STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055979	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Post-Acute Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to ensure three of four sampled residents (Resident 1, 2 and 4) were free from abuse when: 1. Staff failed to separate Residents 1 and 2 immediately after an altercation on 12/25/24 at 3:00 p.m., then Resident 2 sat next to Resident 1 in the sunroom and scratched Resident 1 in the face while the CNA ' s back was turned. Residents 1 and 2 had a known history of verbal altercations with each other. This failure had the potential to cause both residents harm and emotional distress due to cognitive (pertaining to reasoning memory and judgement) impairments. 2. Staff did not provide adequate supervision for Resident 1 after the altercation on 12/25/24 at 3:00 p.m. to prevent an altercation between Residents 1 and 4 on 12/25/24 at 4:40 p.m. This failure resulted in Resident 1 biting Resident 4 on the shoulder and had potential for Resident 4 to be harmed and experience emotional distress. Findings: 1. During a concurrent observation and interview on 1/13/25 at 10:50 a.m. with Resident 2, Resident 2 was lying in bed dressed. Resident 2 stated she did not remember any altercations with another resident. Resident 2 was alert and confused. During a review of Resident 1 ' s Admission Record (AR), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities) and anxiety disorder (emotional state characterized by feelings of unease, worry, fear of apprehension). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Residents 1 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 03 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 ' s cognition was severely impaired. During a concurrent observation and interview on 1/13/25 at 10:53 a.m. with Resident 2 in her room, Resident 2 ' s privacy curtains were completely closed. Resident 2 was lying in bed, dressed. Resident 2 stated I want to sleep leave me alone. During a review of Resident 2 ' s AR, undated, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnosis of metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood), dementia, and anxiety disorder. During a review of Residents 2 ' s Minimum Data Set assessment dated [DATE], indicated Resident 2 ' s BIMS assessment scored 06 of 15. The BIMS assessment indicated Resident 2 ' s cognition was severely impaired. During a concurrent observation and interview on 11/13/25 at 10:56 a.m. with CNA 1, CNA 1 stated she was assigned to one-on-one supervision (1:1-to provide continuous observation of a resident) of Resident 2, to prevent confrontations between Resident 2 and the other residents. CNA 1 stated Resident 2 had a known history of going into other resident ' s rooms and getting close to them which upset the other residents. CNA 1 stated Resident 2 was able to move quickly and needed someone to stay with her. CNA 1 stated Resident 2 did not like other people close to her or loud noises and would become agitated (feeling of severe restlessness, crankiness or uneasiness). During an interview on 1/13/25 at 11:21 a.m. with CNA 2, CNA 2 stated Residents 1 and 2 had a history of not getting along with each other and the staff would try to keep them apart. CNA 2 stated Resident 1 was frequently agitated and would yell loudly which caused Resident 2 to become agitated. CNA 2 stated Resident 2 was on a 1:1 because she threatened to kill Resident 1. CNA 2 stated Resident 1 was frequently involved in verbal altercations in the memory care unit and staff would have to remove her from the situation because she was difficult to redirect. CNA 2 stated Resident 1 should have been on a 1:1 after the altercation because she would normally cause issues with the other residents when agitated. CNA 2 stated the process for resident-to-resident altercations was to immediately separate the residents and move them away from each other. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/13/25 at 11:41 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Nursing Note, dated 12/25/24 at 3:37 p.m. was reviewed, the note indicated, . [Resident 1] was walking to sit them in the sun room when [Resident 2] called her Ugly. [Resident 1] threw water on [Resident 2 ' s] face. [Resident 2] instantly got up and tried to hit her w/ [with] the walker. CNA tried to redirect to separate both of them, but [Resident 2] refused instead sat next to [Resident 1]. When [CNA] turned to move the table [Resident 2] reached [Resident 1] and scratch her cheek. [Resident 2] said I can kill her anytime. She lives close to me . Resident 1 ' s IDT (Interdisciplinary Team- involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident) note dated 12/26/24 was reviewed. The IDT note indicated, . The Interdisciplinary Team (IDT) met to review a resident-to-resident interaction incident occurring on 12/25/24 . Staff attempted to separate the ladies from each other but they both refused. The CNA turnedto [sic] move a table and the peer then reached over and made contact with [Resident 1] by scratching her face . IDT recommends: Monitoring [Resident 1] on q [every] 15 min [minute] behavior monitoring . Resident 2 ' s IDT note dated 12/26/24 indicated, . met to review a resident-to-resident interaction incident occurring on 12/25/24 . IDT recommendation: [Resident 2] was placed on q [every] 15 min [minute] monitoring. We will begin [Resident 2] on one-on-one monitoring . LVN 1 stated staff knew Residents 1 and 2 did not had issues with each other. LVN 1 stated Resident 1 would easily become agitated and get verbally aggressive and loud. LVN 1 stated, [Resident 2] does not like loud noised and it will set her off. LVN 1 stated Resident 1 would frequently cause verbal altercations with other residents, and she was not sure why Resident 1 was not placed on a 1:1 after the incident. LVN 1 stated Resident 2 was placed on a 1:1 because she threatened Resident 1. LVN 1 stated Resident 1 and 2 needed supervision when near each other because their behaviors were unpredictable. LVN 1 stated when there was an altercation between residents the most important thing was to move them away from each other immediately for safety. LVN 1 was unsure why Resident 2 was close enough to scratch Resident 1 after the initial altercation. LVN 1 stated the residents should have been separated after Resident 1 threw the water in Resident 2 ' s face and Resident 2 tried to hit her with the walker. During an interview on 1/13/25 at 1:50 p.m. with the Director of Nursing (DON), the DON stated Residents 1 and 2 had issues with each other prior to the altercation on 12/25/24. The DON stated on 12/25/24 at 3:00 p. m. Residents 1 and 2 had an altercation which started when Resident 2 called Resident 1 ugly, and Resident 1 threw water in her face. The DON stated Resident 2 tried to hit Resident 1 with her walker, but the staff intervened. The DON stated the staff was unable to redirect Resident 2 and she sat next to Resident 1, when the CNA turned their back Resident 2 scratched Resident 1 on the face. The DON was unable to explain why the CNA would turn their back on the residents during an altercation or why Resident 2 was able to sit next to Resident 1. The DON stated Resident 2 was placed on a 1:1 because she threatened to kill Resident 1 and was physically capable of harming her. During an interview on 1/13/25 at 3:25 p.m. with the Social Services Director (SSD), the SSD stated Residents 1 and 2 had an altercation on 12/25/24. The SSD stated Residents 1 and 2 have had verbal altercations with each other in the past. The SSD stated she was part of the IDT meeting on 12/26/24 regarding the incident. The SSD stated a CNA was present during the altercation and had stopped Resident 2 from hitting Resident 1 with her walker but turned their back on the residents to move a table and Resident 2 reached over and scratched Resident 1 ' s face. The SSD stated Resident 2 had stated she knew where Resident 1 lived and could kill her at any time, so the IDT placed Resident 2 on a 1:1 for Resident 1 ' s safety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 1/14/25 at 10:51 a.m. with Registered Nurse (RN) 1, RN 1 stated she was the charge nurse on duty on 12/25/24 during Resident 1 and 2 ' s altercation. RN 1 stated after Resident 1 threw the water at Resident 2, and Resident 2 swung her walker at Resident 1 staff attempted to direct Resident 2 to another chair, but she refused and sat next to Resident 1. RN 1 stated Resident 2 sat next to Resident 1 and when the CNA turned their back, she scratched Resident 1 on the face. Resident 2 told the CNA she could kill Resident 1 at any time. RN 1 stated the residents should not have been close enough for Resident 2 to scratch Resident 1 ' s face. RN 1 stated after an altercation, residents should be moved away from each other to prevent injury. During a telephone interview on 1/20/24 at 11:15 a.m. with CNA 6, CNA 6 stated she was the assigned CNA in the sunroom on 12/25/24 during Residents 1 and 2 ' s altercation. CNA 6 stated Resident 2 was in the sunroom and after the altercation started, she had tried to redirect Resident 2 to a chair away from Resident 1. CNA 6 stated she was unable to redirect Resident 2, and she insisted on sitting next to Resident 1 even though they were agitated with each other. CNA 6 stated she turned her back on the residents briefly and Resident 2 scratched Resident 1 ' s face while her back was turned. CNA 6 stated the process for resident-to-resident altercations was to separate the residents as soon as possible. 2. During an interview on 1/13/25 at 11:17 a.m. Resident 4 was unable to recall altercation with Resident 1 on 12/25/24. During a review of Resident 4 ' s Admission Record (AR), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis of senile degeneration of the brain (group of disorders that cause a gradual decline in cognitive function), anxiety disorder and pain. During a review of Residents 4 ' s Minimum Data Set assessment dated [DATE], indicated Resident 4 ' s BIMS assessment scored 03 of 15. The BIMS assessment indicated Resident 4 ' s cognition was severely impaired. During an interview on 1/13/25 at 11:21 a.m. with CNA 2, CNA 2 stated she was not working the PM shift on 12/25/24 during the altercations between Residents 1 and 2 and Residents 1 and 4. CNA 2 stated she was made aware of the altercations and the staff had been told Resident 2 was on a 1:1. CNA 2 stated Resident 4 was calm and she was surprised Resident 4 was involved in an altercation. CNA 2 stated, I think with that altercation, [Resident 4] was in the wrong place at the wrong time. CNA 2 stated after Resident 1 and 2 ' s altercation earlier in the day, Resident 1 should have been on a 1:1 because she would had a history of causing issues with the other residents when agitated. CNA 2 stated she had asked Resident 4 if she remembered what happened with Resident 1 and she did not remember the incident. CNA 2 stated the process for resident-to-resident altercations was to immediately separate the residents and move them away from each other. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/13/25 at 11:41 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 4 ' s IDT Note, dated 12/29/24 was reviewed. The IDT note indicated, . IDT met to review a resident-to-resident event occurring on 12/25/24. [Resident 4] stood up from a chair to adjust herself, she intended to sit back in chair. A female peer [Resident 1] went to sit in the same chair as [Resident 4] was sitting back down. The peer then lightly bit [Resident 4] on her left shoulder . Staff separate the two residents . Resident 1 ' s IDT note, dated 12/29/24, indicated, . resident-to-resident event occurring on 12/25/2024 . [Resident 1] lightly bit the peer on her shoulder . IDT recommendation: [Resident 1] was placed on 15-minute visual monitoring for 5 days . LVN 1 stated Resident 1 had two altercations on 12/25/24. LVN 1 stated Resident 1 had history of causing verbal altercations with other residents. LVN 1 was unsure why Resident 1 was unsupervised in the dining room after her earlier altercation with Resident 2. LVN 1 stated Resident 4 was calm and not usually involved in altercations. During an interview on 1/13/25 at 1:50 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had two altercations on 12/25/24, an hour and a half apart. The DON stated Residents 1 and 2 had an altercation at 3:00 p.m. and then Resident 1 bit Resident 4 on the shoulder around 4:40 p.m. The DON stated Resident 1 was placed on every 15-minute checks after the first altercation and she was unsure how Resident 1 was in the dining room unsupervised at 4:40 p.m. The DON stated the staff was aware Resident 1 required supervision when in the common areas and would watch her carefully when in close proximity of the other residents. The DON stated staff should have provided extra supervision for Resident 1 in the dining room since she had an altercation earlier in the day. During a telephone interview on 1/14/25 at 10:51 p.m. with Registered Nurse (RN) 1, RN 1 stated she was the charge nurse on duty during both resident altercations on 12/25/24. RN 1 stated Resident 1 had walked in the dining room and Resident 4 stood up from her chair to readjust, Resident 1 tried to sit in the chair Resident 4 was standing in front of. RN 1 stated Resident 4 started to sit back down, and Resident 1 also tried to sit in the chair and bit Resident 4 on the left shoulder. RN 1 stated after the altercation between Residents 1 and 2, she placed the residents on every 15-minute checks. RN 1 stated Resident 1 moved quickly, and staff was unable to intervene and prevent the altercation. RN 1 was declined to state if Resident 1 had enough supervision to prevent the second altercation. During a telephone interview on 1/20/24 at 11:15 a.m. with CNA 6, CNA 6 stated she was present during both of Resident 1 ' s altercations. CNA 6 stated after the first altercation, Resident 1 went to her room and the staff were monitoring her every 15 minutes. CNA 6 stated close to dinner time Resident 1 came into the dining room and tried to sit in Resident 4 ' s chair and bit her on the shoulder. CNA 6 stated none of the staff had predicted she would have another altercation. CNA 6 stated Residents 1 and 4 had never had issues with each other before. During a review of the facility ' s policy and procedure (P&P) titled Freedom from Abuse, Neglect and Exploitation, dated 11/2017, the P&P indicated, . Purpose . keep residents free from abuse, neglect, and corporal punishment of any kind by any person . facility will provide a safe resident environment and protect residents from abuse . Definition of abuse . willful infliction of injury . When the facility has identified abuse, the facility should take appropriate steps . protect residents from additional abuse immediately. This includes but is not limited to . Take steps to prevent further potential abuse . Resident to resident abuse . Cognitive impairment or mental disorder does not preclude a resident from being abusive . Facility will assess the resident and care plan interventions to address resident behaviors that may indicate a risk for abusive, aggressive interactions .