STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055423	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manning Gardens Care Center, Inc	2113 E. Manning Avenue Fresno, CA 93725

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 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** 44708 Based on observation, interview, and record review, the facility failed to implement the recommended diet plan for 1 of 3 residents (Resident 1) when Resident 1 received a swallowing evaluation (a test to visualize the function of the throat and esophagus while swallowing) on 5/2/24 and the facility did not obtain the result of the swallowing evaluation until 5/17/24. This failure was not the standard of practice according to the facility's policy and procedure, titled, Referrals, Social Services, and had the potential to place Resident 1 at risk for inadequate nutritional intake. Findings: During a review of Resident 1's Admission Record (AR), dated 5/26/24, the AR indicated, Resident 1 was admitted on [DATE] and had a history of Hemiplegia (paralysis of one side of the body) and Hemiparesis (one-sided muscle weakness) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side. During a review of Resident 1's Minimum Data Set (MDS - an evaluation of a resident's cognitive and functional status), dated 4/14/24, the MDS indicated the Brief Interview for Mental Status (BIMS) score (an assessment of a resident's cognitive status for memory recall) was 0 (a score of 0 - 7 indicated severe impairment, 8 - 12 indicated moderate impairment, and 13 - 15 indicated minimal to no impairment). During a review of Resident 1's MDS for Functional Abilities and Goals (FAAG), dated 4/14/24, the FAAG indicated, Resident 1 required extensive to total assistance with activities of daily living (transferring, toileting, dressing, personal hygiene, etc.) During a review of Resident 1's MDS for Swallowing/Nutritional Status (SNS), dated 4/14/24, the SNS indicated, Resident 1 had a PEG (percutaneous endoscopic gastrostomy; a surgical procedure in which a hollow tube is inserted into the stomach from the abdomen to deliver nutrition) tube. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 3:45 p.m., with Resident 1's Responsible Party (RP; the person designated to make decisions for the resident), RP stated Resident 1 had a swallow evaluation on 5/2/24 and the facility did not obtain the result of the swallow evaluation. RP stated Resident 1 pulled out his PEG tube on 5/17/24 and was transferred to the hospital. RP stated the hospital's physician called her on 5/17/24 and informed her Resident 1 passed the swallow evaluation on 5/2/24 and a puree (a pudding-like texture that is smooth and blended) diet was recommended. RP stated she declined the PEG tube be reinserted and had Resident 1 returned to the facility with the recommended diet on 5/17/24. During a review of Resident 1's XR Video Swallow Evaluation, dated 5/2/24, the evaluation indicated, Plan/Recommendations: 1. Recommend initiating a puree texture/thin diet (advance up to ground/minced texture. 2. 1:1 feeder. 3. Neutral head positioning. 4. Slow rate of intake. 5. Check for complete oral clearance. During an observation on 5/28/24 at 9:23 a.m. in Resident 1's room, Resident 1 was in bed in clean casual clothes. Resident 1's right arm was contracted (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff), was non-verbal (unable to speak), and followed simple commands. During a review of Resident 1's Progress Notes (PN), dated 5/17/24, 5/18/24, 5/19/24, and 5/20/24 the PN indicated, Resident is s/p (status post) GTUBE (gastric tube) removal, went to dining room to eat [breakfast, lunch, and dinner], resident is a feeder (required feeding assistance), ate 100% of his meal fed by the staff member, no s/s (signs or symptoms) of complication noted while swallowing the food, resident took and tolerated his meds (medications) PO (by mouth) . During an interview on 5/28/24 at 9:57 a.m., with Speech Therapist (ST; a health professional specialized in the treatment of improving the ability to talk and swallow), ST stated Resident 1 was seen on 5/25/24. ST stated a video swallow study (evaluation) was completed on 5/2/24 at the hospital, Resident 1 passed the study and was recommended a puree diet. ST stated ST was not aware of the study until 5/25/24. ST stated she assessed Resident 1's swallowing ability on 5/25/24 and the puree diet was appropriate. ST recommended Resident 1 to be on a puree diet, required to eat in the dining room to observe for aspiration, may have thin liquids (water consistency), no straws, no cup, no glass, fluids to be given only with a spoon, and 1:1 (one resident to one staff member) for all three meals while supervised. During an interview on 5/28/24 at 12:04 p.m., with Director of Nursing (DON), DON stated Resident 1's 5/2/24 swallow evaluation was obtained on 5/17/24 when the hospital called the facility to inform that Resident 1's PEG tube would not be replaced and was recommended a puree diet. DON stated licensed nurses need to make sure that paperwork was brought back from the doctor's office after a resident return from an appointment. DON stated Medical Records (department responsible for maintaining complete and accurate medical documents) was responsible to ensure that medical records were obtained from outside appointments. DON stated Medical Records staff needed to continue contacting the doctor's office until the records were obtained to confirm the results of any test. DON stated a reasonable amount of time to obtain results was within three days. DON stated the charge nurse assigned to Resident 1 on 5/2/24 should have informed Medical Records to request the result of Resident 1's swallow evaluation. DON stated if results are not obtained, residents will not receive the appropriate care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24 at 2:35 p.m., with Registered Nurse (RN), RN stated she was assigned to Resident 1 on 5/2/24. RN stated Certified Nursing Assistant (CNA) escorted Resident 1 to the swallow evaluation appointment on 5/2/24. RN stated Resident 1 returned to the facility with no paperwork. RN stated CNA informed her the hospital would fax (a device that transmits the copy of a document by wire or radio) the result of the swallow evaluation to the facility. RN stated she informed the Director of Social Services (SSD) to contact the hospital to obtain the results of the swallow evaluation. RN stated it was important to obtain the result of the swallow evaluation to implement the appropriate order. During an interview on 5/29/24 at 2:27 p.m., with Director of Social Services (DSS; a person designated to ensure the well-being of an individual), DSS stated on 5/2/24 RN informed her they (the hospital) were going to fax over the results of Resident 1's swallow evaluation. DSS stated RN did not ask DSS to make sure the hospital faxed the result of the swallow evaluation. DSS stated she was not responsible to follow up with hospital to ensure the result of the swallow evaluation was obtained. DSS stated the RN should have followed up with the hospital to obtain the results. DSS stated licensed nurses should have communicated with Medical Records to request pending documents. DSS stated obtaining the required documents was important to make sure the needs of the residents were met. During an interview on 5/29/24 at 2:53 p.m., with Director of Medical Records (DMR), DMR stated she was not aware Resident 1 had a swallow evaluation on 5/2/24. DMR stated licensed nurses were required to inform Medical Records to obtain pertinent (relevant) documents. DMR stated it was important to obtain the proper medical records so care would not be compromised (made vulnerable). During an interview on 5/30/24 at 10:10 a.m. with RD, RD stated the facility was required to obtain the result of the swallow evaluation on the same day in order to implement the appropriate diet so Resident 1 would receive the proper nutritional intake. During an interview on 5/30/24 at 4:30 p.m., with Administrator (ADM), ADM stated he expected staff to obtain Resident 1's swallowing evaluation within two to three days to implement the appropriate diet order, ensuring Resident 1 received adequate nutrition. ADM stated not following up on the swallow evaluation placed Resident 1 at risk for aspiration (choking) and had the potential to cause harm for inadequate nutritional intake. ADM stated the result of the swallow evaluation would have alerted the Speech Therapist to assess Resident 1 could swallow safely. ADM stated licensed nurses were required to inform Medical Records to obtain the follow-up appointment documents in order to ensure residents received the appropriate care. ADM stated the RN should have notified Medical Records and not the Director of Social Services according to facility policy and procedure to obtain the result of the swallow evaluation on 5/2/24 for Resident 1. ADM stated Medical Records was required to continue requesting the pertinent documents until the records were obtained. During a review of the facility's policy and procedure (P&P) titled, Referrals, Social Services, dated 12/08, the P&P indicated, Policy Interpretation and Implementation . 6. Any resident returning from appointments without any paperwork, Charge nurse needs to communicate with Medical records department to obtain follow-up paperwork.