prepared in accordance with professional standards for food services safety for 71of 73 residents when:</p> <ol style="list-style-type: none"> <li>1. A plastic lid was discarded on the pantry shelf in the dry food storage area.</li> <li>2. No air gap (an unobstructed vertical space between the water outlet and the flood level of a fixture), under the food preparation sink.</li> <li>3. One canister of food in the dry food storage area and one box of food in the freezer had incorrect opened, use by and expiration dates.</li> </ol> <p>These failures put the residents at risk for food borne illness that could have eventually led to death.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a concurrent observation and interview on [DATE] at 9:36 a.m. with the Certified Dietary Manager (CDM), in the dry food storage area, a plastic lid was observed on pantry shelving. The CDM stated, .the lid should not be on the shelf with the dry food, there should be trash with the food .</li> </ol> <p>During a concurrent observation and interview on [DATE] at 9:39 a.m. with the CDM, in the dry food storage area, a canister of oatmeal was labeled received on [DATE], use by [DATE], and opened on [DATE]. The CDM stated the labeling was incorrect it could cause confusion and result in Residents receiving expired food.</p> <ol style="list-style-type: none"> <li>2. During a concurrent observation and interview on [DATE] at 9:48 a.m. with the CDM, in the facility's kitchen, the food preparation sink did not have an air gap. The CDM stated she did not know anything about air gaps, maintenance handles that.</li> </ol> <p>During a concurrent observation and interview on [DATE] at 9:16 a.m. with the Maintenance Supervisor (MAINS), in the facilities kitchen, the food preparation sink did not have an air gap. The MAINS stated the food preparation sink should have an air gap, air gaps are to prevent the back up of sewage and contamination of food.</p> <p>During an interview on [DATE] at 2:36 p.m. with the facilities Administrator (ADM), the ADM stated there should be an air gap under the food preparation sink and there was not one.</p> <ol style="list-style-type: none"> <li>3. During a concurrent observation and interview on [DATE] at 9:51 a.m. with the CDM, in the facility's freezer, a box of frozen mixed vegetables was labeled received on [DATE] and use by [DATE]. The CDM stated the labeling was confusing and did not match the use by date listed by the manufacturer.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 4:08 p.m. with the Registered Dietitian (RD), the RD stated, .mislabeling of food could lead to residents receiving expired foods, the food could not taste well or lead to the Residents becoming sick .air gaps are required under sinks used for preparation to prevent food contamination from back flow of sewage .).</p> <p>During a review of the facility's policy and procedure titled, Labeling and Dating of Food dated [DATE], indicated, .All food will be dated, labeled, and prepared for storage to prevent contamination, deterioration, and dehydration .</p> <p>During a review of the CDM job description [undated], the CDM job description indicated . checking food storage rooms . for regulatory compliance . Adhering to all dietary policies and procedures .).</p> <p>During a review of the Food Code U.S Food and Drug Administration, dated 2022, indicated, . .d+[DATE].13 Backflow Prevention, Air Gap. During periods of extraordinary demand, drinking water systems may develop negative pressure (when water flows in the opposite direction) in portions of the system. If a connection exists between the system and a source of contaminated (dirty) water during times of negative pressure, contaminated water may be drawn into and foul (to make dirty) the entire system. Standing water in sinks . and other equipment may become contaminated with cleaning chemicals or food residue .</p>		

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>41608</p> <p>Based on observation, interview and record review, the facility failed to follow their policy for garbage and refuse containers when the lids on two of two outside trash bins were left open.</p> <p>This failure had the potential to attracts animals, insects and pests which could lead to infestations, unsanitary conditions and the spread of disease.</p> <p>Findings:</p> <p>During an observation on 7/9/24 at 9:43 a.m. in the alley behind the facility, a large blue trash bin was observed to be uncovered, the lid of the trash bin was hanging on the back of the bin with the contents inside the bin exposed. A large grey trash bin had the lid propped open with an empty cardboard box.</p> <p>Two cats were at the bottom of the bins.</p> <p>During a concurrent observation and interview on 7/9/24 at 9:43 am with the Certified Dietary Manager (CDM), the CDM stated the trash bins should always be closed to prevent pests from getting into the trash.</p> <p>During a concurrent observation and interview on 7/10/24 at 4:08 p.m. with the Registered Dietitian (RD), the RD stated the trash bins should always be closed to prevent insect infestation.</p> <p>During a concurrent observation and interview on 7/10/24 at 11:30 a.m. with the Maintenance (MAINT), the MAINT stated, the lids to the garbage bins should always be closed. There are a lot of cats in the area and leaving the trash bins open will attract cats and other animals which could bring disease.</p> <p>During an interview on 7/11/24 at 10:30 a.m. with the Administrator (ADM), the ADM stated the trash bins should be closed.</p> <p>During a review of the facility's policy and procedure titled, Policy Statement dated 11/2023, the Policy Statement indicated, . The food service area is maintained in a clean and sanitary manner. 14. Garbage and refuse containers with lids (or otherwise covered).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899</b></p> <p>Based on observation, interview, and record review, the facility failed to maintain an effective infection control program when:</p> <ol style="list-style-type: none"> <li>1. One of 23 sampled residents' (Resident 4) oxygen concentrator (a device that concentrates the oxygen from the ambient air) was being used without a filter.</li> <li>2. Two of 23 sampled residents' (Residents 12 and 58) oxygen concentrator filters were found covered with lint and dust.</li> </ol> <p>These failures placed Residents 4, 12, and 58 at an increased risk to develop respiratory and healthcare-associated infections.</p> <p>Findings:</p> <p>1. During a review of Resident 4's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 7/11/24, the AR indicated, Resident 4 was readmitted from an acute care hospital on 5/10/24 to the facility, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Type 2 Diabetes Mellitus (abnormal levels of blood sugar), Hypertension (high blood pressure), Schizophrenia (is a serious mental disorder in which people interpret reality abnormally) and Dependence on Supplemental Oxygen.</p> <p>During a review of Resident 4's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 5/7/24, the MDS indicated Resident 4's Cognitive (mental) Skills for Daily Decision Making score was 1, indicating Moderate Independence with some difficulty in new situations (0 - Independent, 1 - Modified Independence, 2 - Moderately Impaired, and 3 - Severely Impaired).</p> <p>During a review of Resident 4's Order Summary Report (OSR), dated 7/11/24, the OSR indicated, . Order Summary . May have oxygen at 2L [Liters Per Minute, unit of measurement] via nasal cannula, continuous r/t (related) to COPD.</p> <p>During a review of Resident 4's Nursing Care Plan (CP), dated 6/29/24, the CP indicated, . The resident has Oxygen Therapy r/t COPD . Interventions . The resident has oxygen via nasal prongs at 2L continuously .</p> <p>During an observation on 7/10/24, at 9:30 a.m., in Resident 4's room. Resident 4 was sitting in her wheelchair and had an oxygen cannula (a device used to deliver supplemental oxygen) connected to an oxygen concentrator. The oxygen was being given at 2L/min continuously. The oxygen concentrator filter was operating without the filter installed.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview, on 7/10/24, at 12:05 p.m., in Resident 4's room with Registered Nurse (RN) 1, RN 1 looked at Resident 4's oxygen concentrator and stated the oxygen concentrator was operating without a dust filter and it should. RN 1 stated using the oxygen concentrator without a filter was not acceptable. RN 1 stated Resident 4's respiratory condition could worsen. RN 1 stated maintaining the cleanliness of oxygen concentrator was the responsibility of all staff.</p> <p>During an interview on 7/12/24, at 11:45 a.m., with the Director of Nursing (DON), the DON stated using an oxygen concentrator without a filter was not acceptable and could potentially cause residents to become ill. The DON stated the purpose of the oxygen concentrator was to improve resident's oxygen level. The DON stated residents using dirty oxygen concentrators could have respiratory infection such as Pneumonia (lung infection caused by bacteria) and Bronchitis (inflammation of the airways). The DON stated she expects the oxygen concentrator to be cleaned weekly and as needed for the safety and well-being of all residents receiving oxygen.</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Ensuring equipment is in good operating order . Following Infection and Control policies .</p> <p>During a review of the facility's document titled, Job Description: Registered Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Ensuring that all resident care rooms and treatment areas are clean and safe . Following Infection and Control policies .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Infection Control, dated 10/18, the P&amp;P indicated, . The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment . All personnel will be trained on our infection control policies and practices .</p> <p>During a review of the facility's P&amp;P titled, Oxygen Administration, dated 2/24, the P&amp;P stated, . Preparation . 3. Assemble the equipment and supplies as needed . Steps in the Procedure . Check the mask, tank, humidifier, etc., to be sure they are in good working order and are securely fastened .</p> <p>During a review of the facility's P&amp;P titled, Maintenance Service, dated 12/23, the P&amp;P stated, . 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . 4. Maintenance personnel shall follow the manufacturer's recommended maintenance schedule .</p> <p>During a review of the oxygen concentrator manual titled, [Brand X] Oxygen Concentrator User Manual, dated 11/09, the manual indicated, . Routine Maintenance. Cleaning the Cabinet Filter. CAUTION. DO NOT operate the concentrator without the filter installed. 1. Remove the filter and clean at least once a week depending on environmental conditions. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before installation .</p> <p>2. During a review of Resident 12's AR, dated 7/11/24, the AR indicated, Resident 12 was admitted from an acute care hospital on 6/3/24 to the facility, with diagnoses which included Congestive Heart Failure (CHF - weakness in the heart where fluid accumulates in the lungs), COPD, Muscle Weakness, Difficulty Walking, and Obesity (overweight).</p> <p>(continued on next page)</p>		

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  07/12/2024
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's Brief Interview for Mental Status (BIMS) score was 10 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).</p> <p>During a review of Resident 12's OSR, dated 6/3/24, the OSR indicated, . Order Summary . Oxygen 2 liter/min via Nasal Cannula continuously Dx. [Diagnosis]: COPD .</p> <p>During a review of Resident 12's CP, dated 6/29/24, the CP indicated, . The resident has Oxygen Therapy r/t CHF and COPD . Interventions . The resident has oxygen at 2 LPM [Liters Per Minute] via nasal cannula continuously .</p> <p>During a concurrent observation and interview on 7/9/24, at 10:40 a.m., with Resident 12, in Resident 12's room. Resident 12 had an oxygen cannula connected to an oxygen concentrator. The oxygen was operating at 2L/min continuously. The oxygen concentrator filter was covered with white and gray material. Resident 12 stated the dirty oxygen concentrator filter was not acceptable and she wanted the oxygen concentrator filter to be cleaned or replaced.</p> <p>During a concurrent observation and interview, on 7/10/24, at 12:15 p.m., in Resident 12's room with RN 1, RN 1 looked at Resident 12's oxygen concentrator and stated the oxygen concentrator filter was covered with lint and dust. RN 1 stated using a dirty oxygen concentrator was not acceptable. RN 1 stated Resident 12's respiratory condition could worsen. RN 1 stated maintaining the cleanliness of an oxygen concentrator was the responsibility of all staff.</p> <p>During a review of Resident 58's AR, dated 8/24/23, the AR indicated, Resident 58 was admitted from an acute care hospital on 5/10/24 to the facility, with diagnoses which included Malignant Neoplasm of Thyroid Gland (cancer of the thyroid with symptoms such as neck swelling, voice changes, and difficulty swallowing), Type 2 Diabetes Mellitus, and Hospice Care (end of life care, with focus on symptom management).</p> <p>During a review of Resident 58's MDS, dated [DATE], the MDS indicated Resident 58's BIMS score was 13 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact).</p> <p>During a review of Resident 58's OSR, dated 10/30/23, the OSR indicated, . Order Summary . May have Oxygen 2 to 4 liter/min as needed via Nasal Cannula for SOB [shortness of breath] or respiratory distress .</p> <p>During a review of Resident 58's CP, dated 10/30/23, the CP indicated, . Resident may have oxygen at 2 to 4 L/M for SOB or respiratory distress .</p> <p>During a concurrent observation and interview on 7/9/24, at 10:45 a.m., with Resident 58, in Resident 58's room. Resident 58 had an oxygen cannula connected to an oxygen concentrator. The oxygen was operating at 2L/min continuously. The oxygen concentrator filter was covered with white and gray material. Resident 12 stated the dirty oxygen concentrator filter was not acceptable.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview, on 7/10/24, at 12:20 p.m., in Resident 58's room with RN 1, RN 1 looked at Resident 58's oxygen concentrator and stated the oxygen concentrator filter was covered with lint and dust. RN 1 stated using a dirty oxygen concentrator was not acceptable. RN 1 stated Resident 58's respiratory condition could worsen. RN 1 stated maintaining the cleanliness of an oxygen concentrator is the responsibility of all staff.</p> <p>During an interview on 7/12/24, at 11:47 a.m., with the DON, the DON stated using a dirty oxygen concentrator was not acceptable and could potentially cause residents to become ill. The DON stated the purpose of the oxygen concentrator was to improve resident's oxygen level. The DON stated residents using a dirty oxygen concentrators could have respiratory infection such as Pneumonia or Bronchitis. The DON stated she expects the oxygen concentrator to be cleaned weekly and as needed for the safety and well-being of all residents receiving oxygen.</p> <p>During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Ensuring equipment is in good operating order . Following Infection and Control policies .</p> <p>During a review of the facility's document titled, Job Description: Registered Nurse, undated, the document indicated, . Essential Duties and Responsibilities . Ensuring that all resident care rooms and treatment areas are clean and safe . Following Infection and Control policies .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Infection Control, dated 10/18, the P&amp;P indicated, . The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment . All personnel will be trained on our infection control policies and practices .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Oxygen Administration, dated 2/24, the P&amp;P stated, . Preparation . 3. Assemble the equipment and supplies as needed . Steps in the Procedure . Check the mask, tank, humidifier, etc., to be sure they are in good working order and are securely fastened .</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Maintenance Service, dated 12/23, the P&amp;P stated, . 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . 4. Maintenance personnel shall follow the manufacturer's recommended maintenance schedule .</p> <p>During a review of the oxygen concentrator manual titled, [Brand X] Oxygen Concentrator User Manual, dated 11/09, the manual indicated, . Routine Maintenance. Cleaning the Cabinet Filter. CAUTION. DO NOT operate the concentrator without the filter installed. 1. Remove the filter and clean at least once a week depending on environmental conditions. 2. Clean the cabinet filter with a vacuum cleaner or wash in warm soapy water and rinse thoroughly. 3. Dry the filter thoroughly before installation .</p>		

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NAME OF PROVIDER OR SUPPLIER  Merced Nursing & Rehabilitation Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  510 West 26th 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)
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899</b></p> <p>Based on observation and interview during the survey period of 7/9/24 to 7/12/24, the facility failed to provide the minimum of at least 80 square feet per resident for rooms occupied by residents for two of 29 rooms (rooms [ROOM NUMBERS]), when the amount of usable living space was not adequate for residents.</p> <p>This failure had the potential for residents in rooms [ROOM NUMBERS] to not have reasonable privacy or adequate space.</p> <p>Findings:</p> <p>During an environmental tour with the Maintenance Supervisor (MAINTS) and the Maintenance Staff (MAINT), on 7/11/24, at 4:35 p.m., the inspection indicated the following rooms did not meet the minimum square footage as required by regulation. However, variations were in accordance with the particular needs of the residents. The residents had a reasonable amount of privacy. Closets and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents.</p> <p>These rooms were as follows:</p> <p>Room number(#) Square feet #Residents</p> <p>14 292 4</p> <p>17 289 4</p> <p>Recommend waiver to be continue in effect.</p> <p>-----</p> <p>Health Facilities Evaluator Supervisor Signature</p> <p>Date:</p>