

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 11/08/2024
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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>48424</p> <p>Based on observation, interview, and record review, the facility failed to provide one of six sampled residents (Resident 44) the right to self-administer medications, when Resident 44 stated she wanted to keep her inhaler at bedside and the facility did not allow her to.</p> <p>This failure resulted in Resident 44's right to self-administer medications to be violated and had the potential to cause Resident 44 to experience difficulty breathing as a result of not having her inhaler at the bedside.</p> <p>Findings:</p> <p>During a review of Resident 44's Admission Record (AR- a document which provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/8/2024, the AR indicated, Resident 44 was admitted with the following diagnoses: asthma (lung condition which causes the tubes that carry oxygen in and out of the lungs to become swollen making it difficult to breathe) and traumatic pneumothorax (when air gets trapped between the lung and chest wall after an injury making it hard to breathe).</p> <p>During a review of Resident 44's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 9/17/24, the MDS indicated, a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 29 had no cognitive impairment.</p> <p>During a concurrent observation and interview on 11/5/24 at 10:47 a.m. in Resident 44's room, Resident 44's bedside table and bedside counter were empty, no personal medications observed. Resident 44 stated she wanted to keep her albuterol (a medication which causes the tubes that deliver oxygen in the lungs to open and make breathing easier) inhaler next to her on her bedside table. Resident 44 stated she had asthma that made breathing difficult sometimes and she wanted to have her inhaler close by in case of an emergency. Resident 44 stated nurses told her she was not allowed to keep her medications in her room even though she requested</p> <p>During an interview on 11/07/24 at 2:27 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated he had heard Resident 44 ask licensed nurses if she could keep her inhaler at bedside. CNA 7 stated he remembered the nurses telling her no. CNA 7 stated Resident 44 used her inhaler frequently, up to three times a day.</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
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/07/24 at 2:37 p.m. with Registered Nurse (RN) 1, Resident 44's Order Summary Report, dated 11/7/24, was reviewed. The Order Summary Report indicated, there was no order for self-administration of Resident 44's albuterol inhaler. RN 1 stated residents were allowed to keep their inhalers at the bedside for self-administration. RN 1 stated a doctor's order needed to be obtained for Resident 44 to keep her inhaler at the bedside and self-administer the medication. RN 1 stated Resident 44 had asthma and would have benefited from keeping her inhaler close to her, she was able to follow instructions and could make her own decisions. RN 1 stated staff should not have refused Resident 44's request to keep her inhaler at bedside for self-administration. RN 1 stated it was Resident 44's right to self-administer her own medication and keep it next to her</p> <p>and staff should have allowed her to do so.</p> <p>During an interview on 11/07/24 at 5:52 a.m. With Licensed Vocational Nurse (LVN) 2, LVN 2 stated she thought residents were not allowed to keep medications with them at bedside, she had not been trained on this and was unaware of the policy.</p> <p>During an interview on 11/08/24 at 11:52 a.m. with the Director of Nursing (DON), the DON stated residents were allowed to store their medications at bedside if they desired to. The DON stated if a resident asked a nurse for permission to keep the medications with them, the nurse needed to obtain a doctor's order and assess whether the resident had the ability to properly self-administer.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated 2001, the P&P indicated, .Residents have the right to self-administer medications if the interdisciplinary team (IDT- A group of healthcare professionals from different disciplines who work together to provide personalized care for patients) has determined that it is clinically appropriate and safe for the resident to do so . As part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 2. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration; b. The resident is able to read and understand medication labels; c. The resident can follow directions and tell time to know when to take the medication; d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; e. The resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and f. The resident is able to safely and securely store the medication . 5. Residents who are identified as being able to self-administer medications are asked whether they wish to do so .</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739</p> <p>Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for two of 12 residents (Resident 1 and Resident 3) when:</p> <ol style="list-style-type: none"> 1. Resident 1's care plan was not developed to reflect an assessment and interventions for the use of bed rails. <p>This failure put Resident 1 at risk of harm due to improper use of bed rails.</p> <ol style="list-style-type: none"> 2. Resident 3's care plan was not developed and implemented to reflect assessments and interventions to address Resident 3's edema (medical term for swelling) to the right and left lower legs, or the use of a brace for Resident 3's right leg. <p>These failures resulted in Resident 3 suffering from a wound to the right shin (lower front leg) and Resident 3 suffered from a trauma induced skin injury to the right inner ankle that caused severe pain and negatively affected Resident 3's mobility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an observation on 11/5/24 at 8:35 a.m., Resident 1 was observed in bed sleeping. Bed rails were observed raised on both sides at the head of Resident 1's bed. Fall mats were observed on the right and left side of Resident 1's bed. <p>During a review of Resident 1's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/8/24, the AR indicated, Resident 1 was admitted on [DATE] with diagnoses of Alzheimer's (a disease characterized by a progressive decline in mental abilities), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), psychosis (a mental disorder characterized by a disconnection from reality), fracture of the left femur (a break in the thigh bone), hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke [damage to the brain from interruption of it's blood supply], caused by a brief blockage of blood flow to the brain).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/4/24, the MDS section C indicated, Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 1 was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of Resident 1's medical record, Resident 1 was observed to have no documentation of a care plan for the use of bed rails, no documentation of a bed rail assessment, no physician orders for the use of bed rails, and no consent on file for the use of bed rails.</p> <p>During a concurrent interview and record review on 11/6/24 at 9:44 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's medical record was reviewed. Resident 1's medical record indicated, no physician orders for the use of bed rails for Resident 1, no consent on file for the use of bed rails for Resident 1, no care plan was in place for the use of bed rails for Resident 1 and no bed assessment was documented for the use of bed rails for Resident 1. LVN 1 stated Resident 1 should have orders, a care plan, and a bed assessment for the use of bed rails on Resident 1's bed. LVN 1 stated Resident 1 should have had physician orders for bed rails. LVN 1 stated bed rails were considered a restrictive device. LVN 1 stated if a bed was not assessed for bed rails, the bed rails could be unsafe, and the resident could get hurt. LVN 1 stated a care plan was to ensure staff who assisted Resident 1 with turning and repositioning were using the bed rails appropriately.</p> <p>During a review of the facility's job duties document titled, Floor Nurse, dated 4/2013, the document indicated, . documentation . encourage attending physicians to review treatment plans, record and sign their orders, progress notes, etc., in accordance with established policies . report all discrepancies noted concerning physician's orders . to the Director of Nursing (DON) . use restraints when necessary and in accordance with established policies and procedures . ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan and wishes . monitor your assigned personnel to ensure that they are following established safety regulations in the use of equipment and supplies . review care plans daily to ensure that appropriate can (care) is being rendered. Inform the DON of any changes that need to be made on the care plan . ensure that your nurses' notes reflect that the care plan is being followed when administering nursing care or treatment . review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs . ensure that your assigned certified nursing assistants (CNAs) are aware of the resident care plans. Ensure that the CNAs refer to the resident's care plan prior to administering daily care to the resident .</p> <p>2. During a concurrent observation and interview on 11/5/24 at 11:11 a.m. with Resident 3 in Resident 3's room, Resident 3 was observed dressed, sitting in his wheelchair. Resident 3 was alert and answered questions clearly. Resident 3 stated he had been at the facility for a long time. Resident 3 stated he was at the facility due to having a stroke. Resident 3 stated he was getting daily physical therapy (PT) and returned from PT earlier this morning. Resident 3 stated he wore a brace on his right lower leg which cut into his right ankle. Resident 3 was observed to have a wound on his right lower leg above his foot with no dressing. Resident 3 stated the nurse would put a band aide on his wounds. Resident 3 stated he had pain in his right lower leg above his ankle. Resident 3 stated he took acetaminophen for his pain, which helped his pain.</p> <p>During a record review of Resident 3's AR, dated 11/8/24, the AR indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain) affecting the right dominant side.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of Resident 3's MDS, dated [DATE], the MDS section C indicated, Resident 3 had a BIMS score of 15, which indicated Resident 3 was cognitively intact.</p> <p>During an interview on 11/7/24 at 9:12 a.m. with Resident 3, Resident 3 stated he wore compression stockings years ago, but they kept going missing and were not replaced. Resident 3 stated he took acetaminophen this morning for his leg pain. Resident 3 stated the nurse put an adhesive dressing on his right inner ankle wound this morning.</p> <p>During a concurrent observation and interview on 11/7/24 at 9:27 a.m. with the Certified Nursing Assistant/Rehabilitation Nurse Assistant (CNA/RNA), in the hallway near Resident 3's room, the CNA/RNA was observed applying a right lower extremity brace to Resident 3. The CNA/RNA stated when Resident 3's right leg gets swollen, Resident 3 would let her know. The CNA/RNA stated it had been months since Resident 3 wore compression stockings. The CNA/RNA observed the open wound to Resident 3's right shin with no dressing. The CNA/RNA verbalized observation of an adhesive dressing to Resident 3's right inner ankle. The CNA/RNA stated Resident 3's wounds should have been covered with gauze.</p> <p>During a concurrent observation and interview on 11/7/24 at 12:00 p.m. with Resident 3 and the Clinical Supervisor Nurse (CSN) in Resident 3's room, Resident 3's right inner ankle wound was observed to be bleeding through the adhesive Dressing, onto Resident 3's sock. Resident 3 stated the right leg brace was pinching his skin. The CSN was observed checking Resident 3's right ankle wound. The CSN stated the charge nurse needed to assess the wound immediately to get the right treatment for Resident 3 to prevent infection. The CSN stated applying an adhesive dressing was not the right treatment.</p> <p>During a concurrent observation and interview on 11/7/24 at 1:50 p.m. with the Treatment Nurse (TN) in Resident 3's room, the TN was observed assessing Resident 3's wounds. The TN stated she contacted the Wound Care Nurse Practitioner (NP) and received orders for Resident 3's wound care. The TN stated she was not aware Resident 3 had wounds.</p> <p>During a concurrent interview and record review on 11/8/24 at 8:20 a.m. with the CNA/RNA, Resident 3's Restorative Nursing Referral (RNR), dated 1/5/24, was reviewed. The RNR indicated a list of goals and treatment plan, which did not include the use of a walking brace when ambulating. The CNA/RNA stated the RNR did not indicate the use of a walking brace when ambulating Resident 3. The CNA/RNA stated that Resident 3 was on the RNA program for ambulation with the use of a walking brace. The RNA stated she received training from the Physical Therapist (PT) regarding the brace application during ambulation. The CNA/RNA stated she observed an adhesive dressing on Resident 3's right inner ankle on 11/4/24 and 11/5/24. The CNA/RNA stated she did not report to the nurse about the adhesive dressing on Resident 3's right inner ankle. The CNA/RNA stated she thought the nurse knew about Resident 3's wounds as nurses were the only staff members with access to the locked treatment cart. The CNA/RNA stated she always applied Resident 3's brace when he ambulated. The CNA/RNA stated nurses did not apply the brace to Resident 3. The CNA/RNA stated nurses should have checked the brace when it was applied to Resident 3's leg to be sure the brace fit properly, and the brace was properly applied to Resident 3's leg to prevent injury. The CNA/RNA stated Resident 3 would be injured if the brace was not properly fitted to the resident and was not put on correctly. The CNA/RNA stated she observed a white dressing applied on the right shin area of Resident 3 when she ambulated the resident on 11/5/24. The CNA/RNA stated Resident 3 told her his shin wound was oozing and weeping. The CNA/RNA stated Resident 3 always had swelling in his bilateral lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a concurrent interview and record review on 11/8/24 at 9:01 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 3's Order Summary Report, dated 11/8/24, was reviewed. The Order Summary Report indicated, no order for the use of Resident 3's brace. Resident 3's Care Plan, undated, was also reviewed. The Care Plan indicated; no care plan was in place for monitoring Resident 3's skin while using a brace, and no care plan was in place for monitoring Resident 3's BL LE edema. LVN 1 stated monitoring the skin was important to prevent skin issues. LVN 1 stated the order for Resident 3's use of compression stockings was discontinued on 3/16/24. LVN 1 stated she could not remember why the order for the use of compression stockings for Resident 3 was discontinued. LVN 1 stated she had no time to assess Resident 3's wound or to put a nursing note in Resident 3's electronic medical chart. LVN 1 stated there should have been a physician's order and care plan in place for Resident 3's use of a brace. LVN 1 stated monitoring the application of the brace, and the skin was important to prevent skin issues. LVN 1 stated Resident 3 reported he was bleeding this morning. LVN 1 stated she assessed Resident 3 and observed an open wound to Resident 3's right inner ankle. LVN 1 stated she covered Resident 3's wound with an adhesive dressing. LVN 1 stated Resident 3 informed her his brace was causing the wound to his right inner ankle. LVN 1 stated Resident 3 had been using the brace since she started working at the facility in 2019. LVN 1 stated Resident 3 used the brace when he ambulated with the CNA/RNA. LVN 1 stated the CNA/RNA applied the brace and the nurse would help the CNA/RNA apply the brace to verify it was applied properly and did not harm the resident. LVN 1 stated she did not remember getting training on the brace application.</p> <p>During an interview on 11/8/24 at 9:42 a.m. with the PT, the PT stated Resident 3 was a long-term resident who came to the facility with an AFO (ankle foot orthosis [brace]). The PT stated the AFO was appropriate for the resident. The PT stated that Resident 3's brace required a bigger shoe size. The PT stated if Resident 3's shoe was too tight, the brace would not fit properly. The PT stated he informed the Social Service Director (SSD) two weeks ago to call the family to change the shoes to a one-inch size bigger shoe to properly fit the brace. The PT stated the PT Department instructed the CNA/RNA how to properly put on and take off Resident 3's brace, and to check for skin redness.</p> <p>During an interview on 11/8/24 at 11:33 a.m. with the SSD, the SSD stated she spoke to Resident 3 this morning about how his shoe fit his brace. The SSD stated Resident 3 informed her he believed the problem was the brace and not his shoe. Resident 3 stated he did not want the care conference team to call his daughter since she was very busy. The SSD stated the PT would call the Orthotic company to evaluate Resident 3's brace.</p> <p>During an interview on 11/8/24 at 2:38 p.m. with the Director of Nursing (DON), the DON stated Resident 3 should have had a care plan for edema to monitor the edema. The DON stated the skin could open due to swelling and skin breakdown could occur. The DON stated Resident 3 should have had a physician's order and care plan for the use of a brace when the brace was initially applied to Resident 3. The DON stated nurses should have been applying Resident 3's brace to ensure the brace was properly applied to prevent skin breakdown. The DON stated nurses did not receive training on the use of Resident 3's brace. The DON stated her assessment of Resident 3's right ankle indicated the traumatic wound was caused from using the brace. The DON stated Resident 3's wound to the right inner ankle was avoidable. The DON stated her expectation was that all nurses followed the policies and procedures when providing care and treatment for residents including skin and wound assessment, Medical Doctor (MD) notification of change of resident's condition, and establishing a care plan. The DON stated it was important for nurses to initiate and develop a care plan if issues arise, to monitor the resident's condition and ensure proper care was being followed by staff. The DON stated applying an adhesive dressing to the wound was not appropriate treatment for Resident 3.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 11/8/24 at 3:22 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated it was important to develop an individualized care plan so staff would be aware of the plan of care for the resident.</p> <p>During an interview on 11/8/24 at 3:48 p.m. with the CSN, the CSN stated a care plan should have been initiated when Resident 3's brace was applied. The CNS stated the care plan would have had a specified goal for Resident 3. The CSN stated if a care plan was not done, anything could happen to the resident and put the resident in danger of harm.</p> <p>During a record review of Resident 3's Progress Notes, dated 10/29/24, the Progress Notes indicated Resident 3 started cephalexin 500 mg one capsule four times a day on 10/16/24 for cellulitis (a deep infection of the skin caused by bacteria). The Progress Notes indicated Resident 3 completed cephalexin on 10/25/24.</p> <p>During a record review of Resident 3's Weekly Nursing Note dated 10/29/24, and 11/5/24, the Weekly Nursing Note indicated, no skin breakdown, and no skin impairments treated in the last seven days.</p> <p>During a record review of Resident 3's Physician Progress Note, dated 10/16/24, the Physician Progress Note indicated, . BL (bilateral) LE (lower extremity) edema (swelling)/cellulitis . continue TED (specially designed stockings that help prevent blood clots and swelling in the legs) hose; keep the extremity above the level of the heart to decrease swelling .</p> <p>During a review of the facility's job description document titled, Floor Nurse, dated 4/2013, the document indicated, . documentation . encourage attending physicians to review treatment plans, record and sign their orders, progress notes, etc., in accordance with established policies . report all discrepancies noted concerning physician's orders . to the Director of Nursing (DON) . provide leadership to CNA's nursing personnel assigned to your unit/shift . make daily rounds of your unit/shift to ensure that nursing service personnel are performing their work assignments in accordance with acceptable nursing standards . consult with the resident's physician in providing the resident's care, treatment, rehabilitation, etc., as necessary . review the resident's chart for specific treatments, medication orders . as necessary . make periodic checks to ensure that prescribed treatments are being properly administered by certified nursing assistants and to evaluate the resident's physical and emotional status . ensure that direct nursing care be provided by a certified nursing assistant, and/or a nurse aide trainee qualified to perform the procedure . notify the resident's attending physician and next-of-kin when there is a change in the resident's condition . ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan and wishes . monitor your assigned personnel to ensure that they are following established safety regulations in the use of equipment and supplies . participate, as requested, in the development and implementation of the procedures for the safe operation of all nursing service equipment . ensure that only trained and authorized personnel operate your unit/shift's equipment . review care plans daily to ensure that appropriate can (care) is being rendered. Inform the DON of any changes that need to be made on the care plan . ensure that your nurses' notes reflect that the care plan is being followed when administering nursing care or treatment . review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs . ensure that your assigned certified nursing assistants (CNAs) are aware of the resident care plans. Ensure that the CNAs refer to the resident's care plan prior to administering daily care to the resident .</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of the facility's job description document titled, MDS Coordinator, dated 4/2013, the document indicated, . the primary purpose of your job position is to conduct and coordinate the development and completion of the resident assessment instrument (MDS) and the resident's care plan . work with the Interdisciplinary Care Plan Team in developing a comprehensive resident assessment and care plan for each resident . conduct or coordinate the interviewing of each resident for the resident's assessment . evaluate each resident's condition and pertinent medical data . develop preliminary and comprehensive assessments of the nursing needs of each resident . coordinate the development of a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/need of the resident, indicates the care to be given .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, indicated, . a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . the care planning process will . include an assessment of the resident's strengths and needs . the comprehensive, person-centered care plan will . include measurable objectives and timeframes . describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including . incorporate identified problem areas . identify the professional services that are responsible for each element of care . reflect currently recognized standards of practice for problem areas and conditions . areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan . assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .</p> <p>During a review of the facility's P&P titled, Comprehensive Assessments and the Care Delivery Process, dated 12/2016, indicated, . comprehensive assessments will be conducted to assist in developing person-centered care plans . comprehensive assessments, care planning and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions . symptom or condition-related assessments .</p> <p>During a review of the facility's P&P titled, Change in a Resident's Condition or Status, dated 5/2017, indicated, . our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition . the nurse will notify the resident's Attending Physician or physician on call when thee has been a(an) . discovery of injuries of an unknown source . specific instruction to notify the Physician of changes in the resident's condition . a significant change of condition is a major decline or improvement in the resident's status that . requires interdisciplinary review and/or revision to the care plan .</p> <p>During a review of the facility's P&P titled, Wound Care, dated 2021, indicated, . the purpose of this procedure is to provide guidelines for the care of wounds to promote healing . verify that there is a physician's order for this procedure . review the resident's care plan to assess for any special needs of the resident .</p> <p>51345</p>		

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NAME OF PROVIDER OR SUPPLIER Manning Gardens Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E. Manning Avenue Fresno, CA 93725	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards of practice for one of one residents (Resident 40), when Resident 40 described her waffle mattress (a pressure relief mattress overlay [on top of mattress] that's designed to be placed on top of an existing mattress to redistribute pressure from bony areas of the body, manufacturer name Air Overlay) as uncomfortable and staff did not know how to adjust the mattress.</p> <p>This failure resulted in Resident 40's discomfort while lying in bed and had the potential to put the resident at risk for skin breakdown.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE] at 2:45 p.m., with Resident 40 in her room, Resident 40 was in her bed laying on a waffle mattress (WM) that had an air pump at the foot of the bed connected to the mattress set to firm (highest setting- maximum amount of air inflating the WM). Resident 40 stated she was unable to move in bed, or walk, because of a tumor (an abnormal growth of tissue in the body that occurs when cells divide and grow more than they should, or don't die when they should) on the inside of her right lower leg that was wrapped with gauze by her ankle. Resident 40 stated, The WM made me hot, it was uncomfortable and just doesn't feel right.</p> <p>During a review of Resident 40's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the face sheet indicated, Resident 40 was admitted to the facility on [DATE] with a diagnosis which included Mass/Lump Right Lower Limb (leg) and Morbid Obesity (a person's weight that exceeds an individual's desirable weight by more than 100 pounds).</p> <p>During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function), dated [DATE], the MDS indicated, Resident 40's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (a score of ,d+[DATE] indicates cognitively intact, ,d+[DATE] indicates moderately impaired, and , d+[DATE] indicates severe impairment). The BIMS assessment indicated Resident 40 was cognitively intact.</p> <p>During a review of Resident 40's Physician Orders (PO), dated [DATE], the PO indicated, .Order date: [DATE] at 10:36 p.m. Communication Method: Phone . Order Summary: May resident have App (alternating pressure- a bed that uses air to redistribute pressure and help prevent bedsores) Mattress on to prevent skin breakdown . Confirmed by: Licensed Vocational Nurse (LVN) 3 . Ordered by: Medical Doctor (MD) 1 .</p> <p>During an interview on [DATE] at 4:15 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated the WM was supposed to be adjusted to the comfort level of the resident, but she did not know how to adjust the air pump to make it more comfortable for the resident. CNA 5 stated that Maintenance does that.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 4:20 p.m., with the Maintenance Supervisor (MS) the MS stated they only do the initial set up of the WM and after that, they do not touch it. The MS stated only the nursing staff manipulates the pump or the air mattress after set up.</p> <p>During an interview on [DATE] at 9:25 a.m., with the Senior Account Manager (SAM- for WM Company), the SAM stated the facility needed to follow the instructions for use in the Owner's Manual for the WM that the company provided to the facility.</p> <p>During a review of the Owner's Manual- [Company Name] Air Overlay (OM), not dated, the OM indicated, . Directions for Use: . 8. Decrease firmness if necessary for resident comfort, support, and immersion into the overlay for optimal pressure redistribution (moving pressure off of bony prominences on the body). A common method for sizing an air overlay is to check to see if suitable pressure is selected by sliding one hand between the air overlay and the air/foam base under the residence buttocks. Users should be able to feel the space between their hand and the residents' buttocks with the acceptable range being ,d+[DATE] mm (millimeters- unit of measurement) (1 inch to 1 inch and a half). This handshake procedure is issued by agency for Health Care Policy and Research (AHCP) . B) adjust the firmness by turning the dial; counterclockwise for more immersion (if too much space during hand check, too firm) or clockwise for less immersion (not enough space during hand check, too soft) .</p> <p>During an interview on [DATE] at 11:07 a.m., with Registered Nurse (RN) 1, RN 1 stated she was the nurse for Resident 40. RN 1 stated if Resident 40 was uncomfortable and needed the pressure of the WM fixed, she would call Maintenance to do that. RN 1 stated she did not know how to manipulate the pressure of the WM. RN 1 stated she was never trained on how to use the WM.</p> <p>During an interview on [DATE] at 5:43 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she was the nurse for Resident 40. LVN 3 stated she was not sure if the WM was supposed to be on firm or not. LVN 3 stated that she was never trained on how to work the waffle mattress. LVN 3 stated Resident 40 needed the mattress to prevent skin breakdown, but the mattress needed to be comfortable for her. LVN 3 stated she did not know how to make the mattress more comfortable for the resident.</p> <p>During an interview on [DATE] at 10:38 a.m., with the Director of Staff Development (DSD), the DSD stated Resident 40 needed the WM for immobility (inability to move herself). The DSD stated that if Resident 40 was uncomfortable, nursing staff would tell maintenance and they would fix it. The DSD stated nurses should have monitored the WM and followed the instructions for use in the owner's manual. The DSD stated she had not trained her staff on that WM. The DSD stated staff did not follow the OM and patient harm could have happened.</p> <p>During an interview on [DATE] at 10:59 a.m., with the Director of Nursing (DON), the DON stated the OM was not followed by facility staff. The DON stated nursing staff was referring to Maintenance for anything related to the WM and that was not the right way. The DON stated the expectation for staff would be to follow the OM instruction for use. The DON stated staff were never trained on how to properly monitor and work the WM. The DON stated that because the WM was not inflated to Resident 40's comfort level, she would be uncomfortable and skin breakdown could happen.</p> <p>49949</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of 12 Residents (Resident 1) was assessed for the risk of entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail) from the bed side rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a guard [raised] or lowered position), had no consent (form signed by resident or family explaining the risks of side rail use), no physician order, no indication for use, and no care plans prior to the installation and use when Resident 1 had two bed rails one on both sides at the head of the bed in the guard position (a position that is intended to prevent an individual from inadvertently[accidentally] rolling out of bed).</p> <p>This failure had the potential to cause entrapment, serious harm, injury, or death to Resident 1.</p> <p>Findings:</p> <p>During an observation on 11/5/24 at 8:35 a.m., Resident 1 was observed in bed sleeping. Bed rails were observed raised at the head of Resident 1's bed. Fall mats were observed on the right and left side of Resident 1's bed.</p> <p>During a review of Resident 1's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 11/8/24, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Alzheimer's (a disease characterized by a progressive decline in mental abilities), anxiety disorder (disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), psychosis (a mental disorder characterized by a disconnection from reality), fracture of the left femur (a break in the thigh bone), hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain).</p> <p>During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/4/24, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 1 was severely cognitively impaired.</p> <p>During a review of Resident 1's medical records, the medical records indicated, Resident 1 was observed to have no documentation of a care plan for the use of bed rails, no documentation of a bed rail assessment, no physician orders for the use of bed rails, and no consent on file for the use of bed rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/6/24 at 9:44 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's record was reviewed. Resident 1's record indicated, no physician orders for the use of bed rails for Resident 1, no consent on file for the use of bed rails for Resident 1, no care plan in place for the use of bed rails for Resident 1 and no bed assessment documented for the use of bed rails for Resident 1. LVN 1 stated Resident 1 should have orders, a care plan, and a bed assessment for the use of the bed rails on Resident 1's bed. LVN 1 stated Resident 1 should have had a physician order for bed rails. LVN 1 stated bed rails were considered a restrictive device. LVN 1 stated if a bed was not assessed for bed rails, the bed rails could be unsafe, and the resident could get hurt. LVN 1 stated a care plan was to ensure staff who assisted Resident 1 with turning and repositioning were using the bed rails appropriately.</p> <p>During a concurrent observation and interview on 11/6/24 at 9:56 a.m., in Resident 1's room, the Maintenance Assistant (MAINTA) was observed walking out of Resident 1's room with bed rails in his hands. Certified Nursing Assistant (CNA) 8 was observed fixing the blankets on Resident 1's bed with no bed rails observed on Resident 1's bed. CNA 8 stated Resident 1's bed rails were removed by the MAINTA because Resident 1 was not supposed to have them on her bed.</p> <p>During an interview on 11/6/24 at 10:56 a.m. with the Maintenance Supervisor (MS), the MS stated the LVNs were letting him know which resident's bed rails needed to be removed. The MS stated he did not do a bed assessment to verify the bed was appropriate for the resident's weight, or if maintenance was using the correct rails for the resident's bed. The MS stated the maintenance department would check that the installed bed rails were tight and did not move. The MS stated if the bed rails were improperly installed, they could injure the resident. The MS stated he did not do regular bed rail checks, so there was no bed rail check log. The MS stated the CNAs or nurses would let him know if there was a problem with the bed rails, then the maintenance department would check the rails.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Bed Safety, dated 12/2007, indicated, . the resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement . to try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails .), the facility shall promote the following approaches . inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks . ensure that bed side rails are properly installed using the manufacturer's instructions .identify additional safety measures for residents who have been identified as having higher than usual risk for injury including entrapment (e.g., altered mental status .) . the maintenance department shall provide a copy of the inspections to the Administrator and report results to the QA Committee for appropriate action. Copies of the inspection results and QA Committee recommendations shall be maintained by the Administrator and/or Safety Committee . if side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative . the staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use . after appropriate review and consent . side rails may be used . side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer, and no other reasonable alternatives can be identified .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>48424</p> <p>Based on observation, interview, and record review the facility failed to provide pharmaceutical services to meet the needs of one of six residents (Resident 37) when Resident 37's lorazepam (a controlled medication used to help with anxiety, sleep, and maintain calmness) medication was administered and was not documented on the controlled substances count sheet (This document is typically used in a medical setting to ensure accurate dispensing and administration of medications, as well as to provide a record of how much of a controlled substance has been used and when).</p> <p>This failure had the potential for Resident 37's lorazepam to be mistakenly administered to her twice and cause Resident 37 to experience side effects from an additional dose of medication.</p> <p>Findings:</p> <p>During a review of Resident 37's Admission Record (AR- a document which provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/8/2024, the AR indicated Resident 37 was admitted to the facility with the following diagnoses: major depressive disorder (mood disorder which affects how someone feels, thinks, and functions in daily life), and adjustment disorder (a mental health condition which involves an extreme emotional or behavioral response to a stressful event or change in someone's life).</p> <p>During an observation on 11/06/24 at 2:05 p.m., with Licensed Vocational Nurse (LVN) 1, of Resident 37's medication blister pack (a type of packaging used to hold and protect medications) the blister pack had 25 lorazepam pills.</p> <p>During a concurrent interview and record review on 11/06/24 At 2:05 p.m., with LVN 1, the facility's Narcotic Binder, dated 11/06/24, was reviewed. The Narcotic Binder indicated, Resident 37's last lorazepam administration on 11/06/24 at 8:00 a.m. was not documented in the binder. LVN 1 stated she had forgot to document the lorazepam administration in the Narcotics Binder and it should have been documented as soon as she removed the medication from the blister pack. LVN 1 stated the lorazepam was a controlled substance (a medication which has the potential to be abused due to its addictive properties) and nurses needed to document all controlled substances in the binder as soon as they were taken out of the blister packs. LVN 1 stated it was important to document controlled medications in the binder because it ensured the number of medications available was accurate and it ensured residents actually received their medication.</p> <p>During an interview on 11/7/24 at 5:49 p.m., with LVN 2, LVN 2 stated all controlled substances needed to be signed out of the Narcotics Binder after the medication had been removed from the blister pack. LVN 2 stated it was important to document all narcotics administered because it helped nurses know if the medication was given. LVN 2 stated it was necessary to have an accurate count of all narcotics because it helped to show no one had stolen the medication and no double dose of the medications were administered to the residents.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/08/24 at 11:52 a.m., with the Director of Nursing (DON), the DON stated LVN 1 administered the medication but forgot to sign it out on the Narcotics Binder. The DON stated nurses were supposed to sign for all controlled medications as they took them out of the blister packs. The DON stated the count for controlled medications should always be accurate.</p> <p>During a review of professional reference retrieved from https://www.allcarepharmacy.com/facilityresources/assets/documents/Controlled%20Substances%20Inservice.pdf, titled, Controlled Substances In-Service, undated, indicated, . Complete documentation in the narcotic book prior to administering controlled substances to the resident. Check the count with each administration to ensure accuracy. Initial the MAR after administering the medication.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</p> <p>Based on observation, interview, and record review, the facility failed to ensure the kitchen food was stored and maintained in a safe and sanitary manner when:</p> <ol style="list-style-type: none"> 1. The facility failed to store food in Resident 105's room in a safe manner in accordance with the facility's policy and procedure (P&P) Foods Brought by Family/Visitors. 2. An open jar of garlic was stored in the refrigerator without an open labeled date in accordance with the facility's P&P Sanitation and Infection Control. 3. A case of bran muffins was found in the refrigerator missing half of the labeled date identifying the placed in the freezer date per the facility's P&P Sanitation and Infection Control. 4. Two dented tomato sauce cans were stored in the pantry for use and not set aside in a designated area for return to the vendor or disposed of properly per the facility's P&P Sanitation and Infection Control. <p>These failures had the potential risk of cross contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and exposure of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) from improperly stored and labeled food for 52 of 53 residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on [DATE] at 9:05 a.m., in Resident 105's room with Resident 105 and Registered Nurse (RN) 1, Resident 105 had two lidded bowls, of perishable (likely to decay, spoil, or become unsafe to eat if not kept refrigerated or frozen) food on her bedside table. Resident 105 stated the food had been brought in by family members the day before. Resident 105 stated the food was hot when family brought it in to the facility, but it was cold now. RN 1 stated the food in the bowls were stew with liquid and a bread product called [NAME] (South Asian flatbread made with whole wheat flour). RN 1 stated the food containers were not labeled or dated. <p>During a review of Resident 105's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the face sheet indicated, Resident 105 was admitted to the facility on [DATE] with a diagnosis of Pulmonary Mycobacterial Infection (a lung infection caused by a type of bacteria called mycobacteria, which are naturally found in soil and water, and can be breathed in).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 105's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function), dated [DATE], the MDS indicated Resident 105's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 13 out of 15 (a score of ,d+[DATE] indicates cognitively intact, ,d+[DATE] indicates moderately impaired, and , d+[DATE] indicates severe impairment). The BIMS assessment indicated Resident 105 was cognitively intact.</p> <p>During an interview on [DATE] at 5:38 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the expectation for perishable foods at the resident's bedside would be to make sure the foods were safe for the resident to eat. LVN 3 stated food that was not dry food should have been wasted after the family leaves the facility.</p> <p>During an interview on [DATE] at 9:27 a.m., with the Interim Dietary Manager/Registered Dietician (IDM/RD), the IDM/RD stated the food that was on Resident 105's bedside was perishable and needed to be consumed immediately by the resident or refrigerated. The IDM/RD stated that because the food was not labeled or stored appropriately, we can't be sure it's safe. The IDM/RD stated placing the dated labels on the food containers were important because it would prevent time and temperature abuse and potential food-borne illness (food poisoning). The IDM/RD stated if Resident 105 ate the food on [DATE] that she could have acquired food poisoning and potentially been sent to the hospital. The IDM/RD stated symptoms of food poisoning would be nausea, vomiting, diarrhea, weight loss and dehydration (occurs when you use or lose more fluid than you take in, and your body doesn't have enough water and other fluids to carry out its normal functions). The IDM/RD stated staff did not follow the facility policy and procedure (P&P) Foods Brought by Family/Visitors.</p> <p>During an interview on [DATE] at 11:15 a.m., with the Director of Nursing (DON), the DON stated the expectation for Resident 105's family would have been to take the food that was not eaten at the facility home when they were done visiting with the resident that day. The DON stated they do not store perishable food for the residents. The DON stated staff can't ensure that the food at Resident 105's bedside was safe to eat. The DON stated if Resident 105 had consumed the non-labeled food, that she could have gotten sick. The DON stated staff did not follow the P&P Foods Brought by Family/Visitors.</p> <p>During an interview on [DATE] at 3:28 p.m., with the Infection Preventionist (IP), the IP stated the food at the resident bedside should be considered a meal tray and taken away after the resident had eaten what she wanted. The IP stated the facility educated the family and told them whatever food was left, it needed to be taken back home with them that same day. The IP stated if the food was consumed, the resident could have been hospitalized due to a food-borne illness because the facility did not know if it were safe to eat or not. The IP stated the facility did not follow the P&P Foods Brought by Family/Visitors.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Manning Gardens Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E. Manning Avenue Fresno, CA 93725	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility's P&P titled, Foods Brought by Family/Visitors, dated [DATE], the P&P indicated, Policy Statement: Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a home like environment with the nutritional and safety needs of residents. Policy Interpretation and Implementation: . 4. Family/visitors are asked to prepare and transport food using safe food handling practices, including a. Safe cooling and reheating processes; b. Holding temperatures; c. Preventing cross contamination with raw or undercooked foods; . 7. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility prepared food . b. Containers will be labeled with the resident's name, the item and the use by date . c. No foods requiring refrigeration will be allowed except when can be consumed immediately . 10. Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than two hours will be discarded .</p> <p>49949</p> <p>2. During a concurrent observation and interview on [DATE] at 7:48 p.m., in the kitchen an open jar of garlic had a received labeled date for [DATE] and no open labeled date. Dietary [NAME] (DC) 1 stated the open garlic jar should have an open labeled date along with the received labeled date. DC 1 stated it was important to have an open labeled date on the garlic jar to know the shelf- life (length of time for which an item remains usable, fit for consumption). DC 1 stated kitchen staff does not keep food items longer than two weeks. DC 1 stated the open garlic jar should have been thrown away since it did not have an open labeled date. DC 1 stated kitchen staff does not want to served resident expired food. DC 1 stated serving residents expired food could have caused foodborne illness. DC 1 stated kitchen staff should have labeled the jar when the jar was opened.</p> <p>During an interview on [DATE] at 2:18 p.m., with the Interim Dietary Manager/ Registered Dietitian (IDM/RD), the IDM/RD stated the jar of garlic should have had an opened labeled date The IDM/RD stated an opened labeled date was needed to ensure the jar of garlic was not used beyond the expiration date. The IDM/RD stated using food items beyond the expiration date was putting resident at risk for foodborne illness and cross-contamination. The IDM/RD stated the staff did not follow the policy and procedure for labeling.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2023, the P&P indicated, .All the perishable food items purchased by the department of food and dining services will be stored properly .10. Leftover food or unused portions of packaged foods should be covered, labeled, and dated to assure they will be used first .</p> <p>3. During an observation on [DATE] at 7:50 a.m., in the kitchen with DC 1, 24 bran muffins were in the refrigerator in a sealed box missing half of the labeled date. DC 1 stated the box of bran muffins were brought out of the freezer this morning and were placed in the refrigerator. DC 1 stated she labeled the bran muffins with the date it was placed in the freezer. DC 1 stated she was not able to see the labeled date on the bran muffin and it was missing half of the labeled date. DC 1 stated the labeled date should have been on the bran muffin. DC 1 stated it was important to have the labeled date on the bran muffin to ensured residents were not served expired items. DC 1 stated, serving expired bran muffin to residents could cause residents to be sick. DC 1 stated the bran muffins could have been old and should have been thrown away. DC 1 stated kitchen staff should have labeled the bran muffin with the date it was placed in the freezer.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 2:18 p.m., with the IDM/RD, the IDM/RD stated the policy for labeling was not followed. The IDM/RD stated the bran muffins should have been thrown away when kitchen staff noticed the label date was missing. The IDM/RD stated a missing label date could have cause confusion for the kitchen staff. The IDM/RD stated labeling items was important to ensured bran muffins and other food items were opened and received and safe to consumed. The IDM/RD stated kitchen staff should have clear labeling practices. The IDM/RD stated not following the labeling practice was putting residents at risk for food borne illness. The IDM/RD stated it was the responsibility of the morning cooks or dietary manager to inspect bran muffins before serving it for breakfast.</p> <p>During a review of the facility's menu titled, Fall menus, dated [DATE], the Fall menu indicated, .Bran Muffin cupcake size 2 oz .</p> <p>During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control. dated 2018, the P&P indicated, .6. Frozen food should be labeled with the date it was placed in the freezer .</p> <p>4. During a concurrent observation and interview on [DATE] at 8:28 a.m. in the pantry with DC 1 two dented tomato sauce cans were stored on the shelf ready for use. DC 1 stated she checked the storage pantry every Mondays and Thursdays for dented cans and or expired dated items. DC 1 stated she was not sure why the dented cans were still stored on the shelf for use. DC 1 stated the dented cans should have been transferred to an area to be returned to the supplier and not on the shelf for use. DC 1 stated dented cans were not good to use and had bacteria. DC 1 stated bacteria from the dented cans could have gotten residents sick.</p> <p>During an interview at [DATE] at 2:18 p.m., with the IDM/RD, the IDM/RD stated dented cans should have been moved to the designated area and not on the shelf for use. The IDM/RD stated dented cans could have botulism (a rare but serious toxin produced by bacteria that disease that attacks the body when consumed) and could have gotten residents sick if served. The IDM/RD stated the dented cans should have been inspected for dents on the dated received. The IDM/RD stated kitchen staff did not follow the facilities policy.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, dated 2018, Subject: Canned and Dry Goods Storage: Policy: All the food and non-food items purchased by the Department of Food and Nutrition services will be stored properly .10. Canned food items should be routinely inspected for damages such as dented, bulging, or leaking cans. These items should be set aside in a designated area for return to the vendor or disposed of properly .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739</p> <p>Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (Illnesses caused by viruses or bacteria that people spread to one another through contact with contaminated surfaces, bodily fluids, blood products, insect bites, or through the air) and infections for 53 of 54 residents when:</p> <ol style="list-style-type: none"> 1. Staff stored personal lunch bags and a drink canister on top of the dining room ice-machine and not in the locker room refrigerator per the facility's policy and procedure (P&P) Cafeteria Meals, <p>This failure had the potential for cross-contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and exposure to foodborne illnesses (stomach illness acquired from ingesting contaminated food) for residents, staff, and visitors.</p> <ol style="list-style-type: none"> 2. Resident 2's feeding tube (a flexible plastic tube placed into the stomach or bowel [intestine] to provide nutrition when a person cannot eat or drink safely by mouth) bottle of nourishment did not have a start date indicating when the bottle was hung to determine the discard date per the facility's in-service document Feeding Pump, <p>This failure had the potential to place Resident 2 at risk of receiving an expired tube feeding exposing Resident 2 to bacteria and risk of infection.</p> <ol style="list-style-type: none"> 3. Licensed Vocational Nurse (LVN) 2 did not follow proper procedure for donning the appropriate personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) and proper hand hygiene while providing direct care to Resident 2 who was on enhanced barrier precautions (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) per the facility's P&P Administering Medications through an Enteral Tube. <p>This failure had the potential to place residents at risk of infection due to cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect).</p> <ol style="list-style-type: none"> 4. LVN 1 did not follow proper hand hygiene procedures prior to checking blood sugar levels on Resident 27 and Resident 35, and LVN 1 did not follow proper procedures for sanitizing (to reduce or eliminate pathogenic agents [such as bacteria] on surfaces) the blood glucose meter (glucometer - a device that reads the amount of sugar in the blood) after checking the blood sugar levels on Resident 27 and Resident 35 per the facility's P&P's Obtaining a Fingertick Glucose Level, and To clean and disinfect the Meter. <p>This failure had the potential to place Residents 27 and 35 at risk of infection due to cross-contamination.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>5. Dirty Halloween Decorations were on a table in the dining room where Resident 26 was eating his lunch meal not in accordance with the Infection Control (IC) practices.</p> <p>This failure had the potential to place Resident 26 at risk of infection due to cross-contamination.</p> <p>6. Resident 26's urine catheter (a hollow tube inserted into the bladder to drain or collect urine into a bag) bag was observed on his lap while he was eating his lunch meal not in accordance with the facilities IC practices and per the facility's P&P titled, Catheter Care, Urinary.</p> <p>This failure had the potential to place Resident 26 at risk of infection due to cross-contamination.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on [DATE] at 2:46 p.m., in the dining room, with Dietary [NAME] (DC) 2. Three lunch bags and one drink canister was observed on top of the ice machine. DC 2 stated staff lunch bags and or drink canisters should not be stored on top of the dining room ice machine. DC 2 stated DC 1 and Dietary Services Supervisor were responsible for cleaning the ice machine. DC 2 stated staff lunch bags could have fallen into the ice machine and caused cross contamination. DC 2 stated staff lunch bags and or drink canister were not sanitary.</p> <p>During an interview on [DATE] at 2:18 p.m., with the Registered Dietitian/Interim Dietary Manager (IDM/RD), the IDM/ RD stated personal items such as lunch bags should not be stored on top of the dining room ice machine. The IDM/RD stated staff lunch bags could have bacteria on them and could have fallen into the ice machine. The IDM/RD stated there was a potential risk for cross-contamination to residents, staff and visitors that could have caused them to get sick. The IDM/RD stated staff should have stored lunch bags and canisters in the employee designated locker, refrigerators and not on top of the dining room ice machine. The IDM/RD stated staff did not followed the policy and procedure for Cafeteria Meals.</p> <p>During a concurrent observation and interview on [DATE] at 3:10 p.m., in the dining room with DC 3 , a black lunch bag was observed on top of the ice machine above a posted sign posted stating, Do not place any items on top of the ice machine! DC 3 stated staff lunch bags should not be stored on top of the ice machine. DC 3 stated the ices could have been cross contaminated from staff lunch bags and could have gotten residents infected and sick.</p> <p>During an interview on [DATE] at 6:02 p.m., with the Infection Prevention (IP), the IP stated staff lunch bags were dirty and had bacteria on them. The IP stated staff's dirty lunch bags could have fallen into the ice and caused contamination. The IP stated staff, visitors and resident were at risk for infection from drinking contaminated ice from the ice machine. The IP stated the dietary kitchen staff were responsible for making sure the ice machine was cleaned.</p> <p>During an interview on [DATE] at 6:10 p.m., with the Director of Staff Development (DSD), the DSD stated there should not have been any items on top of the ice machine. The DSD stated the staff should have stored their lunch bags and cups in the staff refrigerator. The DSD stated storing lunch bags and cups in the staff refrigerator could prevent cross-contamination and getting resident sick. The DSD stated an in-service should have been provided to the staff.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Cafeteria Meals, dated revised ,d+[DATE], the P&P indicated, .6. Employees need to utilize their lunch bag in the locker room and refrigerator .</p> <p>2. During a concurrent observation and interview on [DATE] at 9:44 a.m., with LVN 1 in Resident 2's room, Resident 2 was observed dressed, and sleeping in bed. Resident 2's bottle of feeding tube nutrition was observed hanging on an infusion pole undated. LVN 1 stated the feeding tube nutrition bottle should have had a date and time labeled indicating when the bottle was hung and when the feeding started. LVN 1 stated having a date and time on the feeding bottle would let nurses know when the bottle was changed. LVN 1 stated if the bottle was not changed there would be a risk of the feeding to go bad. LVN 1 stated giving Resident 2 a feeding that had gone bad would put Resident 2 at risk of getting sick.</p> <p>During a review of resident 2's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], Resident 2's AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), aphasia (a disorder that makes it difficult to speak), dysphasia (difficulty swallowing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis(muscle weakness or partial paralysis on one side of the body) following cerebral infarction, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated, Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of four (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact), which suggested Resident 2 was severely impaired.</p> <p>During an interview on [DATE] at 11:26 a.m. with the Registered Dietician (RD), the RD stated she did not know the requirement about dating the feeding tube bottle. The RD stated she would need to check the facility's policy on dating the feeding tube bottle of nutrition when hung.</p> <p>During a review of the facility in-service document titled Feeding Pump, dated [DATE], the document indicated, . ask your nutritionist how much formula to add to the feeding bag at a time. Formula can spoil if it hangs in the bag too long . throw the bag out if it has been used for 24 hours . if you are not going to restart the feeding right away, store the feeding set in an airtight container in the refrigerator .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>3. During an observation on [DATE] at 3:02 p.m. in Resident 2's room, Resident 2 was observed laying down in bed with her eyes open. A notice that Resident 2 was on EBP was observed on the wall above Resident 2's bed. LVN 2 was observed checking Resident 2's gastric tube (G-tube - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement by infusing 10 ml (a measure of volume in the metric system) of air into Resident 2's G-tube and listening with a stethoscope (a medical instrument for detecting sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a piece placed upon the area to be examined). LVN 2 placed the supplies to check Resident 2's G-tube placement and begin Resident 2's feeding on a paper towel that was placed on the windowsill next to Resident 2. Resident 2's feeding pump was observed to have a dried, caked on substance on the infusion pump where the feeding tube line was inserted. LVN 2 was observed to leave the room to get assistance with programming the infusion pump. LVN 2 was observed to not perform hand hygiene after removing her gloves and leaving Resident 2's room. LVN 2 did not don a gown prior to performing the procedure on Resident 2.</p> <p>During an interview on [DATE] at 3:23 p.m. with the Clinical Nurse Supervisor (CNS), the CNS stated EBP was for residents with wounds, G-tubes, and Foley catheters (a common type of indwelling catheter inserted into the bladder, used to drain urine). The CNS stated it was important for staff to wear a gown and do handwashing when performing procedures on residents on EBP to prevent infection. The CNS stated staff needed to wash their hands before doing resident care. The CNS stated Resident 2's infusion pump should have been cleaned each time a new bag was hung. The CNS stated a dirty pump could cause Resident 2 to get an infection.</p> <p>During an interview on [DATE] at 5:02 p.m. with the Infection Preventionist (IP), the IP stated staff needed to perform hand washing or hand hygiene with alcohol prior to performing procedures. The IP stated if the hands were soiled, or if staff touched blood, staff would need to wash their hands. The IP stated staff had to do hand hygiene prior to donning gloves. The IP stated hand hygiene was important because hands were full of germs. The IP stated if staff put gloves on without hand hygiene, germs were still spreadable and there would be the possibility for cross-contamination. The IP stated for EBP, her expectations were for staff to don gloves and a gown for high contact activities such as, hygiene, bathing, showering, changing linens, changing briefs, toilet help, g-tube access, dialysis port dressing changes, wound care, catheter care, and care of all assistive devices. The IP stated it was not acceptable to put the feeding tube (FT) supplies on a paper towel on the windowsill. The IP stated the windowsill was not clean. The IP stated placing the tube feeding supplies on the windowsill created a risk for the resident to get an infection. The IP stated if nurses saw the infusion pump was dirty when setting up an infusion, they should clean the pump.</p> <p>During an interview on [DATE] at 11:46 a.m. with the Director of Staff Development (DSD), the DSD stated for residents on EBP, staff needed to use PPE (gown and gloves) when providing direct care to the resident.</p> <p>During a review of Resident 2's Care Plan (CP), undated, the CP indicated, . (Resident 2) is on ENHANCED BARRIER PRECAUTIONS R/T (Related to) INVASIVE DEVICE . date initiated: [DATE] . donning and doffing of PPE before entering and exiting by Health care personnel . educate staff and patient about appropriately disinfect and cleaning of equipment's and environment . perform hand hygiene before and after contact with resident .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During a review of the facility document titled, Medication Administration Competency Checklist for Enteral Tube, dated [DATE], signed by LVN 2, indicated, . (step) 1. Washed hands . placed resident in proper position . wash hands per policy . verify tube placement . attach tube to continuous feeding . wash hands per policy . document .</p> <p>During a review of the facility policy and procedure (P&P), titled, Administering Medications through an Enteral Tube, dated ,d+[DATE], indicated, . steps in the procedure . wash your hands . arrange supplies in the medication room or move the medication cart outside the resident's room . place medications on the bedside table or tray . discard all disposable items into designated containers . wash your hands .</p> <p>4. During an observation on [DATE] at 11:27 a.m. in Resident 27's room, LVN 1 was observed gathering supplies to perform a blood sugar check on Resident 27. LVN 1 placed an unopened bag of cotton balls into a basket that contained supplies for the procedure. LVN 1 did not wash her hands or perform hand hygiene prior to donning gloves. LVN 1 opened the bag of cotton balls at Resident 27's bedside and performed a blood sugar check on Resident 27 by poking his finger and placing a drop of blood on the glucometer strip. LVN 1 discarded the supplies, changed her gloves, and wiped the glucometer with a Sani wipe (a wipe containing a powerful germ-killing formula), but did not wait the two-minute dwell time (the time specified by a manufacturer that a disinfectant must be left on a surface to ensure disinfection) and placed it back into the basket of supplies containing the bag of cotton balls. LVN 1 removed her gloves, performed hand hygiene, and placed the blood sugar meter back into Resident 27's blood sugar meter bag. LVN 1 then placed the glucometer bag and bag of cotton balls back into the medication cart. LVN 1 did not wrap the glucometer with the Sani wipe for two minutes and let it air dry per policy prior to returning the glucometer to the bag. LVN 1 did not wipe the cotton ball bag with Sani wipes and let it sit for two minutes prior to returning it to the medication cart.</p> <p>During a review of Resident 27's AR, dated [DATE], the AR indicated, Resident 27 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, (a condition where the blood sugar levels in the body are too high) and fracture of unspecified lumbar vertebra (break in the bone of the lower part of the spine).</p> <p>During a review of Resident 27's MDS, dated [DATE], the MDS section C indicated Resident 27 had a BIMS score of 15, which indicated Resident 27 was cognitively intact.</p> <p>During a concurrent observation and interview on [DATE] at 11:40 a.m. in Resident 35's room, LVN 1 was observed checking Resident 35's blood sugar. LVN 1 was observed cleaning the glucometer and leaving it in the Sani wipe for the dwell time of two minutes. LVN 1 proceeded to place the clean glucometer back into the supply basket. LVN 1 did not clean the basket prior to placing the glucometer back into the used supply basket. LVN 1 stated she did not wipe the basket, only the glucometer.</p> <p>During a review of Resident 35's AR, dated [DATE], the AR indicated Resident 35 was admitted on [DATE] with diagnoses of type 1 diabetes mellitus with hyperglycemia (elevated sugar in the blood) and psychoactive (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) substance abuse.</p> <p>During a review of Resident 35's MDS, dated [DATE], the MDS section C indicated Resident 35 had a BIMS score of 15, which indicated Resident 35 was cognitively intact.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on [DATE] at 5:02 p.m. with the IP, the IP stated staff should do hand washing or hand hygiene with alcohol prior to performing procedures. The IP stated if the hands were soiled or touched blood, staff would need wash their hands. The IP stated staff had to do hand hygiene prior to donning gloves. The IP Stated it was important to do hand hygiene because hands are full of germs. The IP stated if staff put gloves on without performing hand hygiene, germs were still spreadable and there was the possibility for cross-contamination. The IP stated it was not acceptable to put supplies that were at the resident's bed side back into the medication cart. The IP stated the supplies could have contaminated items in the cart. The IP stated her expectation for the glucometer use was to wash hands, use manufacturer instructions for Sani wipes, make a burrito with the glucometer in the Sani wipe, let sit for two minutes, then air dry. The IP stated there was a risk for infection if the hand hygiene and sanitation of supplies and reusable equipment procedures were not being followed. The IP stated she felt she would need to do monitoring more often.</p> <p>During an interview on [DATE] at 4:14 p.m. with the Director of Nursing (DON), the DON stated when staff performed blood glucose checks, staff should have washed their hands, provided resident privacy, identified the resident, explained the procedure, donned gloves, and performed the procedure. The DON stated staff should had performed hand hygiene, cleaned the meter, taken off their gloves, washed hands, wiped the meter, wrapped the glucometer, and left the glucometer wrapped inside the wipe (followed the time on manufacturer's instructions), then air dried the meter. The DON stated there was a risk of cross-contamination and spreading infection if the supplies were not properly sanitized after use. The DON stated staff should have taken what was needed out of the cotton bag to the resident's bed side. The DON stated staff should have cleaned the cotton bag before putting it back in the medication cart, after completing the same dwell time after cleaning. The DON stated taking supplies from the resident's bed side and putting them back in the medicine cart could have spread infections to other residents from cross-contamination. The DON stated her expectation was nurses should have been following the standards of practice and policies and procedures for performing glucose checks and cleaning the glucometer. The DON stated the IP observed nurses for competency. The DON stated the IP and DON were responsible for monitoring the nurses. The DON stated nurses were not monitored every day.</p> <p>During a review of the facility's (P&P) titled, Obtaining a Fingerstick Glucose Level, dated 2001, indicated, . equipment . disinfected blood glucose meter (glucometer) . ,d+[DATE] cotton balls . always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses . wear clean gloves . discard disposable supplies in the designated containers . clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice . remove gloves . wash hands .</p> <p>During a review of the facility document titled, To clean and disinfect the Meter, undated, the document indicated, . wash hands thoroughly with soap and water. Wear a clean pair of gloves . with ONLY PDI Super Sani Cloth Wipes . rub the entire outside of the meter using 3 circular wiping motions . to disinfect: Using fresh wipes, make sure that all outside surfaces of the meter remain wet for 2 minutes .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>5. During a concurrent observation and interview on [DATE] at 11:54 a.m. with the Certified Nursing Assistant/Restorative Nurse Assistant (CNA/RNA), in the Activities Room Resident 26 was observed dressed sitting in a geriatric chair (Geri-chair - a large, padded chair that is designed to help seniors with limited mobility) at a table eating his meal with dirty Halloween decorations on the table next to his food. The CNA/RNA stated the Halloween decorations should not have been on the table. The CNA/RNA stated the tables should have been cleaned after every activity. The CNA/RNA stated Resident 26 had a change in diet, so she was watching him.</p> <p>During a review of Resident 26's AR dated, [DATE], the AR indicated, Resident 26 was admitted on [DATE] with diagnoses of fracture of lumbar vertebra, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and dysphasia (difficulty swallowing).</p> <p>During a review of Resident 26's MDS, dated [DATE], the MDS section C indicated Resident 26 had a BIMS score of 12, which indicated Resident 26 was moderately impaired.</p> <p>During an interview on [DATE] at 12:15 p.m. with the IP, the IP stated the dining room tables should have been free of any non-meal items. The IP stated the tables should have been wiped down, cleaned, and disinfected after each use. The IP stated whoever was in charge of dining, and Housekeeping should have wiped down the tables. The IP stated all staff training included the frequency of cleaning before and after dining. The IP stated dirty tables and dirty items on the dining table could have caused cross-contamination of the resident's food and placed a risk of infection for the residents. The IP stated residents could get sick.</p> <p>During a review of the facility's job duty document titled, Janitor, dated ,d+[DATE], the document indicated, . the job of Janitor is done for the purpose/s of maintaining an attractive, sanitary and safe facility for residents .</p> <p>6. During a concurrent observation and interview on [DATE] at 11:54 p.m. with the CNA/RNA in the Activities Room, Resident 26 was observed eating his lunch meal with his urine catheter bag placed on his lap. The CNA/RNA stated Resident 26's catheter bag should not have been on his lap. The CNA/RNA stated the urinary catheter bag should have been hanging below Resident 26's waist, on the back of his chair. The CNA/RNA stated Resident 26 had just come back from an appointment and she wanted to hurry and get him his meal, as he had another appointment to go to.</p> <p>During an interview on [DATE] at 12:15 p.m. with the IP, the IP stated staff had foley catheter training. The IP stated the catheter should have been free of any kinks and obstructions, off floor and hung below Resident 26's waist to reduce the risk of infection. The IP stated urine could go back up to the bladder if the catheter was not hung below the waist which would increase the risk of infection. The IP stated having the catheter bag on Resident 26's lap was not acceptable.</p> <p>During a review of the facility's P&P titled, Catheter Care, Urinary, dated ,d+[DATE], indicated, . the purpose of this procedure is to prevent infection of the resident's urinary tract . the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder .</p> <p>49949</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>51345</p>

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<p>F 0911</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents.</p> <p>48424</p> <p>Based on observation during the survey period of 11/5/24 through 11/8/24, the facility failed to ensure each bedroom accommodated no more than four residents in four of 19 rooms (rooms 1, 2, 5, and 6).</p> <p>This failure had the potential for residents to not have reasonable privacy or adequate space.</p> <p>Findings:</p> <p>During the initial tour on 11/5/24 at 08:26 a.m., the following rooms had more than four residents in each bedroom. Although the bedrooms accommodated more than four residents, each room met the particular needs of each resident. There was adequate closet and storage space. Wheelchair and toilet facilities were accessible. There was sufficient room for nursing care and for residents to ambulate. Bedside stands were available for each resident. The health and safety of residents would not be adversely affected by the continuance of this waiver.</p> <p>Room Number Number of Beds</p> <p>1 5</p> <p>2 5</p> <p>5 5</p> <p>6 5</p> <p>Recommend waiver continue in effect.</p> <p>-----</p> <p>HFES Signature Date</p> <p>Request waiver continue in effect.</p> <p>-----</p> <p>Facility Administrator Signature Date</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>48424</p> <p>Based on observation, interview, and record review during the survey period of 11/5/24 through 11/8/24, the facility failed to provide the minimum of at least 80 square feet per resident in eight of 19 multiple resident rooms (rooms 1, 2, 5, 6, 9, 10, 11, and 12).</p> <p>This failure had the potential for residents to not have reasonable accommodations for privacy or adequate space for care to be rendered.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 11/7/23 at 8:30 a.m., with the Maintenance Supervisor (MS), an environmental tour was conducted. The MS measured eight rooms and stated the rooms did not meet the minimum square footage per resident as required by regulation. Variations were in accordance with the particular needs of the residents.</p> <p>There were sufficient room for nursing care and resident ambulation. Wheelchairs and toilet facilities were accessible. The closets and storage space were adequate. Bedside stands were available. The waiver will not adversely affect the health and safety of residents.</p> <p>Room Beds Square Feet</p> <p>1 5 356.9</p> <p>2 5 398.5</p> <p>5 5 345.5</p> <p>6 5 384.0</p> <p>9 3 232.7</p> <p>10 3 239.0</p> <p>11 3 239.7</p> <p>12 3 239.4</p> <p>Recommend waiver continue in effect.</p> <p>-----</p> <p>HFES Signature Date</p> <p>Request waiver continue in effect.</p> <p>(continued on next page)</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>-----</p> <p>Facility Administrator Signature Date</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888</p> <p>Based on observation, interview, and record review, the facility failed to keep the environment free from insects in accordance with the facility's policy and procedure (P&P) Pest Control when flies were observed in resident rooms and in the common areas of the dining room and activities room and had the potential for rodents to enter from two holes on the laundry room wall.</p> <p>These failures led to insects being observed in the facility and had the potential to allow rodents to enter the facility from the outside, posing a risk of infection to residents due to cross-contamination.</p> <p>Findings:</p> <p>1. During a concurrent observation and interview on 11/5/24 at 10:45 a.m., with Resident 40 in her room, Resident 40 was in her bed, had a fly swatter in her hand with three flies were flying around her. Resident 40 stated she hated the flies, and they were always in her room. Resident 40 stated she was unable to move in bed, or walk, because of a tumor (an abnormal growth of tissue in the body that occurs when cells divide and grow more than they should, or don't die when they should) on the inside of her right lower leg wrapped with gauze) by her ankle. Resident 40 stated staff gave her the fly swatter to keep the flies away from the tumor.</p> <p>During an observation on 11/5/24 at 12:15 p.m., in the Resident Dining Room while residents were eating lunch, there were two flies flying around and an electric LED (light emitting diode [type of lighting that converts electricity to light] that attracts multiple species of flying insects while trapping them inside) fly trap on the wall that was inoperable (not working) due to not being plugged in to the wall electrical outlet (power plug).</p> <p>During a review of Resident 40's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the face sheet indicated, Resident 40 was admitted to the facility on [DATE] with a diagnosis which included Mass/Lump Right Lower Limb (leg) and Morbid Obesity (a person's weight that exceeds an individual's desirable weight by more than 100 pounds).</p> <p>During a review of Resident 40's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function), dated 9/21/24, the MDS indicated Resident 40's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 40 was cognitively intact.</p> <p>During an interview on 11/6/24 at 4:45 p.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 40 had asked her to kill flies in her room before. CNA 5 stated she had seen flies in that room and she gets the flies for her.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/7/24 at 6:10 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the expectation of the facility is to be free from flies. LVN 3 stated flies could put the residents at risk of infections. LVN 3 stated Resident 40 was vulnerable because she was very weak and could not move herself in bed.</p> <p>During an interview on 11/8/24 at 9:25 a.m., with CNA 6, CNA 6 stated she had seen flies in Resident 40's room before and they are a constant problem. CNA 6 stated in the past, she had housekeeping clean Resident 40's room because of flies, but after the cleaning she still saw flies and stated, I don't know why.</p> <p>During an interview on 11/8/24 at 11:16 a.m., with the Director of Nursing (DON), the DON stated the expectation was for the facility to be free from flies and insects. The DON stated flies in the facility could spread infections. The DON stated flies in the facility meant the pest control program they had in place was ineffective.</p> <p>During an interview on 11/8/24 at 2:31 p.m., with the Facility Administrator (ADM), the ADM stated flies in the facility was a constant problem. The ADM stated the flies were a legitimate concern for the facility and they could not keep flies out. The ADM stated cross-contamination (the unintentional transfer of harmful bacteria or other microorganisms [a living thing that is so small that it can only be seen with a microscope] from one object to another) could have occurred.</p> <p>During an interview on 11/8/24 at 3:20 p.m., with the Infection Preventionist (IP), the IP stated flies in Resident 40's room and in the lunchroom were an issue. The IP stated flies carry germs and they can cross-contaminate things. The IP stated residents at the facility were vulnerable. The IP stated the expectation for the facility is to be free from flies and for the fly traps to work all the time. The IP stated the facility needed a better plan to keep the flies from entering inside the facility. The IP stated flies in the facility increase resident's risk for infections. The IP stated the pest control program that was put in place was not effective.</p> <p>During an interview on 11/8/24 at 3:40 p.m., with the Maintenance Supervisor (MS), the MS stated there were a lot of flies in the facility on 11/5/24. The MS stated he called a pest control company to come in and they replaced nine fly traps that were not working in the facility. The MS stated the pest control they had in place was ineffective and the facility needed to have the pest control service company come in more often.</p> <p>During a review of the Facility's Map dated 11/8/24, the map indicated, .highlighted locations throughout the facility where 9 LED fly light trap bulbs (light that attracts flies, and they get trapped in the wall unit) had been replaced.</p> <p>During a review of facility's policy and procedure (P&P) titled, Sanitation and Infection Control- Subject: Pest Control, dated 2018, the P&P indicated, Policy: the facility will ensure a pest control prevention program provides . inspection, treatment and prevention of . insect infestation . pest control is designed to maintain a sanitary environment which prevents contamination transmission or spread of disease by insects . Procedures: . 11. It is recommended that a pest control company be retained on a monthly basis, or more often if necessary .</p> <p>49949</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 23's Admission Record, (AR- a document containing resident demographic information and medical diagnosis) dated 11/8/24, the AR indicated, Resident 23 was admitted to the facility on [DATE]. Resident 23's diagnosis included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), anemia (a condition where the body does not have enough healthy red blood cells), chronic kidney disease (CKD- a long-term condition that occurs when the kidneys are damaged and can't filter blood properly), bacteremia (the presence of bacteria in your blood) and pain.</p> <p>During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function), dated 10/11/24, the MDS indicated Resident 23's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 12 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 23 was moderately impaired.</p> <p>During a concurrent observation and interview on 11/5/24 9:25 a.m., in Resident 23's room, two flies were on a curtain and a fly swatter was on the top of the nightstand. Resident 23 was asked why he had a fly swatter on the top of the nightstand and Resident 23 stated it was to kill the flies. Resident 23 stated he did not like the flies in the room and they were there often.</p> <p>During an interview with 11/7/24 at 4:30 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she has been employed at the facility for 11 months. CNA 4 stated during the summer the flies were more noticeable. CNA 4 stated it was not ok for flies to be in the room and flies were dirty. CNA 4 stated it was hard to keep flies out of the rooms. CNA 4 stated she has seen fly swatters in Resident 23's room multiple times. CNA 4 stated she would kill flies in Resident 23's room when she saw one. CNA 4 stated residents had complained about flies in the building. CNA 4 stated there were fly traps and fans to keep the flies out. CNA 4 stated flies were dirty, and caused infections and cross-contamination.</p> <p>During an interview on 11/8/24 at 11:16 a.m., with the Director of Nursing (DON), the DON stated the expectation was for the facility to be free of flies and insects. The DON stated flies in the facility could spread infections. The DON stated flies in the facility meant the pest control program they had in place was ineffective.</p> <p>During an interview on 11/8/24 at 2:31 p.m., with the Facility Administrator (ADM), the ADM stated flies in the facility were a constant problem. The ADM stated the flies were a legitimate concern for the facility and they could not keep the flies out. The ADM stated cross-contamination (the unintentional transfer of harmful bacteria or other microorganisms [a living thing that is so small that it can only be seen with a microscope] from one object to another) could have occurred.</p> <p>During an interview on 11/8/24 at 3:20 p.m., with the Infection Preventionist (IP), the IP stated flies in Resident 40's room and in the lunchroom during meals were an issue. The IP stated flies carried germs and they can cross-contaminate things. The IP stated residents at the facility were vulnerable. The IP stated the expectation for the facility was to be free from flies and for the fly traps to work at all times. The IP stated the facility needed a better plan to keep the flies from entering inside the facility. The IP stated flies in the facility increase resident's risk for infections. The IP stated the pest control program that was in place was not effective.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/8/24 at 3:40 p.m., with the Maintenance Supervisor (MS), the MS stated there were a lot of flies in the facility on 11/5/24. The MS stated he called a pest control company and they replaced nine fly traps that were not working in the facility. The MS stated the pest control that was currently in place was ineffective and the facility needed to have the pest control company come service more often.</p> <p>During a review of the Facility's Map dated 11/8/24, the map indicated, .highlighted locations throughout the facility where 9 LED fly light trap bulbs (light that attracts flies, and they get trapped in the wall unit) had been replaced.</p> <p>During a review of facility's policy and procedure (P&P) titled, Sanitation and Infection Control- Subject: Pest Control, dated 2018, the P&P indicated, Policy: the facility will ensure a pest control prevention program provides . inspection, treatment and prevention of . insect infestation . pest control is designed to maintain a sanitary environment which prevents contamination transmission or spread of disease by insects . Procedures: . 11. It is recommended that a pest control company be retained on a monthly basis, or more often if necessary .</p> <p>48739</p> <p>3. During a concurrent observation and interview on 11/5/24 at 11:54 a.m. with the CNA/RNA, in the Activities Room, flies were observed landing on Residents 15, 26, and 251's food and landing on the residents. The CNA/RNA stated residents eating in the Activities Room were eating there for restorative dining (a program that focuses on establishing a specific dining space for residents who require greater levels of supervision and assist with eating). The CNA/RNA stated she had a fly swatter to keep the flies off the residents. The CNA/RNA was observed swishing the fly swatter over Resident 15, 26, and 251's food while the residents were eating. The CNA/RNA stated flies should not have been in the room where Residents 15, 26, and 251 were eating. The CNA/RNA stated having flies in the room was not comfortable for the residents. The CNA/RNA stated flies could get germs on the resident's food and the residents could get sick.</p> <p>During a review of Resident 15's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information),, dated 11/8/24, the AR indicated, Resident 15 was admitted to the facility on [DATE] with diagnoses of fracture of left femur (a break in the bone of the thigh) and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).</p> <p>During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/18/24, the MDS section C indicated Resident 15 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 15 was severely cognitively impaired.</p> <p>(continued on next page)</p>		

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 11/08/2024
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)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 26's AR dated, 11/8/24, the AR indicated Resident 26 was admitted on [DATE] with diagnoses of fracture of lumbar vertebra, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 26's MDS, dated [DATE], the MDS section C indicated Resident 26 had a BIMS score of 12, which indicated Resident 26 was moderately impaired.</p> <p>During a review of Resident 251's AR, dated 11/8/24, the AR indicated Resident 251 was admitted on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 251's MDS, dated [DATE], the MDS section C indicated Resident 251 had a BIMS score of 3, which indicated Resident 251 was severely cognitively impaired.</p> <p>During a concurrent observation and interview on 11/5/24 at 12:12 p.m. with the Maintenance Assistant (MAINTA) in the Activities room, the MAINTA was observed checking the bug light on the wall The MAINTA stated the bug light was not on.</p> <p>During an interview on 11/07/24 at 5:02 p.m. with the Infection Preventionist (IP), the IP stated the maintenance department had a pest control company that performed pest control service on a regular schedule. The IP stated if anyone informed her or if she saw pests, she would inform the maintenance department. The IP stated flies were a problem for infection control. The IP stated flies put residents at risk for infection if the flies landed on the resident's food. The IP stated if the resident had a wound, the flies could land on the wound then land on other clean areas, exposing those areas to germs. The IP stated if flies landed on a resident's wound, they could lay eggs in the wound. The IP stated there should not be flies in the areas where residents were eating.</p> <p>During a review of the pest control company's documents titled, Service Report, dated 10/14/24, 9/30/24, and 8/22/24, the documents indicated, . fly light not working . recommend keeping doors closed when not in use to control flying activity entering facility . one fly light bulb that needs to be replaced . fly light not working . several fly lights were unplugged .</p> <p>During an interview on 11/8/24 at 3:29 p.m. with the Maintenance Supervisor (MS), the MS stated the fly bulbs had been out on the last three months of the pest control service reports. The MS stated the pest control program was ineffective. The MS stated the pest control company needed to come out to the facility more often to provide pest control service.</p> <p>During a review of the facility job description document titled, . Building & Maintenance Supervisor, dated 4/2013, the document indicated, . responsible for overall management of . maintenance . personnel to ensure a clean, safe and orderly living environment for residents . oversees . pest control .</p> <p>(continued on next page)</p>		

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 11/08/2024
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.			
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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, Pest Control, dated 5/2008, indicated, the facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents . maintenance services assist, when appropriate and necessary, in providing pest control services .</p> <p>4. During a concurrent observation and interview on 11/7/24 at 10:56 a.m. with the Laundry Staff (LS) in the laundry room, two holes were observed in the lower back wall, open to the outside. The LS stated that the holes in the wall were not good. The LS added that if rodents or pests got into clean clothes, they could cause an infection risk to residents.</p> <p>During an interview on 11/7/24 at 5:02 p.m. with the Infection Preventionist (IP), the IP stated that maintenance had a regular company scheduled for pest control. The IP stated that if anyone informed her or if she saw anything related to pests, she would notify maintenance. The IP also stated that holes opening to the outside in the laundry room posed a risk for cross-contamination and infection to residents if rodents entered the room.</p> <p>During an interview on 11/8/24 at 3:29 p.m. with the Maintenance Supervisor (MS), the MS stated that the holes in the laundry room walls were discovered earlier that week when the laundry area was cleaned. The MS stated that there was not a work order for the repair of the holes. The MS stated that there was a risk associated with the holes opening to the outside because rodents could enter through them. The MS stated that rodents could cause cross-contamination in the laundry and pose an infection risk to residents. The MS stated that he had started the yearly inspection on 10/31/24. The MS stated that the board, which incompletely covered one of the holes, had been placed there approximately three to four months ago as a temporary fix. The MS stated that his expectation for the laundry area was for the holes to be properly covered to prevent anything from entering from the outside.</p> <p>During a review of the facility's policy and procedure (P&P) titled Maintenance Service, dated 12/2009, indicated that, . the maintenance department is responsible for maintaining the buildings, keeping the building in good repair and free from hazards, and providing routinely scheduled maintenance service to all areas. The maintenance director is responsible for maintaining the following records/reports: work order requests and maintenance schedules .</p>		