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	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franciscan Post-Acute Care Center	3169 M Street Merced, CA 95348

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered comprehensive care plan for one of six sampled residents (Resident 1) when: 1. Resident 1 was admitted to the facility with diagnoses of Type 2 Diabetes Mellitus (Type 2 DM- a disorder in which blood sugar or glucose levels are abnormally high) and licensed nursing staff did not develop an individualized care plan intervention to monitor Resident 1's blood glucose levels, from 5/4/25 to 5/18/25. This failure resulted in Resident 1 experiencing significant change in condition. On 5/18/25, Resident 1 was found with altered mental status (AMS- change in person's level of awareness, thinking, or behavior, a medical emergency requiring prompt evaluation and treatment), with a blood glucose level of 53 mg/dl (milligram per deciliters- unit of measurement), and requiring emergency transport to a higher level of care. Resident 1 was admitted to the hospital from [DATE] to 6/3/25. 2. Resident 1 was admitted to the facility with diagnoses of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) and licensed nursing staff failed to implement the nursing care plan interventions to monitor Resident 1's oxygen level according to the physician's order. This failure resulted in Resident 1 experiencing significant change in condition. On 5/18/25, Resident 1 was found with AMS, with an oxygen level of 86% (percent- unit of measurement), and requiring emergency transport to a higher level of care. Resident 1 was admitted to the hospital from [DATE] to 6/3/25. Findings: 1. During a review of Resident 1 ' s admission Record, dated 6/6/25, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Muscle Weakness, Hypertension (high blood pressure), Cervicalgia (neck pain) and Congestive Heart Failure (CHF- heart is unable to pump blood efficiently). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	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], the MDS indicated Resident 1 ' s Brief Interview of Mental status assessment (BIMS- assessment of cognitive status for memory and judgement) scored 15 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 was cognitively intact. During a concurrent interview and record review on 6/6/25, at 2:30 p.m. with Registered Nurse (RN) 1, RN 1 stated Resident 1 has a diagnosis of COPD, CHF and Type 2 DM. RN 1 confirmed she worked on 5/17/25 PM shift (afternoon shift, from 2:00 p.m. to 10:30 p.m.) and was the charge nurse for Resident 1. Resident 1's Nursing Note, dated 5/17/25 at 6:39 p.m. was reviewed. The note indicated, . Vital signs . BP (blood pressure) 139/60 - 5/17/25 15:57 (3:57 p.m.) . O2 (oxygen saturation- measure of how well oxygen is being transported throughout the body) 93% - 5/17/25 9:06 a.m . Oxygen via nasal cannula (NC-medical device that provides oxygen through a thin flexible tube with two prongs that fit into the nostrils) . Signed [RN 1] . RN 1 stated there was no documentation related to obtaining Resident 1's blood glucose levels every shift or daily, from admission [DATE]) to discharge (5/18/25). During a concurrent interview and record review on 6/6/25, at 2:33 p.m. with RN 1, Resident 1's Order Summary Report (OSR), dated 6/6/25 was reviewed. The OSR indicated, . Glipizide ER (medication to control Type 2 DM, use to lower blood glucose levels) Oral Tablet Extended Release 24 Hour 5MG (milligrams - unit of measurement). Give 1 tablet by mouth two times a day for DM type 2 . RN 1 stated Resident 1's record indicated he took the prescribed Glipizide from 5/4/25 to 5/17/25 twice a day. During a concurrent interview and record review on 6/6/25, at 2:37 p.m. with RN 1, Resident 1's Food Intake, dated 5/17/25 was reviewed. The Food Intake indicated, . 5/16/25 Breakfast - 51% to 75%, Lunch - Refused, Dinner - 51% to 75% . 5/17/25 Breakfast - Refused, Lunch - Refused, Dinner 51% to 75% . RN 1 stated Resident 1's intake from 5/16/25 to 5/17/25 were reduced compared to 5/15/25 (75% to 100%). During a concurrent interview and record review on 6/6/25, at 2:39 p.m. with RN 1, Resident 1's Diabetes Mellitus care plan dated 5/5/25 was reviewed. The care plan indicated, . Focus . [Resident 1] has Diabetes Mellitus, Glipizide ER Oral Tablet Extended Release 24 hour 5 MG . Interventions . Diabetes medication as ordered by doctor. Monitor/document effectiveness . Educate regarding medications and importance of compliance . RN 1 stated the careplan interventions should have been individualized to meet Resident 1's needs and it was not. RN 1 stated the care plan did not include a blood glucose check and hold glipizide administration during meal refusals. RN 1 stated taking glipizide without food intake could result to severe hypoglycemia (low blood sugar) and avoidable hospitalization. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	During a concurrent phone interview and record review on 6/12/25, at 8:45 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 has a diagnosis of COPD, CHF and Type 2 DM. LVN 1 confirmed she worked on 5/18/25 NOC (evening shift, from 10:00 p.m. to 6:30 a.m.) and was the charge nurse for Resident 1. Resident 1's Nursing Note, dated 5/18/25 at 3:15 a.m. was reviewed. The note indicated, . CN (Charge Nurse) was informed by the CNA (Certified Nurse Assistant) that resident was coughing and was having difficulty expelling mucus (phlegm) to clear throat. CN immediately assess resident . CN noticed that resident was not responding verbally to any commands. Multiple attempts for verbal response were ineffective. VS (Vital Signs) 154/63 (blood pressure), O2 (oxygen) sat [saturation] 86-88% via NC (nasal cannula) at 3L (liters- unit of measurement) . [Ambulance] was call[ed] at 03:55 a.m. left resident via gurney at 04:15 a.m. LVN 1 stated several paramedics came to the facility and checked Resident 1's vital signs, including oxygen level and blood glucose levels. LVN 1 stated she was informed by one paramedics who responded to the emergency call that Resident 1's initial blood glucose level was 53 mg/dl and was given D5W (dextrose, a liquid solution containing 5% dextrose [a type of sugar]). During a concurrent phone interview and record review on 6/12/25, at 8:49 a.m. with LVN 1, Resident 1's Order Summary Report, dated 6/6/25 was reviewed. LVN 1 stated there was no order to check Resident 1's BS (blood sugar) every shift or daily. Resident 1's Food Intake, dated 5/17/25 was reviewed. LVN 1 stated she was not aware of Resident 1's refusing meals while taking his Glipizide. Resident 1 ' s Diabetes Mellitus care plan dated 5/5/25 was reviewed. LVN 1 stated the careplan interventions should be resident specific and it was not. LVN 1 stated the care plan did not include monitoring of meal intake and blood glucose check. LVN 1 stated Resident 1's low level of blood glucose resulted to altered mental status and subsequent hospitalization. During a concurrent interview and record review on 6/12/25 at 2:21 p.m. with the Director of Nursing (DON), the DON stated Resident 1 has a diagnosis of COPD, CHF, Cervicalgia and Type 2 DM. The DON stated Resident 1 was transferred to an acute care hospital (ACH) on 5/18/25 due to AMS, and did not return to their facility. The DON stated Resident 1 was previously admitted (4/20/23) to the facility and was on blood glucose monitoring and she was unsure why it was discontinued on his most recent readmission [DATE]). The DON reviewed Resident 1 ' s Type 2 DM care plan dated 5/5/25 and stated the care plan intervention column was incomplete. The DON stated the purpose of a care plan was to guide staff for a resident's plan of care and the interventions in place to meet the resident goals. The DON stated Resident 1's care plan should be individualized and specific, without specific interventions, Resident 1 could experience a negative outcome, including hypoglycemia or hyperglycemia. During a review of Resident 1's Acute Hospital History and Physical, dated 4/28/25, the record indicated, . [Resident 1] . male with PMHx (Patient's past medical history) sig (significant) for COPD, CHF . DM . who presented to the ER with complaint of mild SOB (shortness of breath) . Recent Labs [laboratory] . Glucose 189 ml/dl . Plan: Admit . Insulin regimen, hypoglycemic precautions . During a review of Resident 1's Ambulance Service Record, dated 5/18/25, the record indicated, . 04:00 [4:00 a.m.] . Chief Complaint . not acting like his usual self . Vital Signs BP [blood pressure] 166/67 . Oxygen Saturation 92% (percent- unit of measurement) . Blood Glucose 53 mg/dl . Comments: low blood sugar . Narrative: Pt found semi-Fowlers in bed at [Facility Name]. Family at scene. Staff states that pt (patient) is not his usual self. Usually converses more but this morning he just yells. Pt has history of COPD and is on 2 LPM (liters per minute - unit of measurement) via nasal cannula. Pt has an oxygen saturation of 88 %, EMS [Emergency Medical Staff] increased oxygen to 3 LPM this improved his oxygen saturation to 93%. Glucose check showed 53 mg/dl. Pt moved to gurney to unit . (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Acute Hospital ED [Emergency Department] Physician Notes, dated 5/18/25 at 7:26 a.m., the note indicated, . Patient presenting from the [Facility Name] for altered mental status male history of COPD, diabetes, hypertension presents for altered mental status. Vital signs with borderline tachycardia (faster heart rate) hypoxemia (low oxygen level) to the low 90s and high 80s on supplemental oxygenation. Exam with diffuse wheezing (sound heard throughout the chest) as well as significant weakness in bilateral upper and lower extremities (arms and legs). Considered a broad differential (symptoms could be attributed to a large number of potential conditions) for this patient who present for altered mental status found to be hypoglycemic . Final Diagnosis this visit: COPD with acute exacerbation (worsening of condition) . Acute hypoxemic respiratory failure . Altered mental status . Hypoglycemia . Disposition: transfer to other hospital [Hospital name] . Condition: Guarded (patient's condition is uncertain) . During a review of the facility ' s policy and procedure (P&P) titled Comprehensive Care Plans, dated 11/2017, the P&P indicated, . provide each resident with a person-centered, comprehensive care plan to address the resident ' s medical, nursing, physical, mental and psychosocial needs . facility Interdisciplinary Team (IDT) will develop and implement a comprehensive, person-center care plan for each resident that includes measurable objectives and timeframes that meet a resident ' s medical, nursing, physical, mental, and psychosocial needs . It will drive the type of care and services that a resident receives and will describe the resident ' s medical, nursing, physical, mental and psychosocial needs and preferences; as well as how the facility will assist in meeting these needs and preferences . During a review of the professional reference titled, Lippincott procedures-Care plan preparation, long-term care, dated 5/19/22, the professional reference indicated, .The care plan for each resident must include: . resident goals, expressed in measurable objectives with timetables to meet the resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment, interventions that describe the services the interdisciplinary team employs to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, evaluation of the fulfillment of goals .The care plan should reflect elements of person-centered are, make every effort to understand what each resident is communicating verbally and non-verbally, and identify what daily routines are important each resident . During a review of a professional reference retrieved from https://www.medicare.gov/what-medicare-covers/what-part-a-covers/whats-a-care-plan-in-skilled-nursing-facilities#:~:text=This%20helps%20keep%20you%20aware,kind%20of%20services%20you%20need titled What ' s a care plan in skilled nursing facilities, undated, the reference indicated, . When your health condition is assessed, skilled nursing facility (SNF) staff prepare or update your care plan . This helps keep you aware of how the care you get will help you reach your health care goals . may include . what kind of services you need . How often you'll need the services . What kind of equipment or supplies you need . Your health goal (or goals), and how your care plan will help you reach your goal . 2. During a review of Resident 1 ' s admission Record, dated 6/6/25, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis that included COPD, Type 2 Diabetes Mellitus, Muscle Weakness, Hypertension, Cervicalgia and CHF. During a review of Residents 1's MDS assessment dated [DATE], indicated Resident 1's BIMS scored 15 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 was cognitively intact. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 6/6/25, at 2:42 p.m. with RN 1, RN 1 stated Resident 1 has a diagnosis of COPD, CHF and Type 2 DM. RN 1 confirmed she worked on 5/17/25 PM shift (afternoon shift, from 2:00 p.m. to 10:30 p.m.) and was the charge nurse for Resident 1. Resident 1's Nursing Note, dated 5/17/25 at 6:39 p.m. was reviewed. The note indicated, . O2 93% - 5/17/25 9:06 a.m. Oxygen via nasal cannula . Signed [RN 1] . RN 1 stated there was no record of Resident 1's oxygen level taken during her shift (from 2:00 p.m. to 10:30 p.m.). During a concurrent interview and record review on 6/6/25, at 2:46 p.m. with RN 1, Resident 1's OSR dated 6/6/25 was reviewed. The OSR indicated, . Administer oxygen @2-3Lmin (Liter per minute - unit of measurement) via nasal cannula . Order Date 5/5/25 . Check oxygen saturation PRN (as needed) every 8 (eight) hours as needed for Dyspnea (shortness of breath) /Cyanosis (discoloration of the skin due to a lack of oxygen in the blood) . Order Date 5/5/25 . RN 1 stated Resident 1's physician's order to check oxygen saturation was not followed. RN 1 stated Resident 1's oxygen saturation level was not checked for 17 hours (from 9:07 a.m. to 2:20 am). RN 1 stated Resident 1's changed in condition could have been discovered sooner if his oxygen saturation level was checked once a shift. Resident 1 ' s COPD and CHF care plan dated 5/5/25 was reviewed. The care plan indicated, . Focus . [Resident 1] has oxygen therapy r/t [related to] CHF. Administer oxygen @2-3L/min via nasal cannula, Continuous for Chronic COPD . Interventions/Tasks . Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD (physician): increased respirations (breathing) . decreased pulse oximetry . cough . RN 1 stated the careplan interventions was not followed. RN 1 stated Resident 1's oxygen saturation level was not checked according to the care plan and physician's order. RN 1 stated Resident 1's changed in condition could have been discovered sooner if his oxygen saturation level was checked during her shift. During a concurrent phone interview and record review on 6/12/25, at 8:45 a.m. with LVN 1, LVN 1 stated Resident 1 has a diagnosis of COPD, CHF and Type 2 DM. LVN 1 confirmed she worked on 5/18/25 NOC (evening shift, from 10:00 p.m. to 6:30 a.m.) and was the charge nurse for Resident 1. Resident 1's Nursing Note, dated 5/18/25 at 3:15 a.m. was reviewed. The note indicated, . CN (Charge Nurse) was informed by the CNA (Certified Nurse Assistant) that resident was coughing and was having difficulty expelling mucus (phlegm) to clear throat. CN immediately assess resident . CN noticed that resident was not responding verbally to any commands. Multiple attempts for verbal response were ineffective. VS (Vital Signs) 154/63 (blood pressure), O2 (oxygen) sat [saturation] 86-88% via NC (nasal cannula) at 3L (liters- unit of measurement) . [Ambulance] was call[ed] at 03:55 a.m. left resident via gurney at 04:15 a.m. LVN 1 stated several paramedics came to the facility and checked Resident 1's vital signs, including oxygen level and blood glucose levels. During a concurrent phone interview and record review on 6/12/25, at 8:55 a.m. with LVN 1, Resident 1's OSR dated 6/6/25 was reviewed. The OSR indicated, . Check oxygen saturation PRN every 8 hours as needed for Dyspnea/Cyanosis . Order Date 5/5/25 . LVN 1 stated Resident 1's physician's order to check oxygen saturation was not followed by the previous shift. LVN 1 stated Resident 1's oxygen saturation level was not checked for more than 12 hours (from 9:07 a.m. to 2:20 am). LVN 1 stated Resident 1 was on continuous oxygen and checking the oxygen saturation level was part of the vital signs, and it was not done. (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	During a concurrent phone interview and record review on 6/12/25, at 9:00 a.m. with LVN 1, Resident 1 ' s COPD and CHF care plan dated 5/5/25 was reviewed. The care plan indicated, . Focus . [Resident 1] has oxygen therapy r/t CHF. Administer oxygen @2-3L/min via nasal cannula, Continuous for Chronic COPD . Interventions/Tasks . Monitor for s/sx (signs and symptoms) of respiratory distress and report to MD: increased respirations (breathing) . decreased pulse oximetry . cough . LVN 1 stated the careplan interventions should be implemented and it was not. LVN 1 stated the facility failed to follow Resident 1's care plan interventions and physician's order to monitor oxygen saturation level every shift, and resulted to altered mental status and subsequent hospitalization. During a concurrent interview and record review on 6/12/25 at 2:21 p.m. with the DON, the DON stated Resident 1 has a diagnosis of COPD, CHF, Cervicalgia and Type 2 DM. The DON stated Resident 1 was transferred to an acute care hospital (ACH) on 5/18/25 due to AMS, and did not return to their facility. The DON reviewed Resident 1's COPD and CHF care plan dated 5/5/25 and stated the care plan intervention to monitor oxygen saturation level every shift was not followed on 5/17/25. The DON stated the purpose of a care plan was to guide staff for a resident's plan of care and the interventions in place to meet the resident goals. The DON stated failure to follow the nursing care plan interventions could lead to a negative outcome, including low oxygen level and respiratory distress. During a review of Resident 1's Acute Hospital History and Physical, dated 4/28/25, the record indicated, . [Resident 1] is a [AGE] year old, male with PMHx (Patient's past medical history) sig (significant) for COPD, CHF . DM . who presented to the ER with complaint of mild SOB (shortness of breath) . Recent Labs [laboratory] . Glucose 189 ml/dl . Plan: Admit . Insulin regimen, hypoglycemic precautions . During a review of Resident 1's Ambulance Service Record, dated 5/18/25, the record indicated, . 04:00 [4:00 a.m.] . Chief Complaint . not acting like his usual self . Vital Signs BP 166/67 . Oxygen Saturation 92% . Blood Glucose 53 mg/dl . Comments: low blood sugar . Narrative: Pt found semi-Fowlers in bed at [Facility Name] . Family at scene. Staff states that pt (patient) is not his usual self. Usually converses more but this morning he just yells. Pt has history of COPD and is on 2 LPM (liters per minute - unit of measurement) via nasal cannula. Pt has an oxygen saturation of 88 %, EMS increased oxygen to 3 LPM this improved his oxygen saturation to 93%. Glucose check showed 53 mg/dl. Pt moved to gurney to unit . During a review of Resident 1's Acute Hospital ED Physician Notes, dated 5/18/25 at 7:26 a.m., the note indicated, . Patient presenting from the [Facility Name] for altered mental status . 74 y.o. male history of COPD, diabetes, hypertension presents for altered mental status. Vital signs with borderline tachycardia, hypoxemia to the low 90s and high 80s on supplemental oxygenation. Exam with diffuse wheezing as well as significant weakness in bilateral upper and lower extremities. Considered a broad differential for this patient who present for altered mental status found to be hypoglycemic . Final Diagnosis this visit: COPD with acute exacerbation . Acute hypoxemic respiratory failure . Altered mental status . Hypoglycemia . Disposition: transfer to other hospital [Hospital name] . Condition: Guarded . (continued on next page)

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F 0657 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled Comprehensive Care Plans, dated 11/2017, the P&P indicated, . provide each resident with a person-centered, comprehensive care plan to address the resident ' s medical, nursing, physical, mental and psychosocial needs . facility Interdisciplinary Team (IDT) will develop and implement a comprehensive, person-center care plan for each resident that includes measurable objectives and timeframes that meet a resident ' s medical, nursing, physical, mental, and psychosocial needs . It will drive the type of care and services that a resident receives and will describe the resident ' s medical, nursing, physical, mental and psychosocial needs and preferences; as well as how the facility will assist in meeting these needs and preferences . During a review of the professional reference titled, Lippincott procedures-Care plan preparation, long-term care, dated 5/19/22, the professional reference indicated, .The care plan for each resident must include: . resident goals, expressed in measurable objectives with timetables to meet the resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment, interventions that describe the services the interdisciplinary team employs to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, evaluation of the fulfillment of goals .The care plan should reflect elements of person-centered are, make every effort to understand what each resident is communicating verbally and non-verbally, and identify what daily routines are important each resident . During a review of a professional reference retrieved from https://www.medicare.gov/what-medicare-covers/what-part-a-covers/whats-a-care-plan-in-skilled-nursing-facilities#:~:text=This%20helps%20keep%20you%20aware,kind%20of%20services%20you%20need titled What ' s a care plan in skilled nursing facilities, undated, the reference indicated, . When your health condition is assessed, skilled nursing facility (SNF) staff prepare or update your care plan . This helps keep you aware of how the care you get will help you reach your health care goals . may include . what kind of services you need . How often you'll need the services . What kind of equipment or supplies you need . Your health goal (or goals), and how your care plan will help you reach your goal .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure resident's food preferences were honored for one of six sampled residents (Resident 3) when sliced tomatoes was placed on Resident 3's lunch plate despite tomatoes being listed as a dislike. This failure had the potential to result in decreased food intake, and could result in unplanned weight loss, compromising Resident 3's nutritional and medical status. Findings: During a concurrent observation and interview on 6/6/25, at 1:27 p.m., with Resident 3, inside Resident 3's room, Resident 3's meal tray ticket indicated disliking tomatoes. Resident 3 received fresh sliced tomatoes with his lunch. Resident 3 stated, I do not like tomatoes. I told them before and it keeps on happening. Resident 3 stated he ate the chicken tenders, potato salad and lemon pudding for lunch. The sliced tomatoes with parsley flakes were left untouched. During a concurrent observation and interview on 6/6/25, at 1:47 p.m., with Certified Nursing Assistant (CNA) 1, inside Resident 3's room, CNA 1 checked Resident 3's meal tray ticket and stated, [Resident 3] was served with chicken tenders, potato salad, tomato marinated tomato salad, lemon pudding and 2% milk. Verification of meal tray ticket with CNA 1, confirmed dislikes in meal ticket were fish, spinach, brussels sprouts or tomatoes. CNA 1 stated the dietary and nursing staff failed to review the contents of Resident 3's meal tray prior to serving his meal. CNA 1 stated the failure could result in reduced meal intake. During a concurrent interview and record review on 6/6/25, at 1:49 p.m., with Dietary [NAME] (DC) 1, Resident 3's lunch meal tray ticket, dated 6/6/25 was reviewed. DC 1 stated Resident 3 was served a marinated tomato salad. DC 1 stated the bottom part of the meal tray ticket indicated Resident 3's dislikes of tomatoes. DC 1 stated the dietary staff failed to honor Resident 3's food preference and could potentially result to reduce meal intake and compromising Resident 3's nutritional status. During an interview on 6/12/25, at 1:49 p.m., with the Dietary Manager (DM), the DM stated the expectation was for the dietary aide and dietary cook to compare the contents of the meal tray to the meal tray ticket during meal preparation. The DM stated Resident 3's meal preferences was not followed on 6/6/25, Resident 3 was served a marinated tomato salad, despite a note on his meal ticket indicating dislikes of tomatoes. The DM stated Resident 3's nutritional status was currently not compromised but could be a potential issue if the mistake keeps on happening during meal preparation. During a review of the facility's policy and procedure (P&P) titled, Menus and Therapeutic Diets, dated 7/2018, the P&P indicated, . 1. Facility menus will meet the nutritional needs of residents in accordance with established national guidelines . 4. Facility will make reasonable effort to accommodate religious, cultural and ethnic needs of the resident population, as well as other input received from residents . (continued on next page)

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	06/12/2025

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Provision of Diet to Meet Needs of Each Resident, dated 7/2018, the P&P indicated, . The facility will provide residents with nourishing, palatable and well-balanced diet to meet daily nutritional and special dietary needs. This will be done while taking into consideration the preferences of each resident . There will be ongoing communication and coordination, taking an IDT approach, to meet the daily nutritional and dietary needs and choices of residents .