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	02/06/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	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** 44708 Based on observation, interview, and record review, the facility failed to protect one of four residents (Resident 1) right to be free from physical abuse by Certified Nursing Assistant (CNA) 1 when a pitcher (a large container with a handle and a lip, used for holding and pouring liquids) filled with hot water by CNA 1 spilled onto Resident 1's left thigh on 2/3/25. This failure resulted in a Resident 1 experiencing second-degree burns (an injury that affects the outer layer of skin and part of the underlying layer of skin) to the left thigh and severe pain that required the administration of hydrocodone (a medication used to treat moderate to severe pain). Findings: During a concurrent observation and interview on 2/6/25 at 2:16 p.m. with Resident 1 in Resident 1's room, a palm size red patch was observed on Resident 1's left anterior (front) and lateral (side) thigh. One quarter size open wound was on the anterior thigh. Two quarter size fluid filled blisters were on the anterior left thigh. Three quarter size fluid filled blisters were on the lateral left thigh. Resident 1 stated on 2/3/25 at 7:30 p.m. she requested water to wash her face before going to bed. Resident 1 stated Certified Nursing Assistant (CNA) 1 brought her hot water in a pitcher without a lid and set the pitcher on the bedside table. Resident 1 stated when she moved the bed up to access the water and the bed moved the bedside table Resident 1 stated CNA 1 responded by moving the bedside table and the pitcher with the hot water tipped over and spilled onto her left thigh. Resident 1 stated the water was scalding (a form of thermal burn resulting from heated fluids such as boiling water or steam) hot. Resident 1 stated she screamed in pain and staff came and placed ice packs on her left thigh and gave her hydrocodone for 10 out of 10 (scale used to measure the level pain a person is experiencing with a score of 0 indicating no pain up to a score of 10 indicating worse pain imaginable) pain. During a review of Resident 1's Admission Record (AR), dated 2/7/25, the AR indicated Resident 1 was admitted on [DATE] with a history of right femur fracture (broken upper leg bone) and unspecified open wound left lower leg. (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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Manning Gardens Care Center, Inc	2113 E. Manning Avenue Fresno, CA 93725

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS; a federally mandated process for clinical assessment of all residents of long term care nursing facilities), dated 11/24/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 15 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent with transfer (unable to move without help from another person or persons) from bed to chair and required assistance with dressing and personal hygiene (habits to maintain cleanliness). During a review of Resident 1's Medication Administration Record (MAR), dated 2/3/25, the MAR indicated, Resident 1 was administered hydrocodone 7.5 mg (milligrams; unit of measurement)/325 mg was administered at 7:37 p.m. with a pain level of 8 (indicating severe pain). During an interview on 2/6/25 at 3:05 p.m. with CNA 1, CNA 1 stated on 2/3/25 around 7 p.m. Resident 1 requested hot water to wash her face before going to bed. CNA 1 stated she went to the dining room and filled a pitcher with the hot water from the dining room sink. CNA 1 stated the water from the resident's room took too long to get hot. CNA 1 stated the pitcher was set on Resident 1's bedside table without a lid and when CNA 1 moved the bedside table, the pitcher tipped over spilling the hot water onto Resident 1's left thigh. CNA 1 stated Resident 1 screamed, was in pain, and Resident 1's left thigh was red. CNA 1 stated she should have filled a basin (a bowl used for washing) for stability instead of a pitcher and did not know the water from the dining room sink was out of the acceptable temperature range. CNA 1 stated extreme hot water can cause severe burn injury to the skin. During a review of the facility's IDT (Interdisciplinary Team; a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) Notes, dated 2/4/25, the IDT Notes indicated, Brought to review by IDT r/t (related to) resident (Resident 1) spilling hot water on self-resulting in a burn injury on 2/3/2025 in PM shift . Around 1900 (7:00 p.m.), assigned staff member (CNA 1) notified LN (Licensed Nurse) that resident spilled hot water on her L (left) thigh. LN went to assess the resident immediately. Upon assessment, redness was noted to the L upper thigh, and resident complained of burning sensation . During a review of the facility's IDT Notes, dated 2/6/25, the IDT Notes indicated, In addendum to previous IDT note it was brought to review by IDT r/t burn injury on 2/3/25 on PM shift. It was brought to Dietary Supervisor attention of PM dietary aide witnessing employee involved in incident taking hot water from the coffee dispenser and not from dining room sink as stated by employee . During an interview on 2/11/24 at 3:39 p.m. with the Dietary Aide (DA), the DA stated she worked in the kitchen on 2/3/25. The DA stated she saw CNA 1 open the door to the kitchen and fill a pink pitcher with hot water from the coffee machine. The DA was unable to recall the time but stated it was after dinner. The DA stated the water in the coffee machine was 165 degrees Fahrenheit (F; unit of measurement). The DA stated exposure to the skin can burn the skin bad. During a review of the facility's video surveillance, dated 2/3/25 at 7:02 p.m., the video surveillance indicated, CNA 1 entered the facility's kitchen with a pink pitcher and stood by the door for eight seconds then proceeded into the hallway with the pink pitcher. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 2/6/25 at 2:45 p.m. with The Registered Dietitian (RD) in the facility's kitchen, the [brand name] coffee machine was on the counter next to the kitchen door. The hot water from the coffee machine was measured with a digital thermometer (a device that measures temperature using a sensor an electronic display) at 165 degrees. The RD stated, the hot water from the coffee machine measured 165 degrees F. The RD stated the hot water temperature was set at the manufacturer's guideline. During a review of the facility's coffee machine [brand name] manufacturer's guideline, the guideline indicated, [brand name] coffee machine's temperature setting range was 160 to 206 degrees F. During a concurrent observation and interview on 2/6/25 at 3:45 p.m. with Maintenance Supervisor (MS) in the facility's dining room, there was a Caution Hot Water sign posted next to the sink. The hot water from the dining room's faucet was measured with a digital thermometer while running and reached 140 degrees F in 39 seconds. The MS stated the dining room's hot water faucet reached 140 degrees F in 39 seconds. MS stated staff and residents used the dining room to eat during break time and mealtimes. MS stated water temperature at 140 degrees F was not safe to use. During a concurrent observation and interview on 2/6/25 at 4:40 p.m. with the MS in the facility's dining room, the valve (a device for controlling the passage of fluid or air through a pipe, duct, etc., especially an automatic device allowing movement in one direction only) to the hot and cold water line was shut off. The hot and cold water was not running when turned on. MS stated the hot water temperature was out of range and the sink was put out of commission (not in service or not in working order) due to the unsafe hot water temperature. During an interview on 2/7/25 at 10:41 a.m. with the Director of Nursing (DON), the DON stated on 2/3/25 Resident 1 requested water to wash her face. The DON stated CNA 1 filled a pitcher with hot water from the coffee machine in the kitchen according to the facility's video surveillance. The DON stated CNA 1 informed her the hot water was obtained from the dining room. The DON stated the dining room's sink hot water temperature should not been hot enough to cause the burn injury to Resident 1's left thigh. The DON stated CNA's were expected to ask the Charge Nurse for hot water when residents request hot water to ensure safety. The DON stated she was not aware the dining room sinks hot water temperature was 140 degrees F. The DON stated the acceptable hot water temperature should be no more than 120 degrees F. The DON stated hot water above 120 degrees F can cause skin injury. The DON stated exposing residents to scalding hot water was physical abuse and it was not acceptable. During an interview on 2/7/25 at 3:44 p.m. with the Administrator (ADM), the ADM stated the facility's video surveillance dated 2/3/25 at 7:02 p.m. indicated CNA 1 obtained the hot water from the coffee machine in the kitchen. The ADM stated CNA 1 used to work in the kitchen and was comfortable going to the kitchen to get hot water. The ADM stated he was aware the facility's dining room sink's water temperature was out of the acceptable range and was waiting for HCAI (Health Care Access and Information; an agency that reviews plans, inspect construction, and enforce building codes in healthcare facilities to ensure safety and quality) to approve installing a permanent valve to control the water temperature. The ADM stated the acceptable water temperature range was 80 to 120 degrees F. The ADM stated temperatures above 120 degrees F can cause skin injury. The ADM stated exposing residents to scalding hot water was physical abuse and it was not acceptable. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated 12/2016, the P&P indicated, Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual . 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents . During a review of the facility's P&P titled, Resident Rights, dated 12/2016, the P&P indicated, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; . During a review of the facility's job description titled, Certified Nursing Assistant, dated 4/2013, the job description indicated, Purpose of Your Job Position: The primary purpose of your job position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors . Major Duties and Responsibilities: . Personnel Functions: Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors . Resident Rights: . Ensure that you treat all residents fairly, and with kindness, dignity, and respect . During a review of Professional Reference from https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/ABA%20Scald%20Injury%20Prevention%20Educator%27s%20Guide.pdf, titled, SCALD INJURY PREVENTION, undated, indicated, . Although scald burns can happen to anyone, young children, older adults and people with disabilities are the most likely to incur such injuries. Most scald burn injuries happen in the home, in connection with the preparation or serving of hot food or beverages, or from exposure to hot tap water in bathtubs or showers . The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. The most common regulatory standard for the maximum temperature of water delivered by residential water heaters to the tap is 120 degrees Fahrenheit . At this temperature, the skin of adults requires an average of five minutes of exposure for a full thickness burn to occur (most severe type of burns). When the temperature of a hot liquid is increased to 140 (degrees) F/60 C (Celsius; unit of measurement) it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180 F/71-82 C, resulting in almost instantaneous burns that will require surgery . High risk groups . Older adults, like young children, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Because they have poor microcirculation, heat is removed from burned tissue rather slowly compared to younger adults. Older adults may also have conditions that make them more prone to falls in the bathtub or shower or while carrying hot liquids . (continued on next page)

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Manning Gardens Care Center, Inc	2113 E. Manning Avenue Fresno, CA 93725

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to protect one of four residents (Resident 1) right to be free from physical abuse by Certified Nursing Assistant (CNA) 1 when a pitcher (a large container with a handle and a lip, used for holding and pouring liquids) filled with hot water by CNA 1 spilled onto Resident 1's left thigh on 2/3/25. This failure resulted in a Resident 1 experiencing second-degree burns (an injury that affects the outer layer of skin and part of the underlying layer of skin) to the left thigh and severe pain that required the administration of hydrocodone (a medication used to treat moderate to severe pain). Findings: During a concurrent observation and interview on 2/6/25 at 2:16 p.m. with Resident 1 in Resident 1's room, a palm size red patch was observed on Resident 1's left anterior (front) and lateral (side) thigh. One quarter size open wound was on the anterior thigh. Two quarter size fluid filled blisters were on the anterior left thigh. Three quarter size fluid filled blisters were on the lateral left thigh. Resident 1 stated on 2/3/25 at 7:30 p.m. she requested water to wash her face before going to bed. Resident 1 stated Certified Nursing Assistant (CNA) 1 brought her hot water in a pitcher without a lid and set the pitcher on the bedside table. Resident 1 stated when she moved the bed up to access the water and the bed moved the bedside table Resident 1 stated CNA 1 responded by moving the bedside table and the pitcher with the hot water tipped over and spilled onto her left thigh. Resident 1 stated the water was scalding (a form of thermal burn resulting from heated fluids such as boiling water or steam) hot. Resident 1 stated she screamed in pain and staff came and placed ice packs on her left thigh and gave her hydrocodone for 10 out of 10 (scale used to measure the level pain a person is experiencing with a score of 0 indicating no pain up to a score of 10 indicating worse pain imaginable) pain. During a review of Resident 1's Admission Record (AR), dated 2/7/25, the AR indicated Resident 1 was admitted on [DATE] with a history of right femur fracture (broken upper leg bone) and unspecified open wound left lower leg. During a review of Resident 1's Minimum Data Set (MDS; a federally mandated process for clinical assessment of all residents of long term care nursing facilities), dated 11/24/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 15 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent with transfer (unable to move without help from another person or persons) from bed to chair and required assistance with dressing and personal hygiene (habits to maintain cleanliness). During a review of Resident 1's Medication Administration Record (MAR), dated 2/3/25, the MAR indicated, Resident 1 was administered hydrocodone 7.5 mg (milligrams; unit of measurement)/325 mg was administered at 7:37 p.m. with a pain level of 8 (indicating severe pain). (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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/6/25 at 3:05 p.m. with CNA 1, CNA 1 stated on 2/3/25 around 7 p.m. Resident 1 requested hot water to wash her face before going to bed. CNA 1 stated she went to the dining room and filled a pitcher with the hot water from the dining room sink. CNA 1 stated the water from the resident's room took too long to get hot. CNA 1 stated the pitcher was set on Resident 1's bedside table without a lid and when CNA 1 moved the bedside table, the pitcher tipped over spilling the hot water onto Resident 1's left thigh. CNA 1 stated Resident 1 screamed, was in pain, and Resident 1's left thigh was red. CNA 1 stated she should have filled a basin (a bowl used for washing) for stability instead of a pitcher and did not know the water from the dining room sink was out of the acceptable temperature range. CNA 1 stated extreme hot water can cause severe burn injury to the skin. During a review of the facility's IDT (Interdisciplinary Team; a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well-being of residents and staff) Notes, dated 2/4/25, the IDT Notes indicated, Brought to review by IDT r/t (related to) resident (Resident 1) spilling hot water on self-resulting in a burn injury on 2/3/2025 in PM shift . Around 1900 (7:00 p.m.), assigned staff member (CNA 1) notified LN (Licensed Nurse) that resident spilled hot water on her L (left) thigh. LN went to assess the resident immediately. Upon assessment, redness was noted to the L upper thigh, and resident complained of burning sensation . During a review of the facility's IDT Notes, dated 2/6/25, the IDT Notes indicated, In addendum to previous IDT note it was brought to review by IDT r/t burn injury on 2/3/25 on PM shift. It was brought to Dietary Supervisor attention of PM dietary aide witnessing employee involved in incident taking hot water from the coffee dispenser and not from dining room sink as stated by employee . During an interview on 2/11/24 at 3:39 p.m. with the Dietary Aide (DA), the DA stated she worked in the kitchen on 2/3/25. The DA stated she saw CNA 1 open the door to the kitchen and fill a pink pitcher with hot water from the coffee machine. The DA was unable to recall the time but stated it was after dinner. The DA stated the water in the coffee machine was 165 degrees Fahrenheit (F; unit of measurement). The DA stated exposure to the skin can burn the skin bad. During a review of the facility's video surveillance, dated 2/3/25 at 7:02 p.m., the video surveillance indicated, CNA 1 entered the facility's kitchen with a pink pitcher and stood by the door for eight seconds then proceeded into the hallway with the pink pitcher. During an observation and interview on 2/6/25 at 2:45 p.m. with The Registered Dietitian (RD) in the facility's kitchen, the [brand name] coffee machine was on the counter next to the kitchen door. The hot water from the coffee machine was measured with a digital thermometer (a device that measures temperature using a sensor an electronic display) at 165 degrees F. The RD stated, the hot water from the coffee machine measured 165 degrees F. The RD stated the hot water temperature was set at the manufacturer's guideline. During a review of the facility's coffee machine [brand name] manufacturer's guideline, the guideline indicated, [brand name] coffee machine's temperature setting range was 160 to 206 degrees F. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 2/6/25 at 3:45 p.m. with Maintenance Supervisor (MS) in the facility's dining room, there was a Caution Hot Water sign posted next to the sink. The hot water from the dining room's faucet was measured with a digital thermometer while running and reached 140 degrees F in 39 seconds. The MS stated the dining room's hot water faucet reached 140 degrees F in 39 seconds. MS stated staff and residents used the dining room to eat during break time and mealtimes. MS stated water temperature at 140 degrees F was not safe to use. During a concurrent observation and interview on 2/6/25 at 4:40 p.m. with the MS in the facility's dining room, the valve to the hot and cold water line was shut off. The hot and cold water was not running when turned on. MS stated the hot water temperature was out of range and the sink was put out of commission (not in service or not in working order) due to the unsafe hot water temperature. During an interview on 2/7/25 at 10:41 a.m. with the Director of Nursing (DON), the DON stated on 2/3/25 Resident 1 requested water to wash her face. The DON stated CNA 1 filled a pitcher with hot water from the coffee machine in the kitchen according to the facility's video surveillance. The DON stated CNA 1 informed her the hot water was obtained from the dining room. The DON stated the dining room's sink hot water temperature should not been hot enough to cause the burn injury to Resident 1's left thigh. The DON stated CNA's were expected to ask the Charge Nurse for hot water when residents request hot water to ensure safety. The DON stated she was not aware the dining room sinks hot water temperature was 140 degrees F. The DON stated the acceptable hot water temperature should be no more than 120 degrees F. The DON stated hot water above 120 degrees F can cause skin injury. The DON stated exposing residents to scalding hot water was physical abuse and it was not acceptable. During an interview on 2/7/25 at 3:44 p.m. with the Administrator (ADM), the ADM stated the facility's video surveillance dated 2/3/25 at 7:02 p.m. indicated CNA 1 obtained the hot water from the coffee machine in the kitchen. The ADM stated CNA 1 used to work in the kitchen and was comfortable going to the kitchen to get hot water. The ADM stated he was aware the facility's dining room sink's water temperature was out of the acceptable range and was waiting for HCAI (Health Care Access and Information; an agency that reviews plans, inspect construction, and enforce building codes in healthcare facilities to ensure safety and quality) to approve installing a permanent valve to control the water temperature. The ADM stated the acceptable water temperature range was 80 to 120 degrees F. The ADM stated temperatures above 120 degrees F can cause skin injury. The ADM stated exposing residents to scalding hot water was physical abuse and it was not acceptable. During a review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated 12/2016, the P&P indicated, Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual . 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents . (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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's P&P titled, Resident Rights, dated 12/2016, the P&P indicated, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; c. be free from abuse, neglect, misappropriation of property, and exploitation; . During a review of the facility's job description titled, Certified Nursing Assistant, dated 4/2013, the job description indicated, Purpose of Your Job Position: The primary purpose of your job position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors . Major Duties and Responsibilities: . Personnel Functions: Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors . Resident Rights: . Ensure that you treat all residents fairly, and with kindness, dignity, and respect . During a review of Professional Reference from https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/ABA%20Scald%20Injury%20Prevention%20Educator%27s%20Guide.pdf, titled, SCALD INJURY PREVENTION, undated, indicated, . Although scald burns can happen to anyone, young children, older adults and people with disabilities are the most likely to incur such injuries. Most scald burn injuries happen in the home, in connection with the preparation or serving of hot food or beverages, or from exposure to hot tap water in bathtubs or showers . The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. The most common regulatory standard for the maximum temperature of water delivered by residential water heaters to the tap is 120 degrees Fahrenheit . At this temperature, the skin of adults requires an average of five minutes of exposure for a full thickness burn to occur (most severe type of burns). When the temperature of a hot liquid is increased to 140 (degrees) F/60 C (Celsius; unit of measurement) it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180 F/71-82 C, resulting in almost instantaneous burns that will require surgery . High risk groups . Older adults, like young children, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Because they have poor microcirculation, heat is removed from burned tissue rather slowly compared to younger adults. Older adults may also have conditions that make them more prone to falls in the bathtub or shower or while carrying hot liquids .

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44708 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards for one of four residents (Resident 1), when a pitcher (a large container with a handle and a lip, used for holding and pouring liquids) filled with hot water by Certified Nursing Assistant (CNA) 1 spilled onto Resident 1's left thigh on 2/3/25. The facility's hot water temperatures were measured in sinks and showers with a digital thermometer (a device that measures temperature using a sensor an electronic display) on 2/6/25. A dining room sink was found to have a hot water temperature of 140 degrees Fahrenheit (F; unit of measurement). The Maintenance Supervisor (MS) who was responsible for maintaining water temperatures was not aware of the dining room sink's temperature of 140 degrees F. The facility's policy and procedure titled, Water Temperatures, Safety of, did not indicate how often the MS should measure, monitor and document the facility's water temperatures. This failure resulted in a Resident 1 experiencing second-degree burns (an injury that affects the outer layer of skin and part of the underlying layer of skin) to the left thigh, severe pain that required the administration of hydrocodone (a medication used to treat moderate to severe pain) and the potential for other residents that used the dining room sink to be burned. Findings: During an interview on 2/6/25 at 2:10 p.m. with the MS, the MS stated the facility's water temperature should be no more than 120 degrees F in the residents' room sinks and shower rooms. The MS stated Maintenance staff was not required to monitor or document the facility's water temperature. The MS stated staff was required to complete a work order if there was an issue with the facility's water supply. The MS stated water temperature above 120 degrees F can burn the skin. During a concurrent observation and interview on 2/6/25 at 2:16 p.m. with Resident 1 in Resident 1's room, a palm size red patch was observed on Resident 1's left anterior (front) and lateral (side) thigh. One quarter size open wound was on the anterior thigh. Two quarter size fluid filled blisters were on the anterior left thigh. Three quarter size fluid filled blisters were on the lateral left thigh. Resident 1 stated on 2/3/25 at 7:30 p.m. she requested water to wash her face before going to bed. Resident 1 stated Certified Nursing Assistant (CNA) 1 brought her hot water in a pitcher without a lid and set the pitcher the bedside table. Resident 1 stated when she moved the bed up to access the water, the bed moved the bedside table. Resident 1 stated CNA 1 responded by moving the bedside table and the pitcher with the hot water tipped over and spilled onto her left thigh. Resident 1 stated the water was scalding (a form of thermal burn resulting from heated fluids such as boiling water or steam) hot. Resident 1 stated she screamed in pain and staff came and placed ice packs on her left thigh and gave her hydrocodone for 10 out of 10 (scale used to measure the level pain a person is experiencing with a score of 0 indicating no pain up to a score of 10 indicating worse pain imaginable) pain. During a review of Resident 1's Admission Record (AR), dated 2/7/25, the AR indicated, Resident 1 was admitted on [DATE] with a history of right femur fracture (broken upper leg bone) and unspecified open wound left lower leg. (continued on next page)

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	02/06/2025

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Manning Gardens Care Center, Inc	2113 E. Manning Avenue Fresno, CA 93725

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS; process for clinical assessment of all residents of long term care nursing facilities), dated 11/24/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 15 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent with transfer (unable to move without help from another person or persons) from bed to chair and required assistance with dressing and personal hygiene (habits to maintain cleanliness). During a review of Resident 1's Medication Administration Record (MAR), dated 2/3/25, the MAR indicated, Resident 1 was administered hydrocodone 7.5 mg (milligrams; unit of measurement)/325 mg was administered at 7:37 p.m. with a pain level of 8 (indicating severe pain). During an interview on 2/6/25 at 3:05 p.m. with CNA 1, CNA 1 stated on 2/3/25 around 7 p.m. Resident 1 requested hot water to wash her face before going to bed. CNA 1 stated she went to the dining room and filled a pitcher with the hot water from the dining room sink. CNA 1 stated the water from the resident's room took too long to get hot. CNA 1 stated the pitcher was set on Resident 1's bedside table without a lid and when CNA 1 moved the bedside table, the pitcher tipped over spilling the hot water onto Resident 1's left thigh. CNA 1 stated Resident 1 screamed, was in pain, and Resident 1's left thigh was red. CNA 1 stated she should have filled a basin (a bowl used for washing) for stability instead of a pitcher. CNA 1 stated, she did not know the water from the dining room sink was out of the acceptable temperature range. CNA 1 stated extreme hot water can cause severe burn injury to the skin. During a review of the facility's IDT (Interdisciplinary Team; a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well being of residents and staff) Notes, dated 2/4/25, the IDT Notes indicated, Brought to review by IDT r/t (related to) resident (Resident 1) spilling hot water on self-resulting in a burn injury on 2/3/2025 in PM shift . Around 1900 (7:00 p.m.), assigned staff member (CNA 1) notified LN (Licensed Nurse) that resident spilled hot water on her L (left) thigh. LN went to assess the resident immediately. Upon assessment, redness was noted to the L upper thigh, and resident complained of burning sensation . During a review of the facility's IDT Notes, dated 2/6/25, the IDT Notes indicated, In addendum to previous IDT note it was brought to review by IDT r/t burn injury on 2/3/25 on PM shift. It was brought to Dietary Supervisor attention of PM dietary aide witnessing employee involved in incident taking hot water from the coffee dispenser and not from dining room sink as stated by employee . During an interview on 2/11/24 at 3:39 p.m. with the Dietary Aide (DA), the DA stated she worked in the kitchen on 2/3/25. The DA stated she saw CNA 1 open the door to the kitchen and fill a pink pitcher with hot water from the coffee machine. The DA was unable to recall the time but stated it was after dinner. The DA stated the water in the coffee machine was 165 degrees F. The DA stated exposure to the skin can burn the skin bad. During a review of the facility's video surveillance, dated 2/3/25 at 7:02 p.m., the video surveillance indicated, CNA 1 entered the facility's kitchen with a pink pitcher and stood by the door for eight seconds then proceeded into the hallway with the pink pitcher. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 2/6/25 at 2:45 p.m. with The Registered Dietitian (RD) in the facility's kitchen, the [brand name] coffee maker was on the counter next to the door. The hot water from the coffee machine was measured with a digital thermometer at 165 degrees F. The RD stated, the hot water from the coffee machine measured 165 degrees F. The RD stated the hot water temperature was set at the manufacturer's guideline. During a review of the facility's coffee machine [brand name] manufacturer's guideline, the guideline indicated, [brand name] coffee machine's temperature setting range was 160 to 206 degrees F. During a concurrent observation and interview on 2/6/25 at 3:45 p.m. with the MS in the facility's dining room, there was a Caution Hot Water sign posted next to the sink. The hot water from the dining room's faucet was measured with a digital thermometer while running and reached 140 degrees F in 39 seconds. The MS stated the dining room's hot water faucet reached 140 degrees F in 39 seconds. MS stated staff and residents used the dining room to eat during break time and mealtimes. MS stated water temperature at 140 degrees F was not safe to use. During an interview on 2/6/25 at 4:15 p.m. with CNA 2, CNA 2 stated staff used the dining room during break time and residents used the dining room during mealtimes. CNA 2 stated she used the dining room sink to wash her hands. CNA 2 stated the hot water was too hot and the cold water was needed to be on with the hot water to wash her hands. CNA 2 stated she did not know the acceptable water temperature and stated hot water can burn skin. During an interview on 2/6/25 at 4:18 p.m. with CNA 3, CNA 3 stated she used the dining room sink to wash her hands. CNA 3 stated the hot water was too hot and the cold water was needed to be on with the hot water to wash her hands. CNA 3 stated she did not know the acceptable water temperature and stated hot water can burn skin. During an interview on 2/6/25 at 4:21 p.m. with CNA 4, CNA 4 stated she used the dining room sink to wash her hands. CNA 3 stated the hot water was too hot and the cold water was needed to be on with the hot water to wash her hands. CNA 4 stated she did not know the acceptable water temperature and stated hot water can burn skin. During an interview on 2/6/25 at 4:25 with Licensed Vocational Nurse (LVN) 1, LVN 1 stated staff and residents used the dining room during break time and mealtimes. LVN 1 stated she was not aware the water temperature from the dining room sink was 140 degrees F. LVN 1 stated if residents requested hot water staff need to get water from the bathroom in their room. LVN 1 stated she did not know the acceptable water temperature. LVN 1 stated hot water can cause skin injury. During an interview on 2/6/25 at 4:30 p.m. with LVN 2, LVN 2 stated staff and residents used the dining room during break time and mealtimes. LVN 2 stated she used the dining room sink to wash her hands. LVN 2 stated she was not aware of how hot the dining room sink water was and she used both hot and cold water to wash her hands. LVN 2 did not know the acceptable water temperature. LVN 2 stated hot water can burn the skin. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/6/25 at 4:36 p.m. with LVN 3, LVN 3 stated staff and residents eat in the dining room during break time and mealtimes. LVN 3 stated staff used the dining room sink to wash their hands. LVN 3 was unable to recall if there was a Caution Hot Water sign posted next to the sink. LVN 3 stated the dining room sink's hot water was too hot and she needed to turn on the cold water with the hot water to wash hands. LVN 3 did not know the acceptable water temperature. LVN 3 stated hot water can cause skin injury. During a concurrent observation and interview on 2/6/25 at 4:40 p.m. with the MS in the facility's dining room, the valve (a device for controlling the passage of fluid or air through a pipe, duct, etc., especially an automatic device allowing movement in one direction only) to the hot and cold water line was shut off. The hot and cold water was not running when turned on. MS stated the hot water temperature was out of range and the sink was put out of commission (not in service or not in working order) due to the unsafe hot water temperature. During a concurrent observation and interview on 2/6/25 at 4:45 p.m. seven residents entered the dining room to have dinner. Residents 2, 3 and 4 were part of the seven residents in the dining area. Resident 2 stated he ate every meal in the dining room and used the dining room sink to wash his hands. Resident 2 stated the hot water in the dining room sink was too hot and he used the hot and cold water together to wash his hands. Resident 2 stated hot water can burn the skin. During a review of Resident 2's AR, dated 2/6/25, the AR indicated, Resident 2 was admitted on [DATE]. During a review of Resident 2's BIMS, dated 12/24/24, the BIMS indicated a score of 15. During an interview on 2/6/25 at 4:47 p.m. with Resident 3, Resident 3 stated she ate every meal in dining room. Resident 3 stated she had not used the dining room sink. Resident 3 stated, she was unaware that the dining room sink's hot water was too hot. Resident 3 stated hot water can burn the skin. During a review of Resident 3's AR, dated 2/6/25, the AR indicated Resident 3 was admitted on [DATE]. During a review of Resident 3's BIMS, dated 1/27/25, the BIMS indicated a score of 15. During an interview on 2/6/25 at 4:50 p.m. with Resident 4, Resident 4 stated she ate every meal in dining room. Resident 4 stated she had not used the dining room sink . Resident 4 stated, she was unaware that the dining room sink's hot water was too hot. Resident 4 stated hot water can burn the skin. During a review of Resident 4's AR, dated 2/6/25, the AR indicated Resident 4 was admitted on [DATE]. During a review of Resident 4's BIMS, dated 1/8/25, the BIMS indicated a score of 15. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/7/25 at 10:41 a.m. with the Director of Nursing (DON), the DON stated, on 2/3/25 Resident 1 requested water to wash her face. The DON stated CNA 1 filled a pitcher with hot water from the coffee machine in the kitchen according to the facility's video surveillance. The DON stated CNA 1 informed her the hot water was obtained from the dining room. The DON stated the dining room sink's hot water temperature should not have been hot enough to cause the burn injury to Resident 1's left thigh. The DON stated CNA's were expected to ask the Charge Nurse for hot water when residents request hot water to ensure safety. The DON stated she was not aware the dining room sink's hot water temperature was 140 degrees F. The DON stated the acceptable hot water temperature should be no more than 120 degrees F. The DON stated hot water above 120 degrees F can cause skin injury. The DON stated the facility's current policy required Maintenance staff to check the facility's water temperatures periodically but did not specify how often Maintenance staff should be checking and documenting the temperatures. The DON stated, she expected Maintenance staff to check water temperatures regularly and have a schedule to check water temperatures to ensure safe temperature levels. The DON stated, water temperatures should be monitored monthly or quarterly and documented. During an interview on 2/7/25 at 3:44 p.m. with the Administrator (ADM), the ADM stated the facility's video surveillance dated 2/3/25 at 7:02 p.m. indicated, CNA 1 obtained the hot water from the coffee machine in the kitchen. The ADM stated, CNA 1 used to work in the kitchen and was comfortable going to the kitchen to get hot water. The ADM stated he was aware the facility's dining room sink's water temperature was out of the acceptable range. The ADM stated the acceptable water temperature range was 80 to 120 degrees F. The ADM stated water temperatures above 120 degrees F can cause skin injury. The ADM stated, a survey team (a group of State Agency employees who inspect and approve facilities for insurance services) informed him last year that the dining room sink's hot water temperature was out of range during the inspection process and he was instructed to post a Caution Hot Water sign next to the sink until the facility installed a valve to ensure safe water temperatures. The ADM stated the facility was still waiting for HCAI (Health Care Access and Information; an agency that reviews plans, inspect construction, and enforce building codes in healthcare facilities to ensure safety and quality) to approve installing a permanent valve to control the water temperature. The ADM stated the facility's current water safety policy and procedure indicated water temperatures should be checked periodically but did not indicate how often. The ADM stated the policy and procedure needed revision to ensure Maintenance staff check the facility's water temperatures weekly and document the water temperatures. During a review of the facility's policy and procedure (P&P) titled, Water Temperatures, Safety of, dated 12/2009, the P&P indicated, Policy Statement: . water in the facility shall be kept within a temperature range to prevent scalding of residents. Policy Interpretation and Implementation: 1. Water heaters that service resident rooms, bathroom, and tub/shower area shall be set to temperatures of no more than 120 (degrees) F (48 C; Celsius - unit of measurement), or the maximum allowable temperature per state regulation. 2. Maintenance staff is responsible for checking thermostats and temperature controls in the facility. 3 Maintenance staff may conduct periodic tap water temperature checks and record the water temperatures if there's a fluctuation or concern with the water temperature . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's job description titled, Building & Maintenance Supervisor, dated 4/2023, the job description indicated, Purpose of Your Job Position: Responsible for overall management of laundry and maintenance/janitorial personnel to ensure a clean, safe and orderly living environment for residents of the Nursing Home . Major Duties and Responsibilities: . Solely responsible for the housekeeping, maintenance, central supply, and laundry services for the facility. The primary function of this position is to ensure nursing home residents enjoy a clean, well maintained, orderly living environment . Develops systems and programs for maximizing the effectiveness of the housekeeping, laundry, central supply, and maintenance functions . Complies with Department of Public Health and State Fire Marshall directives pertaining to the Nursing Home's fire and safety program . Oversees maintenance of plumbing, heating and cooling, refrigeration, electrical and communication systems . During a review of the facility's job description titled, Certified Nursing Assistant, dated 4/2013, the job description indicated, Purpose of Your Job Position: The primary purpose of your job position is to provide your assigned residents with routine daily nursing care in accordance with our established nursing care procedures, and as may be directed by your supervisors . Major Duties and Responsibilities: . Personnel Functions: Perform all assigned tasks in accordance with our established policies and procedures, and as instructed by your supervisors . Resident Rights: . Ensure that you treat all residents fairly, and with kindness, dignity, and respect . During a review of Professional Reference from https://dds.dc.gov/sites/default/files/dc/sites/dds/publication/attachments/ABA%20Scald%20Injury%20Prevention%20Educator%27s%20Guide.pdf, titled, SCALD INJURY PREVENTION, undated, indicated, . Although scald burns can happen to anyone, young children, older adults and people with disabilities are the most likely to incur such injuries. Most scald burn injuries happen in the home, in connection with the preparation or serving of hot food or beverages, or from exposure to hot tap water in bathtubs or showers . The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. The most common regulatory standard for the maximum temperature of water delivered by residential water heaters to the tap is 120 degrees Fahrenheit . At this temperature, the skin of adults requires an average of five minutes of exposure for a full thickness burn to occur (most severe type of burns). When the temperature of a hot liquid is increased to 140 (degrees) F/60 C (Celsius; unit of measurement) it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180 F/71-82 C, resulting in almost instantaneous burns that will require surgery . High risk groups . Older adults, like young children, have thinner skin so hot liquids cause deeper burns with even brief exposure. Their ability to feel heat may be decreased due to certain medical conditions or medications so they may not realize water is too hot until injury has occurred. Because they have poor microcirculation, heat is removed from burned tissue rather slowly compared to younger adults. Older adults may also have conditions that make them more prone to falls in the bathtub or shower or while carrying hot liquids . (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 0689 Level of Harm - Actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure the resident environment remained free of accident hazards for one of four residents (Resident 1), when a pitcher (a large container with a handle and a lip, used for holding and pouring liquids) filled with hot water by Certified Nursing Assistant (CNA) 1 spilled onto Resident 1's left thigh on 2/3/25. The facility's hot water temperatures were measured in sinks and showers with a digital thermometer (a device that measures temperature using a sensor an electronic display) on 2/6/25. A dining room sink was found to have a hot water temperature of 140 degrees Fahrenheit (F; unit of measurement). The Maintenance Supervisor (MS) who was responsible for maintaining water temperatures was not aware of the dining room sink's temperature of 140 degrees F. The facility's policy and procedure titled, Water Temperatures, Safety of, did not indicate how often the MS should measure, monitor and document the facility's water temperatures. This failure resulted in a Resident 1 experiencing second-degree burns (an injury that affects the outer layer of skin and part of the underlying layer of skin) to the left thigh, severe pain that required the administration of hydrocodone (a medication used to treat moderate to severe pain) and the potential for other residents that used the dining room sink to be burned. Findings: During an interview on 2/6/25 at 2:10 p.m. with the MS, the MS stated the facility's water temperature should be no more than 120 degrees F in the residents' room sinks and shower rooms. The MS stated Maintenance staff was not required to monitor or document the facility's water temperature. The MS stated staff was required to complete a work order if there was an issue with the facility's water supply. The MS stated water temperature above 120 degrees F can burn the skin. During a concurrent observation and interview on 2/6/25 at 2:16 p.m. with Resident 1 in Resident 1's room, a palm size red patch was observed on Resident 1's left anterior (front) and lateral (side) thigh. One quarter size open wound was on the anterior thigh. Two quarter size fluid filled blisters were on the anterior left thigh. Three quarter size fluid filled blisters were on the lateral left thigh. Resident 1 stated on 2/3/25 at 7:30 p.m. she requested water to wash her face before going to bed. Resident 1 stated Certified Nursing Assistant (CNA) 1 brought her hot water in a pitcher without a lid and set the pitcher the bedside table. Resident 1 stated when she moved the bed up to access the water, the bed moved the bedside table. Resident 1 stated CNA 1 responded by moving the bedside table and the pitcher with the hot water tipped over and spilled onto her left thigh. Resident 1 stated the water was scalding (a form of thermal burn resulting from heated fluids such as boiling water or steam) hot. Resident 1 stated she screamed in pain and staff came and placed ice packs on her left thigh and gave her hydrocodone for 10 out of 10 (scale used to measure the level pain a person is experiencing with a score of 0 indicating no pain up to a score of 10 indicating worse pain imaginable) pain. During a review of Resident 1's Admission Record (AR), dated 2/7/25, the AR indicated, Resident 1 was admitted on [DATE] with a history of right femur fracture (broken upper leg bone) and unspecified open wound left lower leg. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS; process for clinical assessment of all residents of long term care nursing facilities), dated 11/24/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS; an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 15 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent with transfer (unable to move without help from another person or persons) from bed to chair and required assistance with dressing and personal hygiene (habits to maintain cleanliness). During a review of Resident 1's Medication Administration Record (MAR), dated 2/3/25, the MAR indicated, Resident 1 was administered hydrocodone 7.5 mg (milligrams; unit of measurement)/325 mg was administered at 7:37 p.m. with a pain level of 8 (indicating severe pain). During an interview on 2/6/25 at 3:05 p.m. with CNA 1, CNA 1 stated on 2/3/25 around 7 p.m. Resident 1 requested hot water to wash her face before going to bed. CNA 1 stated she went to the dining room and filled a pitcher with the hot water from the dining room sink. CNA 1 stated the water from the resident's room took too long to get hot. CNA 1 stated the pitcher was set on Resident 1's bedside table without a lid and when CNA 1 moved the bedside table, the pitcher tipped over spilling the hot water onto Resident 1's left thigh. CNA 1 stated Resident 1 screamed, was in pain, and Resident 1's left thigh was red. CNA 1 stated she should have filled a basin (a bowl used for washing) for stability instead of a pitcher. CNA 1 stated, she did not know the water from the dining room sink was out of the acceptable temperature range. CNA 1 stated extreme hot water can cause severe burn injury to the skin. During a review of the facility's IDT (Interdisciplinary Team; a group of staff members consisting of nursing, dietary, rehabilitation, social services, activities, and administration who meet regularly to discuss incidents that occurred involving the well being of residents and staff) Notes, dated 2/4/25, the IDT Notes indicated, Brought to review by IDT r/t (related to) resident (Resident 1) spilling hot water on self-resulting in a burn injury on 2/3/2025 in PM shift . Around 1900 (7:00 p.m.), assigned staff member (CNA 1) notified LN (Licensed Nurse) that resident spilled hot water on her L (left) thigh. LN went to assess the resident immediately. Upon assessment, redness was noted to the L upper thigh, and resident complained of burning sensation . During a review of the facility's IDT Notes, dated 2/6/25, the IDT Notes indicated, In addendum to previous IDT note it was brought to review by IDT r/t burn injury on 2/3/25 on PM shift. It was brought to Dietary Supervisor attention of PM dietary aide witnessing employee involved in incident taking hot water from the coffee dispenser and not from dining room sink as stated by employee . During an interview on 2/11/24 at 3:39 p.m. with the Dietary Aide (DA), the DA stated she worked in the kitchen on 2/3/25. The DA stated she saw CNA 1 open the door to the kitchen and fill a pink pitcher with hot water from the coffee machine. The DA was unable to recall the time but stated it was after dinner. The DA stated the water in the coffee machine was 165 degrees F. The DA stated exposure to the skin can burn the skin bad. During a review of the facility's video surveillance, dated 2/3/25 at 7:02 p.m., the video surveillance indicated, CNA 1 entered the facility's kitchen with a pink pitcher and stood by the door for eight seconds then proceeded into the hallway with the pink pitcher. (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 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 2/6/25 at 2:45 p.m. with The Registered Dietitian (RD) in the facility's kitchen, the [brand name] coffee maker was on the counter next to the door. The hot water from the coffee machine was measured with a digital thermometer at 165 degrees F. The RD stated, the hot water from the coffee machine measured 165 degrees F. The RD stated the hot water temperature was set at the manufacturer's guideline. During a review of the facility's coffee machine [brand name] manufacturer's guideline , the guideline indicated, [brand name] coffee machine's temperature setting range was 160 to 206 degrees F. During a concurrent observation and interview on 2/6/25 at 3:45 p.m. with the MS in the facility's dining room, there was a Caution Hot Water sign posted next to the sink. The hot water from the dining room's faucet was measured with a digital thermometer while running and reached 140 degrees F in 39 seconds. The MS stated the dining room's hot water faucet reached 140 degrees F in 39 seconds. MS stated staff and residents used the dining room to eat during break time and mealtimes. MS stated water temperature at 140 degrees F was not safe to use. During an interview on 2/6/25 at 4:15 p.m. with CNA 2, CNA 2 stated staff used the dining room during break time and residents used the dining room during mealtimes. CNA 2 stated she used the dining room sink to wash her hands. CNA 2 stated the hot water was too hot and the cold water was needed to be on with the hot water to wash her hands. CNA 2 stated she did not know the acceptable water temperature and stated hot water can burn skin. During an interview on 2/6/25 at 4:18 p.m. with CNA 3, CNA 3 stated she used the dining room sink to wash her hands. CNA 3 stated the hot water was too hot and the cold water was needed to be on with the hot water to wash her hands. CNA 3 stated she did not know the acceptable water temperature and stated hot water can burn skin. During an interview on 2/6/25 at 4:21 p.m. with CNA 4, CNA 4 stated she used the dining room sink to wash her hands. CNA 3 stated the hot water was too hot and the cold water was needed to be on with the hot water to wash her hands. CNA 4 stated she did not know the acceptable water temperature and stated hot water can burn skin. During an interview on 2/6/25 at 4:25 with Licensed Vocational Nurse (LVN) 1, LVN 1 stated staff and residents used the dining room during break time and mealtimes. LVN 1 stated she was not aware the water temperature from the dining room sink was 140 degrees F. LVN 1 stated if residents requested hot water staff need to get water from the bathroom in their room. LVN 1 stated she did not know the acceptable water temperature. LVN 1 stated hot water can cause skin injury. During an interview on 2/6/25 at 4:30 p.m. with LVN 2, LVN 2 stated staff and residents used the dining room during break time and mealtimes. LVN 2 stated she used the dining room sink to wash her hands. LVN 2 stated she was not aware of how hot the dining room sink water was and she used both hot and cold water to wash her hands. LVN 2 did not know the acceptable water temperature. LVN 2 stated hot water can burn the skin. (continued on next page)

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	02/06/2025

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/6/25 at 4:36 p.m. with LVN 3, LVN 3 stated staff and residents eat in the dining room during break time and mealtimes. LVN 3 stated staff used the dining room sink to wash their hands. LVN 3 was unable to recall if there was a Caution Hot Water sign posted next to the sink. LVN 3 stated the dining room sink's hot water was too hot and she needed to turn on the cold water with the hot water to wash hands. LVN 3 did not know the acceptable water temperature. LVN 3 stated hot water can cause skin injury. During a concurrent observation and interview on 2/6/25 at 4:40 p.m. with the MS in the facility's dining room, the valve to the hot and cold water line was shut off. The hot and cold water was not running when turned on. MS stated the hot water temperature was out of range and the sink was put out of commission (not in service or not in working order) due to the unsafe hot water temperature. During a concurrent observation and interview on 2/6/25 at 4:45 p.m. seven residents entered the dining room to have dinner. Residents 2, 3 and 4 were part of the seven residents in the dining area. Resident 2 stated he ate every meal i [TRUNCATED]