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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health-Licensing and Certification during a RECERTIFICATION SURVEY. Representing the California Department of Public Health: 29470 RN HFEN, 39605 RN HFEN, 39982 RN HFEN, 40038 RN HFEN Capacity: 79 Census: 73 Sample: 37	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accommodate the needs for two of 37 sampled residents (Resident 60 and Resident 174) when: 1. Resident 60's call light was not within her reach when she needed assistance. This failure resulted in Resident 60's need for assistance not being met. 2. Resident 174's call light was not within her reach.	F 558	1) Resident #60, call light was immediately placed within reach by nursing staff. 2) Resident # 17, call light was immediately placed within reach by DSD. All residents have the potential to be affected but no others had call light without being within reach. DON, DSD and supervisors completed rounds immediately to ensure other patients where not affected.	9/10/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/29/2018

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 1 This failure had the potential to deny Resident 174's right to be be provided necessary assistance. Findings: 1. On 8/7/18 at 9:56 a.m., during an observation in Resident 60's room, Resident 60 called out for help five times. Resident 60 sat in her wheelchair at the foot of her bed. Resident 60's call light was clipped to the bed sheet at the head of the bed. Resident 60 stated, "I need help." On 8/7/18 at 10:00 a.m., during an observation and concurrent interview in Resident 60's room, Licensed Nurse (LN) 1 placed the call light in Resident 60's hands. LN 1 stated, "She should have her call light. They [staff] need to hook it to her. It was hooked on the bed." Resident 60 stated to use the call light, "you press the button." On 8/9/18 at 8:22 a.m., during an observation and concurrent interview in Resident 60's room, Resident 60 sat in her wheelchair with the call light clipped to her clothing on her shoulder. LN 2 stated the call light should not be on the bed if the resident is in the wheelchair. LN 2 stated, "I clip it on the wheelchair or on her with the call light button within her reach." LN 2 stated it was the responsibility of the staff to ensure call lights are within the residents' reach. LN 2 stated, "If they [residents] need help they can easily call for help... If they push the call light, then we come." LN 2 stated if the call light was not accessible to the resident for assistance, the resident could not call for help and, "We [staff] would not be able to meet their needs." On 8/9/18 at 8:29 a.m., during an observation and	F 558	3) Staff have been in serviced on insuring call lights are within reach during their room rounds, when passing the hallways and providing care. In-service for call lights was started on 8/21/2018 for all staff and is to be completed by 9/10/2018 by DSD and DON. Please see attached in service documents, enclosed lesson plan and P&P 4)Daily room rounds will be conducted by supervisory staff and report given to DON with DON to report during morning stand up meeting and monthly facility QAPI meeting to track and trend any deficient practice. To be completed by 9/10/2018. Department heads, shift supervisors, DSD & DON conduct daily room rounds to ensure call lights are within reach and report to DON during stand up each morning rooms found with deficient practice. Facility will track and trend rooms and staff with ongoing issues of call light's within reach.	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 2	F 558		

concurrent interview in Resident 60's room, Resident 60 sat in her wheelchair with the call light hanging on her shirt. Resident 60 stated, "I can reach the call light." Resident 60 stated if the call light was on her bed, she would not be able to reach it.

On 8/9/18 at 8:33 a.m., during an interview in Resident 60's room, Certified Nursing Assistant (CNA) 1 stated, "The call light should always be within the resident's reach. So if they need help, they can easily push the button." CNA 1 stated if the resident could not reach her call light, the staff would not know if the resident needed something. CNA 1 stated, "We [staff] will not be able to give them what they need"

On 8/9/18 at 8:49 a.m., during an interview, the Director of Staff Development stated, "We should be answering call lights timely and call lights should be within residents' reach ... If the resident is on the wheelchair, it should be in the residents reach, so that the resident can call us to ask for what she needed."

On 8/10/18 at 8:02 a.m., during an interview, the Director of Nursing (DON) stated the call light should be always be within reach for the resident so the resident can call for any assistance. The DON stated, "If they [residents] are in need of immediate help then we cannot fulfill their needs if call light is not within their reach."

Resident 60's Minimum Data Set (MDS) assessment (a resident tool used to identify resident care needs) dated 7/8/18, indicated a Brief Interview for Mental Status (BIMS) score (an assessment of cognitive status) of 11 points out of 15 possible points which indicated Resident 60

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 3	F 558		

was cognitively intact.

Resident 60's care plan revised on 4/28/18, indicated the resident was at risk for falls related to balance problems... "Be sure the resident's call lights is within reach and encourage the resident to use it for assistance as needed..."

2. Resident 174's "facesheet" (a document with personal identifiable information) indicated the medical diagnoses of nontraumatic intracerebral hemorrhage (bleeding inside the brain) and hemiplegia (complete paralysis of half of the body) and hemiparesis (weakness of one entire side of the body) affecting the left side of the resident's body.

Resident 174's Minimum Data Set (MDS) Assessment (an assessment of a resident's functional and cognitive status), dated 7/30/18, indicated Resident 174's Brief Interview for Mental Status (BIMS)(an assessment of a resident's cognitive status) score was 3 out of 15 which indicated the resident was cognitively impaired. Under MDS section B for ability to understand others, Resident 174 is usually able to understand verbal content.

Resident 174's MDS section G for functional limitation in range of motion, dated 7/30/18, indicated Resident 174 had upper and lower extremity impairment on one side. Resident 174's care plan dated 7/19/18, indicated "[Resident 174] is at risk for falls...r/t [related to] decreased strength & [and] functional ability d/t [due to]...left side hemiparesis..."

On 8/7/18 at 2 p.m., during an observation and concurrent interview in Resident 174's room,

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 4	F 558		

Resident 174 was laying on her back with the call light attached to the fitted sheet at the head of her bed. Resident 174 attempted to use the call light and was unable to locate the call light. Certified Nursing Assistant (CNA) 3 stated she clipped the call light to the right side of the bed because the call light tend to fall behind the resident and fall off the bed. CNA 3 stated the call light should be in reach of the resident to be able to use.

On 8/8/18 at 7:51 a.m., during an observation and concurrent interview in Resident 174's room, the call light was hanging off the bed frame at the head of her bed. Resident 174 stated she was unable to to locate the call light.

On 8/8/18 at 8:06 a.m., during an observation and concurrent interview in Resident 174's room, the Director of Staff Development (DSD) retrieved and repositioned the call light which was hanging on the head of the bed frame. The DSD stated the clip on the call light was not attached to the bed sheet. The DSD clipped the call light to the right side of the bed sheet next to Resident 174.

Resident 174's care plan dated 7/19/18, indicated "...Be sure the resident's call light is within reach and encourage (The resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance..."

The facility policy and procedure titled, "Answering the Call Light" dated 10/10, indicated "The purpose of this procedure is to respond to the resident's requests and needs... 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident..."

The facility policy and procedure titled, "Quality of

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 558	Continued From page 5 Life - Accommodation of Needs" dated 8/9, indicated "... The resident's needs... shall be accommodated to the extent possible... Staff shall interact with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication, and maintains dignity..."	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		9/10/18

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a clean, safe, comfortable and homelike environment for three of 37 sampled residents (Resident 2, Resident 32 and Resident 70) when urinals were hanging from the top edge of each resident trash can. This failure resulted in an unsanitary environment and possibly could negatively residents' highest practicable well-being. Findings: On 8/7/18 at 11:00 a.m., during an observation in Resident 2, Resident 32 and Resident 70's room, empty urinals were hanging on the edge of each resident's trash can located at the side of each bed. On 8/7/18 at 1:25 p.m., during an observation and concurrent interview, Licensed Nurse (LN) 3 stated it was not a good practice to hang residents' urinals on the trash can because it caused infection or cross contamination. On 8/7/18 at 7:38 a.m., during an interview,	F 584	1) Residents 2, 32 & 70 urinals where immediately removed from the trash cans by the nursing staff. 2) Any resident using urinal have the potential to be affected, but no other's have urinals placed at the edge of trash can. 3) Facility purchased bedside urinal holders and placed them immediately at bedside with easy access. DSD will monitor all new residents or those residents who's functioning level has changed to ensure urinal holders are placed on the bed. MDS to notify DSD of any function changes to current residents that would require a urinal and need for a bedside holder. 4) Staff have been in serviced to the location of urinal holders and availability for new residents. In services where initiated on 8/21/2018 for all nursing staff by DSD and DON.	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 7 Certified Nursing Assistant (CNA) 2 stated its not a good practice to hang resident urinals inside resident trash cans. On 8/8/18 at 8:05 a.m., during an interview, LN 4 stated it was not a good practice to hang urinals on resident trash cans. On 8/9/18 at 10:10 a.m., during an interview, the Director of Nursing (DON) stated that trash cans were dirty and it was not a good practice to hand urinals from resident trash cans. 8/10/18 at 8:30 a.m., during an interview, the DON stated that the facility did not have a policy and procedure on storage of urinals. Resident 32's Minimun data set (MDS) (A resident tool used to identify resident care needs) dated 5/31/18, indicated Resident 32's cognitive status score was 3 out of 15 which indicated Resident 32 had severe cognitive impairement. Resident 2's MDS assesment dated 8/2/18, indicated the cognitive status was 3 out of 15 which indicated severe cognitive impairement. Resident 70's MDS assesment dated 6/6/18, indicated the cognitive status was 3 out of 15 which indicated severe cognitive impairement.	F 584	5) DSD will report to QAPI any identified issues of missing bedside urinal holders as well as usage of these holders. Will track usage and need for facility ordering of more units.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		9/10/18

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 8 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a comprehensive care plan	F 656	1) Resident #69's care plan was immediately addressed and updated	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 9 for one of 37 sampled residents (Resident 69) when a care plan for psychotropic (affecting mental activity, behaviors, and perceptions) medication had no resident specific targeted behaviors identified for monitoring. This failure had the potential for the resident not to receive the appropriate plan of care for the use of psychotropic medication. Findings: Resident 69's "facesheet" (a document with personal identifiable information) indicated a medical diagnosis of major depressive disorder (a disorder characterized by feelings of prolonged unexplained sadness). Resident 69's record titled "MEDICATION ADMINISTRATION RECORD" dated 8/1/18-8/31/18, indicated "...Citalopram (a medication used to treat depression)...40 MG [milligrams](unit of measurement) Give 1 tablet by mouth one time a day for Depression m/b [manifested by] self isolation..." Resident 69's care plan dated 7/12/18, indicated "...[Resident 69] uses antidepressant medication (Citalopram 40mg) r/t [related to] Depression..." There was no indication of Resident 69's specific targeted behaviors. On 8/9/18 at 1:32 p.m., during an interview and concurrent record review, Licensed Nurse (LN) 5 was unable to find Resident 69's specific targeted behaviors in the care plan. LN 5 stated the care plan for Resident 69 is incomplete. LN 5 stated the nurses were responsible for completing the documentation for the resident's plan of care.	F 656	reflecting appropriate target behavior of social isolation m/b keeping to himself and staying in room r/t use of antidepressant medication by Licensed Nurse. 2) All other resident's had the potential to be affected but no other's where identified to be affected. MDS, Social Services and DON reviewed all other residents to ensure proper targeted behaviors are being monitored 3) Licensed Staff have been in serviced on ensuring appropriate target behaviors for the use of psychotropic medications are added to the care plan on 8/21/2018 by DON. 4) MDS Nurse will review upon completion of comprehensive assessment monthly and correct any identified issues during her audit and report to monthly QAPI meeting any deficient practices and need for follow up in-services. QAPI will track and trend identified issues and Charge Nurses needing education with care plans.	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10 On 8/9/18 at 3:21 p.m., during an interview and concurrent record review, the Director of Nursing (DON) and LN 4 reviewed the care plan for the Resident 69's psychotropic medication. LN 4 stated they were aware the resident has the behavior of staying in his room and keeping to himself, but it is not documented in the care plan. The DON stated the behavior should be documented in the care plan. The DON stated the care plan should have been individualized to the resident's behaviors. The DON stated nurses were responsible in completing the resident's care plans. The facility policy and procedure titled "Care Plans- Comprehensive" dated 9/10, indicated "...An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas..."	F 656		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and	F 761		9/10/18

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 11 Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the safe storage and labeling of medications when: 1. One of two medication refrigerators had an internal temperature of 20 degrees Fahrenheit (F - scale of temperature) against the facility policy of between 36 degrees and 46 degrees F. 2. An opened medication bottle, Lactulose (a medication used to treat constipation), did not indicate an open date. These failures had the potential for residents to receive potentially unsafe medications. Findings: 1. On 8/9/18 at 8:08 a.m., during an observation, interview, and record review in the memory care unit medication room, the Director of Nursing (DON) and Licensed Nurse (LN) 6 opened the medication storage room in station two. LN 6 opened the locked refrigerator and stated the	F 761	A) 1) Medications where immediately removed from compromised refrigerator by DON and where immediately reordered from pharmacy. Medication's where destroyed according to facility policy. 2)New temperature log was created to reflect all shifts and times. Compromised refrigerator was replaced on he same day. Licensed staff was in serviced by DON on 8/21/2018 on new temperature log and monitoring every shift. Also educated to report any discrepancies to maintenance/ supervisor. 3) No residents where affecting by incident because all medication where removed immediately and destroyed. 4) Supervisor/ Maintenance will monitor temperature log daily and report any	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 12 refrigerator temperature was 20 degrees Fahrenheit. LN 6 reviewed a document titled "TEMPERATURE LOG" dated 8/2018. LN 6 stated the refrigerator temperature should be between 36 degrees to 46 degrees Fahrenheit. The temperature log did not have the time when the refrigerator was last checked. LN 6 stated she does her temperature checks at the beginning of her shift. LN 6 stated she had already checked the refrigerator today and the temperature was at 36 degrees Fahrenheit. LN 6 was unable to find the time she checked the refrigerator. LN 6 stated the medications in the refrigerator could freeze at a temperature of 20 degrees Fahrenheit. On 8/9/18 at 8:15 a.m., during an observation and concurrent interview in the memory care unit medication room, the DON stated the medication refrigerators are checked at the beginning of the shift. The DON removed the medications from the refrigerator and stated all the medications were sealed. The DON reviewed the medications that were in the refrigerator. There was one unopened insulin (medication used to treat high blood sugar) box for Resident 54, one unopened insulin box for Resident 7, an open box of 26 individually wrapped bisacodyl (medication used to relieve constipation) suppositories (solid dosage form of medication administered through the anus), and an emergency kit (e-kit - a storage supply containing a variety of medications for immediate and emergent situations) had the following medications: Item 1: Lorazepam ([redacted])(a medication used to treat anxiety)(disorder characterized by feelings of excessive worry, that can interfere with one's daily activities) 2 mg/ml (milligram/milliliter - units of measurement) injection vial with a quantity of	F 761	discrepancies to the DON and review during monthly QAPI meeting. B) 1)Lactulose was immediately removed from the cart by Licensed Nurse and reordered from pharmacy. New bottle was appropriately labeled upon opening. 2)No other residents where affected by this practice. 3) Licensed staff was educated on facility policy of labeling medication once it is opened on 8/21/2018 by DON. 4) Nursing staff will monitor daily for appropriate labeling of medications. Any discrepancies will be reported to DON. DON will report any labeling discrepancies during monthly QAPI meeting.	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 13 two (1) ml vials. Item 2: Glarine Insulin ([redacted] - a medication used to treat high blood sugar) 100 units/ml with a quantity of one 3-ml vial. Item 3: Isophane Insulin (NPH - a medication used to treat high blood sugar) 100 units/ml with a quantity of one 3-ml vial. Item 4: Regular Insulin ([redacted]) 100 units/ml with a quantity of one 3-ml vial. Item 5: Lispro Insulin ([redacted]) 100 unit/ml with a quantity of one 3-ml vial. Item 6: Prochlorperazine ([redacted] - a medication used to control severe nausea and vomiting) 25 mg suppository with a quantity of two suppositories. Item 7: Promethazine ([redacted] - a medication used to treat or prevent nausea and vomiting from illness or motion sickness) 25 mg suppository quantity two suppositories On 8/10/18 at 9:45 a.m., during a phone interview, the pharmacy consultant (PC) stated some medications can be held at a lower temperature depending on the packet insert of the medication. The PC stated it depends on the time the medication was held at the temperature. The PC stated he checks the refrigerator logs and the refrigerator temperatures when he visits the facility. On 8/10/18 at 10:20 a.m., during a phone interview, the PC stated there was a potential for the medications in the refrigerator to freeze at the	F 761		

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 14	F 761		

20 degrees Fahrenheit. The PC stated the nurses should not use the medications and should follow the facility policy and remove the medications from the refrigerator and destroy the medications per policy.

The facility policy and procedure titled "Storage of Medications" dated 4/07, indicated "...The facility shall store all drugs and biologicals in a safe, secure, and orderly manner...2. The nursing staff shall be responsible for maintaining medication and storage AND preparation areas in a clean, safe, sanitary manner...4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..."

The pharmacy policy and procedure titled "MEDICATION STORAGE IN THE FACILITY" dated 4/08, indicated, "...K. Medications requiring "refrigeration" or "temperatures between 2 [degrees] C [Celsius] (36 [degrees] F [Fahrenheit]) and 8 [degrees] C (46 [degrees] F)" are kept in a refrigerator with a thermometer to allow temperature monitoring...."

2. Resident 31's record titled "MEDICATION ADMINISTRATION RECORD" dated 8/1/18-8/31/18, indicated "...Lactulose Solution 10 GM/15ML [gram/milliliter](unit of measurement) Give 30 ml by mouth three times a day for Constipation...Order Date 08/08/2018" The record reflects Lactulose was administered 8/8/18 at 5 p.m. and 8/9/18 at 8 a.m..

On 8/09/18 at 10:12 a.m., during a medication cart (med cart) observation, Licensed Nurse (LN) 5 obtained a medication bottle from med cart 3. LN 5 stated the medication bottle is Lactulose for

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15 Resident 31. LN 5 stated the seal was broken on the cap of the medication. LN 5 stated the medication was opened. LN 5 stated the medication did not have an open dated on the label. LN 5 stated she gave the medication this morning and it was given yesterday. LN 5 stated the nurses were suppose to put the open dates on medications. On 8/09/18 at 10:25 a.m., during an interview, the Director of Nursing (DON) stated it is the facility practice to label any medications with an open date to ensure the medication is not old. The facility policy and procedure titled "Labeling of Medication Containers" dated 4/07, indicated "...3. Labels for individual drug containers shall include all necessary information, such as: ...f. The date that the medication was dispensed..."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		9/10/18

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 16 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to prepare, store, and serve food in accordance with professional standards for food safety when: 1. The ice machine had a yellow biological substance on the front shield of the evaporator (part where the ice cubes were formed) and water trough (receptacle under the evaporator that collects water to make ice). 2. A 14-day old package of romaine lettuce was in one of two kitchen refrigerators available for use beyond the two to seven day use-by date. These failures resulted in unsafe food handling practices which placed the residents at risk of contracting foodborne illness. Findings: 1. On 8/7/18 at 7:41 a.m., during an observation of the ice machine, located on station one hallway, and concurrent interview, the Maintenance Supervisor (MS) opened the top front panel cover of the ice machine and turned it off for inspection. There was thick, slimy yellow substance covering the base of the front evaporator shield and the water trough. The MS stated, "I don't know what it [yellow matter] is... It [ice machine] is being cleaned every 3 months." On 8/7/18 at 8:01 a.m., during an observation by the kitchen hallway and concurrent interview, the	F 812	A) 1) Ice machine was immediately taken out of service. Facility purchased ice from an outside source. 2) All residents had the potential to be affected however no residents where affected by the practice. 3) Ice machine was serviced and cleaned on 8/9/2018 by an outside contractor. Maintenance/Dietary staff will monitor the ice machine weekly. If found with buildup or other issues will take machine out of service and contact service provider. 4) Maintenance/ Dietary staff will report monthly any abnormal findings of the ice machine and maintenance will provide during monthly QAPI. B) 1) Lettuce was immediately tossed out by Dietary Supervisor. 2) All residents had the potential to be affected however lettuce was not being served according to dietary menu. 3)Dietary staff to be provided with in service on use by dates and appropriate actions to take when food has passed the	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 17 Dietary Service Supervisor (DSS) was examining, touching and smelling the yellow substance on the white napkin (from the kitchen) used to wipe the inside of the ice machine. The DSS stated, "I don't know what it is. It is odorless... It is probably not okay to use the ice machine. I will tell the administrator. We will get petty cash and buy ice." On 8/7/18 at 8:04 a.m., during an interview, the Administrator (ADM) stated, "I don't know what it is [yellow substance]. I will make sure it [ice machine] gets cleaned." On 8/7/18 at 8:24 a.m., during an interview, the DSS stated, "I am going to grab some ice right now... We shut the ice machine down. The cleaning company will come on Thursday [8/9/18]." On 8/7/18 at 12:54 p.m., during an observation of the ice machine and a concurrent interview, the ice machine had residual slimy, yellow substance covering the base of the front evaporator shield and the water trough. The Registered Dietitian (RD) stated, "I do take a look at the ice machine monthly. I checked the inside a couple of months ago." The RD stated the maintenance supervisor opened the ice machine for her when she checked it. The RD stated, "It [ice machine] is not clean." On 8/7/18 at 1:11 p.m., during an interview, the MS stated, "I am not sure what it is. The cleaning company is coming on Thursday [8/9/18]... The recommended cleaning is every 6 months but we might have to adjust it [cleaning] to every month. I will take it up with the administrator." The Policy and Procedure for the Ice Machine	F 812	expiration date. To be done by Dietary Supervisor on 8/31/2018 4) DSS and RD to monitor weekly for use by dates. 5) Dietary supervisor to report to monthly QAPI DSS or RD's findings.	

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 18	F 812		

was requested from DSS and Social Services Director (SSD). On 8/7/18 at 1:25 p.m., SSD stated, "We don't have one."

On 8/9/18 at 9:00 a.m., during an interview, the MS stated, "I never opened it [ice machine] for the RD. The MS stated everybody used the ice from the ice machine. The MS stated, "It [ice] is probably not safe."

On 8/9/18 at 9:50 a.m., during an observation of the ice machine and a concurrent interview, the ice machine had residual dried yellow substance covering the base of the front evaporator shield and the water trough. The Refrigeration Technician (RT) stated, "It [yellow substance] is algae [water organisms] from the water... It is a bacterial growth in the water." The RT stated he used cleaner and sanitizer to clean the ice machine. The RT stated, "We clean it the best we can. After 2 months I don't know what happens and what it looks like... It [yellow substance] is bad."

On 8/9/18 at 9:57 a.m., during an interview, the DSS stated everybody used the ice from the ice machine, staff and residents. The DSS stated, "We do serve ice to the residents... We felt better not to use the ice to be on the safe side. Residents are more vulnerable. They could get sick."

On 8/9/18 at 11:27 a.m., during an interview, the RT stated, "This time it is severe. It wasn't like this the last time I came here... Its Algae - water related mold... They should check it every month and let me know... They don't check it. He [MS] relies on us[cleaning company]. I will discuss with my boss and give a recommendation to come

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 19 more often." On 8/9/18 at 1:58 p.m., during an interview, the MS stated. "I never touch it [ice machine]. I call him [RT] to come every 3 months." On 8/9/18 at 2:00 p.m., during an interview, the Director of Nursing (DON) stated she had never checked the ice machine. The DON stated, "I just clean the outside if there are ice on the floor." The DON stated she does not know what the contract was of the cleaning of the ice machine. On 8/9/18 at 2:06 p.m., during an interview, the Administrator (ADM) stated, "Nobody is responsible for checking the ice machine in between cleaning schedule. If the production of ice is not what it is supposed to be or if it is loud (unlike normal), they tell me and we call the company to check it." On 8/10/18 at 7:50 a.m., during an interview, the ADM stated, "There is no written contract with [Cleaning Company], just a service agreement. The maintenance supervisor just call them every 3 months." On 8/10/18 at 7:54 a.m., during an interview, the DON stated the staff and residents used the ice for drinks to make it cold. The DON stated the ice machine was shut off after the inspection. The DON stated, "We want to make sure that the ice is safe for consumption to the residents. I would not want the residents to consume unsafe ice." On 8/10/18 at 2:30 p.m., the DSS provided the model number of the ice machine - [redacted].	F 812		

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 20	F 812		

The facility provided Ice Machine Manual Instructions titled, "Section 4 Maintenance" indicated "... Clean and sanitize the ice machine every six months for efficient operation. If the ice machine requires more frequent cleaning and sanitizing, consult a qualified service company... Ice machine sanitizer disinfects and removes algae and slime..."

The professional standard, "Food Code U.S. Public Health FDA [Food and Drug Administration]...2017" indicated, "...3-202.16 Ice. Ice for use as a food or a cooling medium shall be made from DRINKING WATER"...3-304.11 Food Contact with Equipment and Utensils. FOOD shall only contact surfaces of (A) EQUIPMENT and UTENSILS that are cleaned as specified under Part 4-6 of this Code and SANITIZED as specified under Part 4-7 of this code...4-602.11...(A) EQUIPMENT FOOD-CONTACT SURFACES...shall be cleaned...in equipment such as ice bins...(a) At a frequency specified by the manufacturer of (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold... 4-702.11...FOOD CONTACT SURFACES of EQUIPMENT shall be sanitized before use after cleaning..."

The facility policy and procedure titled, " Food Preparation and Service" dated October 2017, indicated "Food and Nutrition services employees shall prepare and serve food in a manner that complies with safe food handling practices..."

The facility policy and procedure titled, "Preventing Foodborne Illness - Food Handling" dated July 2014, indicated "... Food will be stored, prepared, handled and served so that the risk of

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21	F 812		

foodborne illness is minimized... 1. This facility recognizes that critical factors implicated in foodborne illness are... c. Contaminated equipment; and d. Unsafe food sources..."

2. On 8/07/18 at 7:10 a.m., during an observation and concurrent interview in the kitchen, there were two refrigerators in the kitchen. One refrigerator had romaine lettuce dated 7/24/18. The Dietary Service Supervisor (DSS) stated the date written on the bag of romaine lettuce was the date it (romaine lettuce) went in the refrigerator. The DSS stated, "It is 2 weeks old. It is still good."

On 8/07/18 at 1:20 p.m., during an interview and concurrent record review, the Registered Dietitian (RD) reviewed the "Suggested Refrigerated Storage Guidelines". The RD stated the lettuce fell under "all other vegetables". The RD stated, "The lettuce is good for 2-7 days."

On 8/09/18 at 10:07 a.m., during an interview, the DSS stated, "I monitor for expiration, I check all refrigerators and freezers every Monday... The lettuce was past the use-by date. Use-by date is new for me. The guidelines says 2 to 7 days, it was a week past the use-by date." The DSS stated the lettuce could potentially cause foodborne-illness if fed to the residents.

On 8/09/18 at 2:21 p.m., during an interview, the Dietary Cook (DC) stated the DSS checked the expiration dates of food items in the kitchen. The DC stated, "The lettuce (romaine) is good for 3 days ... Two week old lettuce is not good anymore. It is too old." The DC stated the residents could have upset stomach or get sick from eating expired or old food.

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	510 WEST 26TH STREET MERCED, CA 95340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 22 The facility document titled. "SUGGESTED REFRIGERATED STORAGE GUIDELINES" dated 2012, indicated "... All other vegetables 2-7 days, based on quality..." The facility policy and procedure titled, "Food Receiving and Storage" dated July 2014, indicated, "... Foods shall be received and stored in a manner that complies with safe food handling practices ... 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)..."	F 812		
F 912 SS=B	Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii) §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by: Based on observation during the survey period 8/7/18 to 8/10/18, the facility failed to provide and maintain minimum square footage for each resident in two of 79 rooms. Findings: On 8/7/18 at 9 a.m., during initial observations, the following rooms failed to provide 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 was adequate. Bedside stands were available. There was sufficient room for nursing care and for resident ambulation. Wheelchairs and toilet facilities were accessible.	F 912	Facility requests waiver for resident's rooms 14 & 17.	8/24/18

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 _____	08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCED NURSING & REHABILITATION CTR	**510 WEST 26TH STREET MERCED, CA 95340**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 912	Continued From page 23	F 912		

The waiver will not adversely affect the health and safety of residents.

The waiver involves the following rooms:

Rm#	SQ. FT.	Number of Residents
14	292	4
17	289	4

Recommend waiver continue in effect.

_____
Health Facilities Evaluator Nurse Signature
Date

Request Waiver for above identified resident rooms.

_____
Administrator Signature Date