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	04/20/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a resident-centered comprehensive care plan for one of five sampled residents (Resident 1) when Resident 1 had known behaviors of getting up unassisted from bed, refusing to use his walker, call light and TLSO brace (thoracolumbosacral orthosis, is a type of back brace used to limit motion and promote healing in the thoracic [upper midback] spine, lumbar [lower back] spine, and sacral [triangular bone at the base of the lumbar spine connecting the spine to the pelvis] areas) and the facility did not develop and implement interventions that were person-specific in the comprehensive care plan. This failure placed Resident 1 at risk for falls and had the potential for pain and complications from his L1 fracture (a break in the first vertebra of the lower back [lumbar spine]). (Cross reference F658)Findings: During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of fifth lumbar vertebra (one of the bones that make up the spinal column), protein calorie malnutrition (undernutrition resulting from insufficient intake of protein and/or calories), type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (heart disorder which causes the heart to not pump blood efficiently), low back pain, and falls.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 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 not cognitively impaired.During a concurrent observation and interview on 4/20/26 at 10:28 a.m. with Resident 1, Resident 1 was lying on his bed dressed and wearing nonskid socks on his feet. Resident 1 stated he had a history of falls prior to his admission at the facility. Resident 1 had a black back brace lying on his bedside table. Resident 1 stated he had a fracture in his back.During a concurrent observation and interview on 4/20/26 at 10:34 a.m. with Certified Nursing Assistant (CNA) 1, outside Resident 1's room, Resident 1 was observed getting out of bed and walking toward the bathroom unassisted and not wearing his back brace. CNA 1 stated Resident 1 had a recent fall on PM shift and injured his back. CNA 1 stated resident 1 needed supervision for safety when ambulating (walking) but he was not good at using his call light to ask for help walking to the bathroom.During a concurrent interview on 4/20/26 at 11:06 a.m. with CNA 2 and CNA 3, CNA 3 stated she had taken care of Resident 1 in the past and he was noncompliant with using his call light, asking for help while walking or using his walker. CNA 3 stated Resident 1 was alert and oriented and aware he needed help ambulating but would get up by himself anyway. CNA 2 stated Resident 1 would get wobbly when walking to the bathroom, so he required supervision. CNA 2 stated Resident 1 was not good about calling for help to the bathroom or using his walker.During an interview on 4/20/26 at 11:18 a.m. with the Physical Therapy Assistant (PTA), the PTA stated Resident 1 was not consistent with participating with therapy. The PTA stated Resident 1 needed to use his walker to ambulate safely (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but refused to use it.During a concurrent interview and record review on 4/20/26 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Nursing SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/25/26 was reviewed. The SBAR indicated, . c/o Unwitnessed fall. Change in mental status. The following orders were received: Sent out resident to acute [care hospital] . LVN 1 stated Resident 1 refused to use his walker and would not use his call light to call for help. Resident 1's fall care plan, dated 3/25/26, was reviewed and indicated, . had an unwitnessed fall. will be free of complications. TSLO [TLSO] brace for ambulation. LVN 1 stated she was unaware Resident 1 was supposed to wear a back brace when walking and had never seen him wear it. LVN 1 stated it was important for Resident 1 to follow the care plan and wear his TLSO brace to treat his fractures. LVN 1 reviewed Resident 1's care plans and was unable to locate a care plan related to his noncompliance with the call light, walker or back brace. LVN 1 stated care plans were used to notify the staff how to provide the residents with individualized care and meet their needs.During a concurrent interview and record review on 4/20/26 at 12:21 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was found on the ground in his room after an unwitnessed fall on 3/25/26. The DON stated Resident 1 was admitted to the hospital for pneumonia after his fall and was found to have an L1 fracture while at the hospital. The DON stated Resident 1 was not compliant with asking for help to the bathroom, wearing his back brace or using his walker. Resident 1's care plans were reviewed, the DON stated she was unable to locate a care plan for Resident 1's noncompliance with using his walker, back brace and call light. The DON stated there should be a care plan in Resident 1's medical records addressing his noncompliance and refusal of care. During an interview on 4/20/26 at 12:44 p.m. with Resident 1, in Resident 1's room, Resident 1 was sitting at the edge of his bed and the TLSO brace was observed on his bedside table. Resident 1 was evasive and stated he would wear the brace when I need it. During an interview on 4/20/26 at 12:49 p.m. with CNA 1, CNA 1 stated she was aware Resident 1had a back brace but was unaware he was supposed to wear it while ambulating according to the care plan. CNA 1 stated she had never seen Resident 1 use the back brace.During an interview on 4/20/26 at 12:51 p.m. with the Physical Therapy Assistant (PTA), the PTA stated Resident 1 had a TLSO brace at bedside but was noncompliant with wearing it. The PTA stated Resident 1 should wear the brace when he was out of bed because he had a fracture in his back.During a review of the facility's policy and procedures (P&P) titled Comprehensive Care Plans, dated 11/2017, the P&P indicated, . To 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-centered care plan for each resident that includes measurable objectives and timeframes. Care plan will include. Services that would have been provided but the resident has refused. care planning process will be an on-going process.During a review of the facility's P&P titled Resident Rights. Refusal of Treatment, dated 11/2017, the P&P indicated, . resident has the right to request, refuse and/or discontinue treatment. The resident has the right to refuse treatment or services. The facility is responsible to provide care that allows the resident to attain or maintain his or her highest practicable physical, mental and psychosocial well-being. Services that would otherwise be required, but are refused must be described in the comprehensive care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure services provided met professional standards of practice for one of five sampled residents (Resident 1) when Resident 1 sustained an L1 fracture (a break in the first vertebra of the lower back [lumbar spine]) during a fall at the facility on 3/25/26 and was hospitalized , the resident returned to the facility on 3/30/26 with an order from the acute care hospital to wear a TLSO (thoracolumbosacral orthosis, is a type of back brace used to limit motion and promote healing in the thoracic [upper midback] spine, lumbar, and sacral [triangular bone at the base of the lumbar spine connecting the spine to the pelvis] areas) brace while ambulating (ability to walk) and the facility did not enter the order or follow up with Resident 1's physician.This failure resulted in staff not being aware Resident 1 was supposed to wear his back brace while ambulating and his compliance with wearing the brace was not monitored placing Resident 1 at risk for severe back pain and further injury. (Cross reference F656)Findings:During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included a fracture of the fifth lumbar vertebra (one of the bones that make up the spinal column), protein calorie malnutrition (undernutrition resulting from insufficient intake of protein and/or calories), type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (heart disorder which causes the heart to not pump blood efficiently), low back pain, and falls.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 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 not cognitively impaired.During a concurrent observation and interview on 4/20/26 at 10:28 a.m. with Resident 1, Resident 1 was lying on his bed dressed and wearing nonskid socks on his feet. Resident 1 stated he had a history of falls prior to his admission at the facility. Resident 1 had a black back brace lying on his bedside table. Resident 1 stated he had a fracture in his back.During a concurrent observation and interview on 4/20/26 at 10:34 a.m. with Certified Nursing Assistant (CNA) 1, outside Resident 1's room, Resident 1 was observed getting out of bed and walking toward the bathroom unassisted and not wearing his back brace. CNA 1 stated Resident 1 had a recent fall on PM shift and injured his back. CNA 1 stated Resident 1 needed supervision for safety when ambulating but he was not good at using his call light to ask for help walking to the bathroom.During a concurrent interview and record review on 4/20/26 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Nursing SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/25/26 was reviewed. The SBAR indicated, . c/o Unwitnessed fall. Change in mental status. The following orders were received: Sent out resident to acute [care hospital]. LVN 1 stated Resident 1 refused to use his walker and would not use his call light to call for help. Resident 1's fall care plan, dated 3/25/26, was reviewed and indicated, . had an unwitnessed fall. will be free of complications. TSLO [TLSO] brace for ambulation. LVN 1 stated she was unaware Resident 1 was supposed to wear a back brace when walking and had never seen him wear it. Resident 1's Order Summary Report (OSR), undated, was reviewed and LVN 1 was unable to locate a physician order for the TLSO brace. LVN 1 stated it was important for Resident 1 to follow the care plan and wear his TLSO brace to treat his fractures.During a review of Resident 1's ACH document titled CT Spine Lumbar w/o Contrast, dated 3/25/26, the results indicated, . Nondisplaced fracture of the vertebral body of L1.During a concurrent interview and record review on 4/20/26 at 12:21 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was found on the ground in his room after an unwitnessed fall on 3/25/26. The DON stated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 was admitted to the hospital for pneumonia after his fall and was found to have an L1 fracture while at the hospital. Resident 1's Acute Care Hospital (ACH) Patient Discharge Instructions, dated 3/30/26, was reviewed and indicated, . Discharge Orders. Please wear TLSO brace when getting out of bed and working with therapy. The DON reviewed the OSR and stated she was unable to find an order for the brace. The DON stated the brace was in the hospital discharge instructions and should have been entered into the OSR when Resident 1 was readmitted on [DATE]. Resident 1's fall care plan dated 3/25/26 was reviewed and the DON stated the TLSO brace was on the care plan but also needed to be in the OSR so the staff could monitor for compliance and potential skin breakdown under the brace. The DON stated her expectation would have been for the admission nurse to review the hospital paperwork and notify Resident 1's physician of the order. The DON stated the TLSO brace was important to stabilize Resident 1's fracture while walking.During an interview on 4/20/26 at 12:44 p.m. with Resident 1, in Resident 1's room, Resident 1 was sitting at the edge of his bed and the TLSO brace was observed on his bedside table. Resident 1 was evasive and stated he would wear the brace when I need it. During an interview on 4/20/26 at 12:49 p.m. with CNA 1, CNA 1 stated she was aware Resident 1had a back brace but was unaware he was supposed to wear it while ambulating according to the care plan. CNA 1 stated she had never seen Resident 1 use the back brace.During an interview on 4/20/26 at 12:51 p.m. with the Physical Therapy Assistant (PTA), the PTA stated Resident 1 had a TLSO brace at bedside but was noncompliant with wearing it. The PTA stated Resident 1 should wear the brace when he was out of bed because he had a fracture in his back.During a review of the facility's policy and procedure (P&P) titled Physician Services, dated 6/2018, the P&P indicated, . support medical supervision of the care of each resident is provided by a physician and that orders for the resident's immediate care and needs are provided throughout the resident's stay. The physician admission orders for the resident's immediate care can serve as the physician's personal approval of the admission if the orders are provided by a physician.During a review of a professional reference retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC11878868/#:~:text=medication%20safety%2C%20readmissions-,Ba titled Lessons Learned When Discharging Older Adults to Skilled Nursing Facilities, dated 6/3/2022, the reference indicated, . When patients transition from an inpatient hospital stay to a skilled nursing facility (SNF), the information that is sent with them is essential to proper care in the facility. To facilitate this transition, discharge paperwork from the hospitalization is provided to SNF medical staff immediately prior to and at the time of discharge. This includes. follow-up care they will need after discharge. The nursing staff at the SNF are under strict guidance to follow these instructions for care. Patients are vulnerable to complications during times of transition. follow-up is critical for patient safety. Communicate need for additional care, treatment, or procedures in the discharge paperwork so that the SNF can ensure these plans are enacted.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for one of three sampled Residents (Resident 2) when Certified Nursing Assistant (CNA) 1 completed a two-person required mechanical lift (a mobile floor lift system that rolls on wheels and is intended to lift, suspend and transfer a medically dependent person from a bed, shower, toilet or wheelchair) transfer without assistance.This failure placed Resident 2 at risk for falls and significant injuries.Findings:During an observation on 4/20/26 at 10:25 a.m., Certified Nursing Assistant (CNA) 1 was observed operating a mechanical lift alone with Resident 2 in a sling, lowering him into his wheelchair. There were no other staff members observed in the resident's room.During an interview on 4/20/26 at 10:34 a.m. with CNA 1, CNA 1 stated she was using the mechanical lift without assistance of another staff member. CNA 1 stated there needed to be two staff members present when operating a mechanical lift for residents' safety. CNA 1 stated she was unable to find another CNA to help her but should have waited because it placed Resident 2's safety at risk and placed him at risk for falling.During an interview on 4/20/26 at 10:40 a.m. with Resident 3, Resident 3 was lying in bed dressed. Resident 3 stated the staff used a mechanical lift whenever they took her out of bed. Resident 3 stated occasionally a CNA would operate the mechanical lift alone, but there were usually two CNAs using it.During an observation on 4/20/26 at 11:03 a.m. with Resident 3, Resident 3 was lying in his wheelchair with a blue mechanical lift sling under him. Resident 3 was alert with confusion.During a concurrent interview on 4/20/26 at 11:06 a.m. with CNAs 2 and 3, CNA 2 stated they were required to always have a second staff member when using a mechanical lift. CNA 3 stated it was unsafe to use the lift alone because anything could happen without another person to guide the lift.During an interview on 4/20/26 at 11:18 a.m. with the Physical Therapy Assistant (PTA), the PTA stated there should always be two staff members using the mechanical lift. The PTA stated one staff member needed to operate the mechanical lift and the other staff to guide the resident onto the chair or bed and make sure they land in the correct place.During a concurrent interview and record review on 4/20/26 at 11:30 a.m. with the Director of Staff Development (DSD), the DSD stated all nursing staff were trained on using the mechanical lift with competency checked during the annual training on 6/12/25. The DSD stated the staff were instructed that two staff members were required to operate a mechanical lift for resident safety. The DSD stated the staff had to pass competencies before they were allowed to perform a skill on the floor. CNA 1's CNA Core Clinical Competencies, dated 6/12/25, indicated, . Date 6/12/25. Mechanical lift [pass box marked] .During an interview on 4/20/26 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated two people were required to use a mechanical lift. LVN 1 stated if a CNA could not find another CNA they should notify the nurse for assistance. LVN 1 stated if staff used the mechanical lift by themselves, it placed the residents at risk for falls. LVN 1 stated it was important to have two people during transfer, one to keep an eye on the resident and the second to step in if something gets stuck or help move the resident if they are not positioned correctly.During a review of Resident 2's Assistance for Daily Living (ADL) care plan, dated 10/12/2020, the care plan indicated, . has an ADL self-care performance deficit. Transferred by staff using mechanical lift 2-to-3-person assistance. Transfer: [name of resident] is totally dependent on (2) staff for transferring. requires Mechanical lift with (2) staff assistance for transfers.During an interview on 4/20/26 at 12:21 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the staff to have two people operating the mechanical lift for resident safety. The DON stated if the CNA could not find another CNA for assistance, they should have asked the nurse or herself to help.During a review of the facility's policy and procedure (P&P) titled, Accident Hazards/Supervision/Devices, dated 7/2018, the P&P indicated, . provide an environment that is free from controllable accident hazards and provision of supervision and devices needed to prevent avoidable accidents. Assistive (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Devices/Equipment Hazards. Assistive devices and equipment will be used and maintained according to manufacturer recommendations. staff will be trained on the use of assistive devices and transfer equipment.During a telephone interview on 4/21/26 at 4:14 p.m. with the Administrator (ADM) the ADM stated the facility did not have a specific mechanical lift P&P and they followed manufacturer guidelines.During a review of the facility's Operating Instructions, undated, for the mechanical lift, the instructions did not indicate how many staff members were required to safely operate the mechanical lift.During a telephone interview on 4/22/26 at 10:29 p.m. with the DON, the DON stated the facility did not have a P&P for the mechanical lift but used the manufacturer's guidelines. The DON stated there were instructions hanging on each mechanical lift. The DON stated the manufacturer guidelines did not specify two person transfer but it was the facility's process to always use two people for mechanical lift transfers.