

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055979	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2024
NAME OF PROVIDER OR SUPPLIER  Franciscan Post-Acute Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3169 M Street Merced, CA 95348	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123</b></p> <p>Based on interview and record review, the facility failed to ensure residents were free from an unnecessary physical restraint (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to the resident's body; or cannot be removed easily by the resident; and or restricts the resident's freedom of movement or normal access to his/her body) for three of six sampled residents (Residents 2, 3 and 4) when Residents 2, 3 and 4 had wedge pillows (triangular pillow to elevate the body) intentionally placed under their mattresses, out of their reach, restricting the residents freedom of movement and prevented them from getting out of bed.</p> <p>This failure violated Resident 2, 3 and 4 ' s rights to be free from physical restraints and placed them at risk for a decline in physical functioning and falls.</p> <p>Findings:</p> <p>During an observation on 8/29/24 at 11:08 a.m. with Resident 2, Resident 2 was lying in bed, the left side of the bed up against the wall and the right side of the mattress had an object under the sheet which tilted the mattress to the left. Resident 2 ' s movement was restricted by the position of the mattress.</p> <p>During a concurrent observation and interview on 8/29/24 at 11:11 a.m. with CNA 1, in Resident 2 ' s room, CNA 1 pulled up Resident 2 ' s bed sheet and uncovered a black wedge pillow under the mattress causing the resident to roll to her left side. CNA 1 stated Resident 2 had a history of falling and the wedge pillow restricted her movement to prevent falls. CNA 1 stated the wedge was placed under the mattress so Resident 1 could not reach and remove it.</p> <p>During a review of Resident 2 ' s Admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis of atherosclerotic heart disease (a sticky substance called plaque builds up in the arteries and limits blood flow to the heart), atrial fibrillation (irregular and often very rapid heartbeat), dementia (loss of memory, language, problem-solving and thinking abilities) and unsteadiness on feet.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Residents 2 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 99 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment and 99 indicates the resident was unable to complete the assessment). The BIMS assessment indicated Resident 2 was not cognitively able to participate in the assessment.</p> <p>During an observation on 8/29/24 at 11:30 a.m. in Resident 3 ' s room, Resident 3 was observed in bed, the bed was against the wall on one side. A black wedge pillow was placed under his mattress turning him to the left, restricting his ability to get out of bed.</p> <p>During a review of Resident 3 ' s Admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis of epilepsy (chronic brain disorder causes recurrent seizures [sudden, uncontrolled burst of electrical activity in the brain]), contracture (permanent tightening of the muscles, tendons and skin causing the joints to become very stiff), difficulty in walking, and dementia.</p> <p>During a review of Residents 3 ' s Minimum Data Set assessment dated [DATE], indicated Resident 3 ' s Brief Interview of Mental status assessment scored 99. The BIMS assessment indicated Resident 3 was not cognitively able to participate in the assessment.</p> <p>During an observation on 8/29/24 at 11:34 a.m. in Resident 4 ' s room, Resident 4 was observed with two black wedge pillows under the right side of her mattress and causing the mattress to lean to the left. Resident 4 was attempting to sit up with her upper body off the mattress and tried to look out to the hallway which was to her right while calling out to staff in her native language. Resident 4 was unable to turn all the way to the right because the position of the mattress prevented her from getting out of bed.</p> <p>During a review of Resident 4 ' s Admission Record, undated, the admission record indicated, Resident 4 was admitted to the facility on [DATE] with diagnosis of Parkinson ' s Disease (movement disorder of the nervous system [nerve cells that controls the body ' s activities] that worsens over time), abnormalities of gait (manner of walking) and mobility, dementia, and difficulty in walking.</p> <p>During a review of Residents 4 ' s Minimum Data Set assessment dated [DATE], indicated Resident 4 ' s Brief Interview of Mental status assessment scored 99 The BIMS assessment indicated Resident 4 was cognitively not able to participate in the assessment.</p> <p>During a concurrent observation and interview on 8/29/24 at 11:37 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 2 ' s room, Resident 2 was lying in bed with a black wedge pillow under her mattress. LVN 1 walked into Resident 3 ' s room and Resident 3 was observed lying in bed with one wedge pillow under his mattress. LVN 1 walked into Resident 4 ' s room and two black wedge pillows were observed under the right side of the mattress. LVN 1 stated Residents 2, 3 and 4 had wedge pillows placed under their mattresses because they were high fall risks and the wedges kept them in bed to prevent falls. LVN 1 stated the staff put the wedge pillows under the mattress because they were out of the residents ' reach and prevented them from removing the pillow. LVN 1 stated the use of wedge pillows under the mattress could be considered restraints if the residents were unable to get out of bed.</p> <p>(continued on next page)</p>		

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<p>F 0604</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 8/29/24 at 11:50 a.m., Resident 2 ' s physician ' s orders for August 2024 were reviewed. LVN 1 stated she was unable to locate an order to place wedge pillows under the mattress for fall prevention. LVN 1 stated she was unable to locate a care plan intervention for the use of the wedge pillow under the mattress to prevent falls. LVN 1 reviewed Resident 3 ' s physician orders dated August 2024 and stated she was unable to locate an order to place wedge pillows under the mattress. Resident 3 ' s care plans were reviewed, LVN 1 stated she was unable to locate an intervention for the wedge pillow. LVN 1 reviewed Resident 4 ' s physician orders dated August 2024 and stated she was unable to locate an order for wedge pillows under the mattress. Resident 4 ' s care plans were reviewed and LVN 1 stated she was unable to locate any documentation for the wedge pillow as an intervention to prevent falls. LVN 1 stated the wedge pillows were being used as a fall prevention intervention, so they needed a physician ' s order and care plan.</p> <p>During an interview on 8/29/24 at 1:18 p.m. with Physical Therapy Assistant (PTA) 1, PTA 1 stated wedge pillows should not be placed under the mattress if the resident could not remove it themselves. PTA 1 stated a wedge pillow under the mattress increased a residents fall risk because the residents could try to climb over it and fall. PTA 1 stated the wedge pillows under the mattresses would take the residents freedom of mobility away and could be considered a restraint.</p> <p>During an interview on 8/29/24 at 1:30 p.m. with CNA 2, CNA 2 stated when the wedge pillows was placed directly under the resident, they could pull the wedge pillows out. CNA 2 stated the wedge pillows were placed under the mattress to prevent the resident from removing it and keep them in bed. CNA 2 stated the staff needed to keep the residents in bed, so they do not fall.</p> <p>During an interview on 8/29/24 at 1:43 p.m. with the Director of Nursing (DON), the DON stated wedge pillows should not be placed under the mattress because the residents could remove it. The DON stated if the residents were unable to move freely in bed it could be considered a restraint.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Freedom from Abuse, Neglect and Exploitation Physical Restraint, dated 11/2017, the P&amp;P indicated, . an environment that prohibits the use of physical restraints for convenience . or to inhibit a resident ' s freedom of movement . A physical restraint as any manual method, physical or mechanical device, equipment or material that meets all the following criteria . Is attached or adjacent to the resident ' s body . Cannot be removed easily by the resident . Restricts the resident ' s freedom of movement . the resident will be able to . remove the restraint or device intentionally . The review process will include assessment, monitoring, care planning by the IDT [Interdisciplinary Team- a team of healthcare providers who meet to plan resident care] .</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of a professional reference found at <a href="https://canhr.org/restraint-free-care/">https://canhr.org/restraint-free-care/</a> titled, Restraint-Free Care, dated 10/24/22, the reference indicated, . restraints are dangerous and often cause harm to nursing home residents . In most cases, nursing home use of restraints is a form of neglect or abuse . physical restraint is a device, item or practice that restricts a resident ' s freedom of movement . physical restraint as any manual method, physical or mechanical device . is attached or adjacent to the resident ' s body . Cannot be removed easily by the resident .Restricts the resident ' s freedom of movement . The way an item is used determines if it is considered a physical restraint . if they are used to restrict residents ' movement and residents cannot easily remove them . Other methods of restraint include moving a chair or bed against a wall so residents cannot get out . Restraints often cause incontinence, poor circulation, weak muscles . loss of mobility and increased illness . also diminish independence . Residents have the right to be free from involuntary seclusion and any physical restraint not required to treat the resident ' s medical symptoms .</p>