

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Manning Gardens Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment when the transition strip (a narrow piece of material used to bridge the gap between two different types of flooring) between the residents' room and hallway to room [ROOM NUMBER] was approximately 0.5 inches (unit of measurement) in height and the transition strip to room [ROOM NUMBER], 3, 4, 5, 6, 9, 10, 12, 14, 15, 16, 17, 18, 19, 20, and 21 were cracked and uneven. This failure had the potential to result in hazardous conditions for four of four sampled residents (Resident 1, 2, 3, and 4) which could lead to falls and injury. Findings: During a concurrent observation and interview on 2/13/26 at 9:33 a.m. with Resident 1 in room [ROOM NUMBER], Resident 1 was sitting on his bed. Resident 1 stated he fell one month ago. Resident 1 stated he was sitting in his wheelchair while going backward to get out of his room. Resident 1 stated there was a lip (transition strip) on the floor between the room and hallway, and Resident 1 was unable to push his wheelchair pass the lip. Resident 1 stated he stood up to push the wheelchair back behind him and when the wheelchair moved back, he lost his balance and fell onto the floor landing on his bottom. Resident 1 stated he hurt his back during the fall. Resident 1 stated he pushed himself backward while sitting in the wheelchair to get out of his room because the back wheels were bigger making it easier to get over the lip. Resident 1 pointed to the transition strip at the entrance, which was cracked and uneven. During a record review of Resident 1's admission Record (AR), dated 2/13/26, the AR indicated Resident 1 had a diagnosis of Hepatitis C (a viral infection that causes liver swelling and inflammation), Coccidioidomycosis (also known as Valley Fever is a fungal infection caused by inhaling Coccidioides spores found in the soil of arid regions like the southwestern U.S. and California) and Muscle Weakness. During a record review of 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), dated 1/22/26, the BIMS score was 15 (a score of 0 to 7 indicated severe cognitive impairment, 8 to 12 indicated moderate cognitive impairment, and 13 to 15 indicated minimal to no cognitive impairment). During a concurrent observation and interview on 2/13/26 at 10:05 a.m. with the Director of Maintenance (DOM), the transition strip to room [ROOM NUMBER] was measured to be approximately 0.25 inches in height. The DOM stated the transition strip was cracked and uneven and needed to be replaced. The transition strip to room [ROOM NUMBER] was made of wood and was approximately 0.5 inches in height. The DOM stated the standard American Disability Act (ADA) height requirement for a transition strip was 0.25 inches. The transition strip to rooms 2, 3, 4, 5, 6, 9, 10, 12, 14, 15, 16, 17, 18, 19, 20 and 21 were made of plastic and measured to be approximately 0.25 inches in height. The DOM stated the transition strips to rooms 1, 2, 3, 4, 5, 6, 9, 10, 12, 14, 15, 16, 17, 18, 19, 20, and 21 could be difficult for residents to get pass safely. The DOM stated the transition pieces were high, uneven, and cracked which could tip the</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055423	Facility ID: 055423 If continuation sheet Page 1 of 4

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>resident over in the wheelchair and fall. During a concurrent observation and interview on 2/13/26 at 10:10 a.m. with Resident 2 outside room [ROOM NUMBER] in the hallway, Resident 2 was sitting in his wheelchair with two family members. Resident 2 stated room [ROOM NUMBER] was his room. Resident 2 stated the transition strip made it difficult to go in and out of his room. Resident 2 stated sometimes the transition strip would cause the wheelchair to spin. Resident 2 stated the transition strip would cause the wheelchair to turn as he crossed the transition strip. Resident 2 stated the transition strip could cause a fall. During a record review of Resident 2's AR, dated 2/13/26, the AR indicated Resident 2 had a diagnosis of Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease that causes severe, long-term breathing difficulty), Hypertensive Heart Disease (chronic high blood pressure leading to heart muscle thickening, stiffening, and eventual failure), Dorsalgia (pain in any part of the back, including the neck, mid-back, or lower back), and Dementia (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking). During a record review of Resident 2's BIMS, dated 2/9/26, the BIMS score was 11. During a concurrent observation and interview on 2/13/26 at 10:30 a.m. with Resident 3 in room [ROOM NUMBER], Resident 3 was sitting in her wheelchair next to bed 2. Resident 3 stated she had been using the wheelchair for mobilization for seven years due to a history of fibromyalgia (a chronic, non-progressive neurological condition characterized by musculoskeletal pain, fatigue, sleep disturbances and disruption in mental processes). Resident 3 stated the transition strip in her room was not an issue for her because she was strong enough to pass it in her wheelchair, but the transition strip could be difficult for other residents. Resident 3 stated she has seen residents go backward in their wheelchair to get in and out of their rooms because the back wheels were bigger which made it easier to pass the transition strip. Resident 3 stated going backward in the wheelchair could cause a fall. Resident 3 stated some residents shuffle (not lifting the feet off the floor completely when walking), and an uneven and cracked transition strip could cause them to trip and fall. Resident 3 stated the transition strip should be smooth, flat, and even to provide easy access to pass. During a record review of Resident 3's AR, dated 2/13/26, the AR indicated Resident 3 had a diagnosis of Sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, resulting in widespread inflammation, tissue damage, and potential organ failure), Type 2 Diabetes Mellitus (a chronic metabolic disorder characterized by high blood sugar due to insulin resistance), Cellulitis (acute, spreading bacterial infection of the deep dermis and subcutaneous tissue) and Hypertensive Heart Disease. During a record review of Resident 3's BIMS, dated 2/18/26, the BIMS score was 14. During a concurrent observation and interview on 2/13/26 at 10:35 a.m. with Resident 4 in room [ROOM NUMBER], Resident 4 was lying in bed 3. Resident 4 stated she used a walker and wheelchair for mobilization. Resident 4 stated the bump (transition strip) on the floor at the entrance was difficult to pass. Resident 4 stated she was unable to get pass the transition strip using her walker and wheelchair and must call staff for assistance when going in and out of her room. During a record review of Resident 4's AR, dated 2/13/26, the AR indicated Resident 4 had a diagnosis of Discitis of lumbar region (medical condition characterized by inflammation of the intervertebral disc space in the lower back), Sepsis, Type 2 Diabetes Mellitus, and Cutaneous Abscess of back (a localized, painful collection of pus, dead tissue, and bacteria that forms within the deep skin layers on the back). During a record review of Resident 4's BIMS, dated 1/17/26, the BIMS score was 13. During an interview on 2/13/26 at 10:44 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated pushing the residents in and out of the rooms in the wheelchair was difficult because the transition strips were bumpy. CNA 1 stated some transition strips were more cracked and</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>uneven than others and could cause a fall. During an interview on 2/13/26 at 10:54 a.m. with CNA 3, CNA 3 stated the transition strips to the residents' rooms were difficult to push residents in and out of their rooms in their wheelchairs and with the shower chair (an assistive device designed to provide a stable, water-resistant seating surface for individuals who have limited mobility, poor balance, or reduced physical strength). CNA 3 stated the shower chairs had small and hard wheels which made it more difficult to get pass the transition strips. CNA 3 stated going backward in a wheelchair could cause the wheelchair to tilt backward, resulting in a fall. CNA 3 stated the transition strip could cause a fall going forward in a wheelchair or shower chair since the transition strip was not flat, smooth, and even. CNA 3 stated assisting heavier residents in a wheelchair and shower chair was more difficult to get pass the transition strips and had a higher risk of falling. During a concurrent observation and interview on 2/13/26 at 11:48 a.m. with the Director of Staff Development (DSD), the transition strips to rooms 1, 2, 3, 4, 5, 6, 9, 10, 12, 14, 15, 16, 17, 18, 19, 20, and 21 were observed. The DSD stated the transition strips were cracked and uneven and could be a fall hazard. The DSD stated the transition strip should be flat, smooth, and even so residents and staff could pass without difficulty. The DSD stated the facility should be a safe, functional, sanitary, and comfortable environment for residents and staff. During an interview on 2/20/26 at 3:26 p.m. with the Administrator (ADM), the ADM stated the transition strip was not hazardous. The ADM stated residents walked past the transition strips 1000 times and there was no fall. The ADM stated Resident 1 chose to go backward in the wheelchair and caused himself to fall. The ADM stated the facility should provide a safe, functional, sanitary, and comfortable environment for residents and staff. During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 7/2027, the P&P indicated, Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation: .2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (Quality Assurance and Performance Improvement - a mandatory, data-driven framework for nursing homes and home health agencies to improve care quality and resident safety) reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 3. When accident hazards are identified, the QAPI/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. During a review of the facility's P&P titled, Maintenance Service, dated 2001, the P&P indicated, Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation: 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: .b. maintaining the building in good repair and free from hazards. During a professional reference review retrieved from https://www.access-board.gov/files/ada/ADA-Standards.pdf titled, Americans with Disabilities Act (ADA) Standards, dated 2010, the professional reference indicated, ADA CHAPTER 1: APPLICATION AND ADMINISTRATION. (Section) 101.1 General. This document contains scoping and technical requirements for accessibility to sites, facilities, buildings, and elements by individuals with disabilities. The requirements are to be applied during the design, construction, additions to, and alteration of sites, facilities, buildings, and elements to the extent required by regulations issued by Federal agencies under the Americans with Disabilities Act of 1990 (ADA). CHAPTER 3: BUILDING BLOCKS. 302. Floor or Ground Surfaces. 302.1 General. Floor and ground surfaces shall be</p> <p>(continued on next page)</p>		

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