

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/19/2025
NAME OF PROVIDER OR SUPPLIER Manning Gardens Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E. Manning Avenue Fresno, CA 93725	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with acceptable standards of practice, manufacturer instructions, and the facilities medication management policies when: 1. Discontinued medications for three of 51 sampled Residents (Residents 32, 30, and 9) were found in the East Station medication cart, indicating medications without active orders were stored in the cart. These failures had the potential to result in medication errors, including the risk of administering medications that were no longer prescribed, which could result in adverse effects or harm to the residents. 2. An opened bottle of sterile (completely free from germs so nothing could grow in it or cause an infection) sodium chloride (saltwater solution used to clean wounds or body parts), which was labeled for single use only, had been kept in the [NAME] Treatment Cart after it was opened. This failure had the potential to result in contamination and posed a risk to residents' health and safety for 51 sampled residents. Findings: 1. During an observation 12/17/25 at 2:45 p.m., the medication cart for East Station was inspected. The medication cart was observed to have Ondansetron (a prescription anti-nausea and anti-vomiting medication) ODT (orally disintegrating tablet-dissolves quickly in the mouth without water) 4 milligram (mg- a small unit to measure weight often used to measure medicine) tablets that were individually packaged and stored. The medications were stored in separate bubble packs and labeled with each resident's identifier labeled in the medication cart. During a concurrent interview and review on 12/17/25 at 3:02 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 30's electronic health record, undated was reviewed. LVN 1 stated Resident 30 did not have an active order for [Brand name]. The bubble pack issue date was reviewed with LVN 1 and indicated the ondansetron was issued on 11/19/25. A review of the Medication Administration Record (MAR) dated 12/2025, indicated the medication was ordered to be used as needed for 14 days and was discontinued on 12/2/25. During a concurrent interview and record review on 12/17/25 at 3:05 p.m. with LVN 1, Resident 32's electronic health record, undated was reviewed. LVN 1 stated Resident 32 did not have an active order for [ondansetron]. During a concurrent interview and review of Resident 9's electronic health record on 12/17/25 at 3:08 p.m. with LVN 1, LVN 1 stated Resident 9 did not have an active order for [ondansetron]. During an interview on 12/17/25 at 3:10p.m. with LVN 1, LVN 1 stated the process was to remove medications from the medication cart as soon as an order was discontinued. LVN 1 stated she removed the discontinued medications and completed the destruction of the medications. LVN 1 stated as long as the medication was not a narcotic (a strong medicine used to relieve pain that could also make a person feel sleepy or relaxed and could be addictive [a person's body could start to depend on the medicine, making it hard to stop using it even if it was harmful]; if not used correctly), she could perform the destruction independently . LVN 1 also stated if medications remained in the cart without an active order, there was a risk of medication error, and these medications should not be stored in the medication cart because they were not active medications. During a review of Resident 9's Medication Administration Record (MAR), dated November 2025, the MAR indicated Resident 9 did not have an active order for [ondansetron]. During (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a review of Resident 32's Progress Note, dated 11/12/25, the Progress Note indicated the facility received Resident 32's ondansetron from the pharmacy; however, Resident 32 refused to take the medication. The physician was notified and subsequently ordered [ondansetron] to be discarded. During an interview on 12/19/25 at 2:05p.m. with the Director of Nursing (DON), the DON stated there should not be discontinued medications stored in the medication carts. During a review of facilities policy and procedure (P&P) titled, Storage of Medications, dated 11/2020, the P&P indicated, discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. During a review of facilities P&P titled, Discontinued Medications, dated 4/2007, the P&P indicated, .discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies. 2. During an observation on 12/16/25 at 3:57p.m. of the [NAME] Treatment Cart, a partially used 100 milliliter (ml-a unit of measurement used to measure liquid, such as medicine or water) bottle of sodium chloride irrigation solution was observed stored in the cart. The product label clearly stated DO NOT REUSE in bold lettering and indicated the contents were sterile in the unopened package. During a concurrent observation and interview on 12/16/25 at 4:07 p.m. with Treatment Nurse (TN) 1, TN 1 stated her practice was to keep opened sodium chloride bottles for 24 hours. TN 1 stated she opened the bottle and poured the anticipated amount needed into a medication cup, then recapped the bottle and stored the opened bottle for up to 24 hours. TN 1 stated the bottle would be considered not sterile since it had been opened. TN 1 stated there was a risk of contamination with reuse of the bottles, because the product did not contain preservatives. TN 1 stated residents were at risk because they already had wounds and new bacteria could be introduced to the residents through the sodium chloride solution. During an interview on 12/19/25 at 10:15a.m. with the Infection Preventionist (IP), the IP stated if a bottle indicated do not reuse, it should not be reused. The IP further stated there was a risk of contamination associated with reuse of the bottle. During an interview on 12/19/25 at 2:05p.m. with the DON, the DON stated she did not know the bottle label indicated DO NOT REUSE. The DON stated the bottles should not be reused if the label specified this. During a review of sodium chloride-sodium chloride irrigant monograph by [Brand Name of solution] dated 9/23, the package insert warning indicated, after opening container, its contents should be used promptly to minimize the possibility of bacterial (germs) growth.discard unused portion of irrigating solution since it contains no preservatives.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation practices were followed in the kitchen when the ice machine and food preparation sink did not have an air gap. These failures had the potential for contaminated water to flow back into the sink and ice machine and result in pathogenic (viruses, bacteria and other types of germs that can cause disease) microorganism (small organism that can only be viewed under a microscope) growth that could inadvertently (accidentally) be transferred to food and water served to residents and staff in the facility, causing foodborne illness. During a concurrent observation and interview on 12/16/25 at 8:50 a.m. during the initial tour in the kitchen, observed food preparation sink did not have an air gap and ice machine located in the dining room did not have a functioning air gap. Dietary [NAME] (DC) 2 stated she was not aware the ice machine did not have a functioning air gap and the drain basin behind the ice machine was dirty and appeared to not have been cleaned. DC 2 stated the Certified Dietary Manager (CDM) was responsible for cleaning the ice machine and was not sure if she also cleaned the drain basin. During a concurrent observation and interview on 12/16/25 at 2:35 p.m. with the CDM in the kitchen. The CDM stated the food preparation sink did not have an air gap and ever since she assumed her position as CDM four years ago there was no air gap. The CDM stated the facility had been working on it for almost two years now and she was not sure when they started to install the air gap. The CDM stated it was her responsibility to deep clean the ice machine once a month. The CDM stated she did not notice the drain tube from the ice machine was pushed down past the grill covering the drain basin. The CDM stated the drain basin was also dirty and the air gap was not functioning as it should have been. The CDM stated there was no facility P&P specific to an air gap. During a concurrent observation and interview on 12/16/25 at 2:45 p.m. with the Maintenance Supervisor (MS), the MS stated the facility was aware of the food prep sink inside the kitchen did not have an air gap. The MS stated he was not sure when the work would start because the facility already had a contract signed and submitted. The MS stated he was not responsible to deep clean the ice machine but they called him when there were issues. The MS checked the air gap behind the ice machine and stated the drain from the ice machine was pushed down by at least four inches past the grill covering the drain basin. The MS pulled the drain pipe and stated the tip was dirty and there should be at least two inches gap between the tip of the drain pipe and the drain basin. The MS stated the purpose of the air gap was to prevent the backing of dirty water into the ice machine and the food prep sink which could cause residents and staff to get sick. During a phone interview on 12/19/25 at 10:45 a.m. with the Registered Dietitian (RD), the RD stated it was important to ensure there was an air gap installed under the food prep sink and ice machine to prevent back flow of dirty water to the sink which could contaminate food in the sink. The RD stated an air gap was important for the ice machine to prevent contamination of the water and ice to prevent food borne illnesses to residents and staff. During a review of facility's policy and procedure (P&P) titled, Food Preparation, dated 2023, the P&P indicated, .Employees will prepare food in a clean and safe manner to protect residents and staff from foodborne illness . Sinks, cutting boards, utensils and equipment will be cleaned and sanitized after each use . During a review of a professional reference titled, FDA Food Code Section 5-402.11 Backflow Prevention, dated 2022, the FDA Food Code indicated, . 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed . During a review of the Food and Drug Administration (FDA), Food Code Section 5-203.14 Backflow Prevention Device, dated 2022, the FDA Food Code indicated, . A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT .backflow prevention is required by LAW, by: (A) Providing an air gap .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to maintain infection prevention and control standards for three of 14 sampled residents (Resident 13, 33, and 64) when:1. Licensed Vocational Nurse (LVN) 3 administered an insulin (medication injected into the body to treat high blood sugar levels) injection to Resident 33 without changing gloves or performing hand hygiene. Immediately afterward, LVN 3 gave Resident 33 a medication by mouth (PO).This failure had the potential to cause pathogens (germs that can enter the body and cause illness) to spread to Resident 33 as a result of cross contamination (unintentional transfer of harmful germs or allergens from one surface or object to another).2. Urinals for Resident 13 and Resident 64 were not labeled with the date they were first used and the room number.These failures had the potential for Resident 13 and Resident 64 to be exposed to cross contamination when urinals were used by other residents. Findings: 1. During an observation on 12/17/25 at 11:52 a.m. during a medication pass for Resident 33, LVN 3 administered an insulin injection into Resident 33's abdomen and then prepared and administered Resident 33 their PO gabapentin (medication used primarily to nerve pain and partial seizures) medication without changing gloves or performing hand hygiene. During an interview on 12/19/25 at 9:57 a.m. with LVN 3, LVN 3 stated he should not have given the insulin injection first. LVN 3 stated the proper order of medication administration was mouth first and then injection. LVN 3 stated he should have changed his gloves or done hand hygiene after giving the injection because the abdomen was considered a dirty area and he had the possibility to come in contact with the resident's blood. LVN 3 stated the improper administration order could have caused Resident 33 to receive an infection due to cross contamination from pathogens on his abdomen traveling to his mouth. During an interview on 12/19/25 at 10:11 a.m. with the Infection Preventionist (IP), the IP stated LVN 3 should have changed his gloves or performed hand hygiene when giving an injection to a PO medication. The IP stated the insulin injection was administered in the abdomen and that was considered a dirty area. The IP stated pathogens could have traveled to Resident 33's mouth during administration of the PO medications. The IP stated nurses should never go from a dirty to clean area because it could cause cross contamination. During an interview on 12/19/25 at 10:42 a.m. with the Director of Nursing (DON), the DON stated nurses should know when to perform hand hygiene or change gloves when giving medications. The DON stated it was important for the nurses to follow proper infection control standards because it stopped cross contamination from occurring. During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK138494/, the article titled, Indications for glove use in health care, undated, the PR indicated, . Change gloves: between tasks and procedures on the same patient, and after contact with material that may contain a high concentration of microorganisms . During a review of the PR, found on https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, the article titled, Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, the PR indicated, . [employees should clean their hands] Before moving from work on a soiled body site to a clean body site on the same patient . (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the PR, found on https://www.cdc.gov/injection-safety/hcp/infection-control/index.html, the article titled, Considerations for Blood Glucose Monitoring and Insulin Administration dated 8/7/24, the PR indicated, . Change gloves between patient contacts. Change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces. Discard gloves in appropriate receptacles (containers). Perform hand hygiene immediately after removing gloves and before touching other medical supplies intended for use on other persons . 2. During an observation on 12/16/25 at 9:28 a.m. during initial tour at Resident 64's bedside, observed a urinal (pee bottle) with no lid containing a small amount of yellow urine hung on the side of a garbage can at bedside, urinal did not have label with date, room, and bed number. During an observation on 12/16/25 at 9:32 a.m. during initial tour in Resident 13's room, Resident 13 was lying in bed and did not answer questions asked. The urinal was observed with no lid containing a small amount of urine, hung on the side of a garbage can at bedside, the urinal did not have a label with the date, room, and bed number. During a review of Resident 13's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive [process of thinking, knowing, learning, and understanding], physical abilities and needs) assessment, dated 12/10/25, the MDS assessment indicated Resident 13's Brief Interview for Mental Status (BIMS- screening tool to assess resident cognitive status) 0-15 scale (0-6 severe cognitive deficit, 7-12-moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 13 had no cognitive deficit. During a review of Resident 64's MDS assessment, dated 4/18/25, the MDS assessment indicated Resident 64's BIMS assessment score was 15 out of 15 which indicated Resident 64 had no cognitive deficit. During an interview on 12/16/25 at 9:49 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated urinals of Resident 13 and 64 did not have a label with the date, room, and bed number and should have. CNA 3 stated the practice was to change urinals every seven days or weekly and to ensure the urinals were labeled with date, room number, and resident name. CNA 3 stated it was to ensure staff knew when it was replaced and which resident the urinal belonged to and to avoid residents using other resident's urinal. During an interview on 12/18/25 at 2:35p.m. with the Infection Preventionist (IP), the IP stated urinals were changed every seven days and as needed. The IP stated the facility practice was to ensure urinals were labeled with the date and room number including bed number of the resident. The IP stated the labeling urinals was an infection control issue and to prevent cross contamination. During an interview on 12/19/25 at 2:45 p.m. with the Director of Nursing (DON), the DON stated her expectation was for urinals to be labeled with the date and room number and to be replaced every seven days and as needed. The DON stated CNAs were responsible for ensuring urinals were changed every seven days and labeled to reduce infection. During a review of facility's policy and procedure titled, Disinfection of Bedpan/Urinals, dated 2001, the P&P indicated, .Bedpans and urinals are for single resident use only . Discard bedpans and urinals every seven days or when damaged . Bedpan/Urinal must be labeled with room number and date .		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed to promote and facilitate one of six sampled residents (Resident 45), right to self-determination when the facility denied Resident 45's request to use an iron to press his clothes and refused his request for hot water to make instant coffee in his room. The facility did not complete individualized assessment of Resident 45's ability to safely perform these tasks, nor did the facility attempt to identify or implement alternative interventions or accommodations to incorporate the resident's stated preferences into his care plan. Instead, the requests were denied based on generalized safety concerns without evidence of an interdisciplinary team review, despite Resident 45 identifying these preferences as very important. These failures resulted in the restriction of Resident 45's preferences and had the potential to cause frustration, decreased autonomy or reduced quality of life. Findings: During a review of Resident 45's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 10/15/25, the AR indicated Resident 45 had the following diagnoses: protein-calorie malnutrition (a condition where a person did not get enough protein and calories from food, causing the body to become weak and not work the way it should) and esophageal obstruction (a condition where something blocked the esophagus [the tube that carried food and drinks from the mouth down to the stomach [a organ that held food and mixed it with acids to help break it down so the body could use it], making it hard for food or liquid to pass from the mouth to the stomach). During a review of Resident 45's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 10/22/25, 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 45 had no cognitive impairment. During an interview on 12/16/25 at 9:49 a.m. with Resident 45 in his room, Resident 45 stated the facility would not provide hot water for him to make instant coffee at his bedside. Resident 45 reported the facility offered room-temperature water or already prepared coffee but would not provide prepared coffee before 7:00a.m. Resident 45 stated he typically awoke at approximately 5:00 a.m. and preferred to have coffee around that time. Resident 45 stated he did not understand the difference between 5:00 a.m. and 7:00 a.m. and stated being unable to have coffee when he awoke made him feel frustrated and punished. Resident 45 stated he was accustomed to ironing his clothes at home and stated his personal appearance was important to him and reflected how he was perceived by the public. Resident 45 stated when his clothes were wrinkled, he felt unkempt and preferred to remain in his room. During an interview on 12/18/25 at 8:45 a.m. with Resident 45 in his room, Resident 45 stated this was a new issue. Resident 45 stated he was previously admitted to the facility in January 2025, and during that admission, he was allowed to iron his clothes in his room. Resident 45 stated upon his readmission in October 2025, he was informed that he could no longer have an iron. Resident 45 reported staff entered his room on one occasion and removed the iron from his closet, informing him that he was no longer permitted to have it. Resident 45 stated he spoke with staff in the office regarding this issue and no alternatives were provided. Resident 45 stated the same individuals who had previously allowed him to have an iron were the same individuals who later informed him he could no longer have one. Resident 45 stated he requested permission to iron his clothes in the laundry room; however, this request was denied due to stated liability concerns. Resident 45 also stated hot water had previously been available but was later discontinued. Resident 45 stated the current process required him to ask a Certified Nursing Assistant (CNA) for hot water, who would then go to the kitchen. Resident 45 stated if the request was made before 7 a.m., the CNA informed him that he would need to wait until 7:00a.m. Resident 45 stated he did not understand the significance of this time restriction. Resident 45 further stated when hot water was provided, it was barely warm and that he had difficulty (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dissolving powdered creamer in it, the water in the bathroom was warmer. During an interview on 12/18/25 at 11:06 a.m. with CNA 1, CNA 1 described Resident 45 as alert and independent. CNA 1 stated Resident 45 was quiet and did not like to receive a lot of assistance and attempted to complete his own care. CNA 1 stated she was aware of the situation involving Resident 45's iron. CNA 1 stated she observed Resident 45 ironing in his room the previous week and reported this to the nurse supervisor. CNA 1 stated the Social Services Director (SSD) subsequently removed the iron from Resident 45's room for safety reasons. CNA 1 stated Resident 45 frequently requested coffee or hot water. CNA 1 stated staff were not permitted to provide residents with hot water and that there were time restrictions on when coffee could be provided. CNA 1 stated residents could not get coffee before 7:00a.m. due to the kitchen being busy with the tray line. CNA 1 stated that her process was to notify the nurse and ask whether hot water could be provided; however, the nurse would state that it could not be given. CNA 1 stated she would return to the resident and offer coffee from the kitchen and if the request was made before 7:00a.m., informed the resident that coffee would be provided after 7:00 a.m. During an interview on 12/18/25 at 11:21 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was aware of the incident in which Resident 45 was found ironing in his room. LVN 2 stated residents were not permitted to have an iron at bedside due to safety concerns and stated she believed the iron was removed from Resident 45's room. LVN 2 stated the process required the CNA to ask her whether the resident could receive hot water. LVN 2 stated coffee could be provided; however, plain hot water could not be given due to safety concerns. LVN 2 described Resident 45 as alert and independent, requiring monitoring only, and stated he was his own responsible party. During an interview on 12/18/25 at 11:40 a.m. with the SSD, the SSD stated when Resident 45 was admitted in October, his family reported that he preferred his clothes to be neatly pressed and ironed. SSD stated staff discussed with the family that Resident 45 would not be permitted to iron his clothes due to safety concerns, and the family expressed understanding. The SSD stated she did not discuss this issue directly with Resident 45. The SSD stated for safety reasons, residents were not allowed to iron their clothes. The SSD stated at the time of Resident 45's admission in October, there would have been no way Resident 45 could physically perform the task; however, he had shown significant improvement since that time. The SSD stated decisions regarding such matters were not made by her alone but required input from the interdisciplinary team (IDT). The SSD stated she would discuss such issues with IDT to determine how it could be addressed. During a concurrent interview and record review on 12/18/25 at 11:52 a.m. with the SSD, Resident 45's electronic health record, undated was reviewed. The SSD stated she did not observe any documentation in Resident 45's health record regarding a preference for ironing his clothes or the incident in which he was found with an iron. The SSD stated if the charge nurse had spoken with Resident 45 and he was not receptive, the matter could have been referred to the IDT. During a concurrent interview and record review on 12/19/25 at 11:03 a.m. with the Clinical Supervisor (CS) 1, Resident 45's electronic health record, undated was reviewed. CS 1 stated the facility supported residents' choices regarding their daily routines by discussing their choices and preferences with them. CS 1 stated during admission, residents were asked if they needed anything, and that any identified choices or preferences were assessed by the SSD. CS 1 stated the IDT would be notified if issues arose. CS 1 stated when balancing resident choice and safety, the facility ensured that choices could be supported safely through education and teaching. CS 1 stated self-determination meant the ability to do things independently and that this provided residents with satisfaction. CS 1 stated she was familiar with Resident 45 and reported that he had shown improvement, including progress in activities of daily living. When asked how the resident was involved in decisions related to his requests to iron his clothes and have hot water, CS 1 stated nursing staff were expected to refer to the facility policy and follow it. CS 1 stated decisions regarding whether such requests were permitted would be made by the IDT. CS 1 stated Resident 45 had not been assessed for his ability to iron and that such assessment should have occurred. CS 1 stated the facility did not evaluate Resident 45's ability to safely handle hot water due to potential (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk for burn injury. CS 1 stated such factors such as resident cognitive status, mobility, ADL's and personal choices were considered when determining how activities could be safely supported. CS 1 stated IDT was responsible for approving such requests and that the IDT should meet with Resident 45 to listen to his choices. CS 1 stated there were no IDT notes in Resident 45's record addressing these issues or preferences. CS 1 stated the facility did not provide hot water to residents and only supplied room-temperature water. CS 1 stated the kitchen prepared coffee at a specific temperature and would not provide hot water at the same temperature as coffee. CS 1 stated providing hot water would require supervision and noted that if a resident was alert and able to eat and drink independently, supervision should not be necessary. CS 1 stated ironing would require supervision. CS 1 stated resident preferences were discussed with residents and incorporated into the care plan; however, Resident 45's care plan did not address ironing or having hot water in his room. CS 1 stated there was no nursing documentation in the care plan regarding these preferences. CS 1 stated Resident 45 should have been reassessed and that any changes in abilities, whether improvement or decline, should have been documented through a progress note and care plan update. CS 1 stated supporting resident requests promoted satisfaction, improved well-being and honored resident choice and emphasized that the facility was the resident's home and residents should have input into decisions affecting their daily lives. During an interview on 12/19/25 at 1:40 p.m. with the Director of Nursing (DON), the [NAME] was asked how the facility supported residents in making choices about their daily routines. The DON stated any electronic device brought into the facility was required to be inspected by maintenance prior to use. The DON stated resident capability was considered when evaluating requests and acknowledged that Resident 45 had since improved, Resident 45 was initially very weak upon readmission and appropriate notification should have occurred. When asked how the facility balanced resident choice with safety when a resident wished to perform tasks independently, the DON stated accommodations could be made based on the resident's functional abilities and level of independence with activities of daily living. The DON stated self-determination meant allowing residents to make their own choices while ensuring safety. When asked whether Resident 45 was involved in decisions related to his requests to iron clothes and receive hot water, the DON stated Resident 45 did not bring the requests directly to her attention and she was not aware at the time. The DON stated staff did not currently have a method to measure water temperature if water was heated and that plan would need to be developed. The DON stated the facility aimed to provide person-centered care and that resident requests should be reviewed by the IDT to identify appropriate solutions. The DON further stated when residents requested specific activities or accommodations, the requests should be reevaluated. The DON stated supporting these requests promoted resident self-determination by encouraging independence and allowing residents to complete tasks independently when safe to do so. During a review of Resident 45's MDS Section F-Preferences for Customary Routine and Activities (MDS- F), dated 10/22/25, the MDS- F indicated Resident 45 indicated that choosing what clothes to wear was very important and rated this preference as a 1 (Very Important). Resident 45 also indicated that having snacks available between meals was very important, rating this preference as a 1 (Very Important). During a review of Resident 45's MDS Section GG-Functional Abilities-admission (MDS- GG), dated 10/22/25, the MDS- GG indicated Resident 185 had no impairment or functional limitation in range of motion of the upper and lower extremities. The MDS further indicated Resident 45 required set-up or clean-up assistance with eating. During a review of the facilities policy and procedure (P&P) titled, Resident Rights, dated 12/2016, the P&P indicated, federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to: e. self-determination. During a review of the facilities P&P titled, Quality of Life-Resident Self Determination and Participation, dated 12/2016, the P&P indicated, 1. Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including a. daily routine, such as sleeping walking, eating exercise and bathing schedules. e. activities, hobbies and interests. 2. (continued on next page)		

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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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In order to facilitate resident choices, the administration and staff b. gather information about the residents' personal preferences on initial assessment and periodically thereafter and document these preferences in the medical record.c. include information gathered about the resident's preferences in the care planning process.4. Residents are provided assistance as needed to engage in their preferred activities on a routine basis.During a review of the facilities P&P titled, Quality of Life-Dignity, dated 2/2020, the P&P indicated, the facility culture is one that supports and encourages humanization and individuation of residents and honors resident choices, preferences, values and beliefs.some examples of ways In which respect for choices and values are exercised include: clothing-residents are encouraged to dress in clothing that they prefer, d. schedules-residents may choose when to sleep, eat and conduct activities of daily living.staff do not handle or move a resident's personal belongings without the resident's permission.During a review of the facilities P&P titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated, 2. the interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risk for individual residents.3. the care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices.4. Implementing interventions to reduce accident risks and hazards shall include the following: a. communicating specific interventions to all relevant staff.b. assigning responsibility for carrying out interventions.c. provide training, as necessary.d. ensuring that interventions are implemented.e. documenting interventions.the facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach to safety, which considers the hazards identified in the environment and individual resident risk factors, and then adjusts interventions accordingly.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy on change in condition or status for one of three sampled residents (Resident 17), when Resident 17 was transferred out to general acute care hospital (GACH) on 12/17/25 and there was no documentation the medical doctor was notified and no information in Resident 17's medical record regarding a change in condition. This failure had the potential to place Resident 17 at risk of not meeting significant changes in needs. Findings: During a review of Resident 17's admission Record (AR-a document containing resident profile information), dated 12/3/25, the AR indicated Resident 17 was admitted to the facility on [DATE] with diagnoses which included alcoholic cirrhosis of liver with ascites (severe liver scarring from long-term heavy drinking causing high blood pressure in the liver that forces fluid to build up in the abdomen, leading to painful swelling, weight gain, and shortness of breath), hepatomegaly (enlarged liver) and subdural hematoma (brain bleed). During a concurrent observation and interview on 12/16/25 at 9:33 a.m. during initial tour in Resident 17's room, Resident 17 was observed with rounded abdominal area and appeared uncomfortable while sitting at the edge of the bed watching TV. Resident 17 stated she was uncomfortable because of her abdomen and stated the hospital was not able to drain fluid when she was sent out to GACH on 12/13/25. Resident 17 was tearful and stated her abdomen was getting uncomfortable and it was hard to sleep at night and stated the facility need to do something. During a concurrent observation and interview on 12/19/25 at 9:15 a.m. in Resident 17's room, Resident 17 was observed sitting at the edge of her bed watching TV and was smiling. Resident 17 stated she was sent out to the emergency room on [DATE]. Resident 17 stated, They removed 3.7 L [liter-unit of measurement] and I am feeling much better now. During a concurrent interview and record review on 12/19/25 at 9:34 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 17's clinical record, undated was reviewed. LVN 2 stated she was familiar with Resident 17 and she was the assigned nurse. LVN 2 stated the clinical record indicated Resident 17 was sent out to the emergency department on 12/17/25. LVN 2 stated she was not able to find documentation of Resident 17's assessment and notification of the medical doctor. LVN 2 stated the practice was to document a complete head to toe assessment, MD notification, and reason why Resident 17 was sent out. During a concurrent interview and record review on 12/19/25 at 10 a.m. with Clinical Supervisor (CS) 1, Resident 17's clinical record was reviewed. CS 1 stated Resident 17 was sent out to GACH on 12/17/25 and she was not able to find nursing progress note. CS 1 stated there should have been a significant change of condition created and documented assessment when Resident 17 was sent out to GACH and there was none. CS 1 stated she did not find documentation MD and family were notified of Resident 17's transfer to GACH. During an interview on 12/19/25 at 2:32 p.m. with the Director of Nursing (DON), the DON stated her expectation was to ensure the nurse documents in resident's clinical records and vital signs (V/S- measurements of the body's most basic functions like temperature, heart rate, respiratory rate), resident condition at time of transfer and family and MD notification when sending resident to GACH. The DON stated a change of condition should have been completed. During a review of facility policy (P&P) titled, Change in a Resident's Condition or Status, dated 5/17, the P&P indicated, .1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): .g. need to transfer the resident to a hospital/treatment center . 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff . The nurse will record in the resident's medical record information relative to changes in the resident's medical/ mental condition or status .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1Based on observation, interview, and record review, the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for one of five sampled residents (Resident 17), when Resident 17 did not have a care plan when she was sent out to the general care hospital (GACH) on 12/17/25 and a paracentesis (medical procedure where a needle is inserted into the abdomen to drain excess fluid [ascites]) procedure was performed. Resident 17 returned to the facility on [DATE] and there was no care plan created to care for the paracentesis procedure.This failure placed Resident 17 at risk for complications such as persistent fluid leakage, infection, bleeding and low blood pressure which could lead to worsening health. During a concurrent observation and interview on 12/19/25 at 9:15 a.m. in Resident 17's room, Resident 17 was seated at the edge of her bed watching TV. Resident 17 stated she went to the hospital emergency department on 12/17/25 because her abdomen was getting too uncomfortable and 3.7 L (liter-unit of measurement) was removed. Resident stated she returned to the facility the same day. During a review of Resident 17's admission Record [AR-document containing resident profile information], dated 12/3/25, the AR indicated Resident 17 was admitted to the facility on [DATE] with diagnoses which included alcoholic cirrhosis of liver with ascites (liver is severely scarred causing fluid to build up in the abdomen due to high pressure in liver blood vessels leading to significant bloating, swelling and discomfort), hepatomegaly (enlarged liver) and subdural hematoma (brain bleed).During a review of Resident 17's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment, dated 12/5/25, the MDS assessment indicated Resident 17's Brief Interview for Mental Status (BIMS-screening tool to assess resident cognitive status) 0-15 scale (0-6 severe cognitive deficit, 7-12-moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 17 had no cognitive deficit. During a review of Resident 17's Order Summary, dated 12/19/25, the Order Summary indicated, . May send resident out to [emergency room] for further [evaluation] and [treatment] . Start Date: 12/17/2025 . During a concurrent interview and record review on 12/19/25 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 5, Resident 17's clinical record, undated was reviewed. LVN 5 stated Resident 17 was sent out to the GACH on 12/17/25 and returned to the facility the same day. LVN 5 stated Resident 17 had a paracentesis (medical procedure where a needle is inserted into the abdomen to drain excess fluid) done when she was out at the GACH. LVN 5 stated she did not find a care plan initiated to care for Resident 17's procedure. LVN 5 stated care plans were important in order to care for the needs of the residents. LVN 5 stated it was the responsibility of licensed nurses to make sure care plans were initiated for any significant changes. During a concurrent interview and record review on 12/19/25 at 10:05 a.m. with LVN 3, Resident 17's clinical record, undated was reviewed. LVN 3 stated the clinical record indicated there was no care plan created when Resident 17 was sent out to the GACH and a paracentesis was performed on 12/17/25. LVN 3 stated Resident 17 returned to the facility the same day on 12/17/25. LVN 3 stated the licensed nurse who sent Resident 17 to GACH should have started a care plan for the paracentesis but there was none. During an interview on 12/19/25 at 2:45 p.m. with the Director of Nursing (DON), the DON stated her expectation was for charge nurses to create a care plan and clinical supervisors to help. The DON stated the care plan was important because it lets the nursing team know the type of care each resident needs. The DON stated each resident should be made aware of the type of care they were receiving. The DON stated care plans should be individualized and should be created as soon as possible when there was a change of condition. During a review of facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 12/16, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the P&P indicated, .The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. Describe services that would otherwise be provided . Incorporate identified problem areas; Incorporate risk factors associated with identified problems . Reflect treatment goals, timetables and objectives . Aid in preventing or reducing decline in the resident's functional status and or functional levels .		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of practice for one of three sampled residents (Resident 41), when Resident 41's physician order to check Vitamin D level (blood test result showing how much Vitamin D the body has stored, indicating if body has enough for healthy bones, muscles, and immune functions [fighting off harmful invaders like germs]) ordered on 10/17/25 was not carried out and no follow-up by the nursing staff. This deficient practice placed Resident 41 at risk of developing Vitamin D deficiency and not recognizing the signs and symptoms resulting in not treating the deficiency. Findings: During a review of Resident 41's, admission Record (AR-a document containing resident profile information), dated 12/19/25, the AR indicated Resident 41 was admitted to the facility on [DATE] with diagnoses which included malignant neoplasm of thyroid gland (small, butterfly shaped gland in the neck-thyroid cancer), multiple myeloma (blood cancer), aplastic anemia (blood disorder where the bone marrow stops producing enough new blood cells) and Vitamin D deficiency (lack of vitamin D). During a review of Resident 41's, Order Summary Report (OSR), dated 12/19/25, the OSR indicated, . [brand name] Oral Tablet 25 [microgram (MCG)-unit of measurement] . Give 2 (two) tablet by mouth one time a day related to VITAMIN D DEFICIENCY . Order date:9/23/25 . During a review of Resident 41's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment, dated 9/30/25, the MDS assessment indicated Resident 41's Brief Interview for Mental Status (BIMS- screening tool to assess resident cognitive status) 0-15 scale (0-6 severe cognitive deficit, 7-12-moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 41 had no cognitive deficit. During a review of the facility document titled, Note to Attending Physician/Prescriber, dated 11/16/25, the The Note to Attending Physician/Prescriber indicated, . This resident is receiving Vitamin D. Please consider to order Vitamin D level on next lab day to monitor therapy . Noted 11/17/25. During a concurrent interview and record review on 12/19/25 at 9:28 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 41's clinical record, undated was reviewed. LVN 2 stated the nurse supervisor was responsible in carrying out pharmacy recommendations. LVN 2 stated Resident 41 had an order to check Vitamin D level in November but was not able to find a Vitamin D level result and was not sure if it was completed. During a concurrent interview and record review on 12/19/25 at 9: 55 a.m. with Clinical Supervisor (CS) 1, Resident 41's clinical records titled, Note to Attending Physician/Prescriber and laboratory results undated was reviewed. CS 1 stated Resident 41 had an order to check Vitamin D level on 10/17/25 but she did not find a laboratory result. CS 1 stated it should have been completed because the laboratory draws and collects samples in the facility three times a week (every Monday, Wednesday, and Friday). CS 1 stated it was her responsibility to ensure physician orders were carried out. CS 1 stated she did not know what happened and why the order was not completed, because she did not follow up with the laboratory. CS 1 stated Resident 41's Vitamin D level may be elevated or below normal and caused complications to Resident 41 and staff were not addressing the issue. During an interview on 12/19/25 at 3:04 p.m. with the Director of Nursing (DON), DON stated it was her responsibility to review pharmacy recommendations and ensure orders were carried out. The DON stated Resident 41's Vitamin D level was not done and should have been. The DON stated LVN 3 entered the order but did not contact the laboratory. The DON stated Resident 41's Vitamin D level may not be within therapeutic level and did not treat which could have resulted in complications because the laboratory was not completed. During a review of facility's policy and procedure (P&P) titled, Medication Regimen Review (MMR), dated 5/19, the P&P indicated, . 5. The MMR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problem, medication errors and other irregularities, for example . inadequate monitoring for adverse consequences . 14. The Consultant Pharmacist provides the Director of Nursing Services and (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Director with a written, signed and dated copy of all medication regimen reports. 15. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. During a professional reference review of an article retrieved from https://www.ncbi.nlm.nih.gov/books/NBK43696/, undated, the article indicated, .Whether they are printed on paper or available for electronic access, development and implementation of well designed , preprinted physician orders requires engineering, education, and enforcement . Orders are the initial means that enable physicians to communicate with a variety of interdisciplinary hospital caregivers, and they represent the starting point for action and care. In the healthcare environment, nothing goes forward without calling on the assistance of and providing direction through physician orders .		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food in accordance with resident preferences for one of three sampled residents (Resident 7), when Resident 7 preferred to receive gravy on his tray and Resident 7 was not served gravy. This failure had the potential for Resident 7 to not consume his preferred food and not to receive the full nutritional benefit of his meal which could lead to weight loss. Findings: During a review of Resident 7's admission Record (AR- a document containing resident profile information), dated 12/17/25, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses which included intellectual disability, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and dysphagia (difficulty swallowing). During a review of Resident 7's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 8/12/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 14 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 7 had no cognitive impairment. During observation on 12/16/25 at 11:49 a.m. in the dining room, Resident 7 was served lunch with minced meat, minced green vegetables, minced bread and drinks. There was no four-ounce (unit of measure) gravy served to Resident 7. Resident 7 started to eat lunch and did not respond to questions. During a concurrent interview and record review on 12/16/25 at 11:55 a.m. with Certified Nursing Assistant (CNA) 2, Resident 7's meal ticket, dated 12/16/25 was reviewed, CNA 2 stated Resident 7's four-ounce gravy should have been included in his meal tray but it was not. CNA 2 stated she did not know why Resident 7 should have gravy in his meal tray. CNA 2 stated she did not check the food in Resident 7's meal tray before she served Resident 7 and should have. CNA 2 stated she did not check the meal trays because she saw Licensed Vocational Nurse (LVN) 4 checked all the meal trays served to residents eating in the dining room. During an interview on 12/16/25 at 12:05 p.m. with LVN 4, LVN 4 stated she checked the meal trays for residents eating in the dining room before it was served to residents. LVN 4 stated she was not sure she noticed Resident 7's gravy was missing in his meal tray. LVN 4 stated Resident 7's gravy should have been included in the meal tray if it was listed in the diet slip. LVN 4 stated gravy was ordered to add to resident's food to add moisture, enhanced taste of food and for ease of swallowing. LVN 4 stated not having gravy added to Resident 7's food may result in difficulty swallowing food resulting in not consuming all of his food leading to possible weight loss. During an interview on 12/17/25 at 2:30p.m. with the Certified Dietary Manager (CDM), the CDM stated Resident 7 was supposed to receive the gravy on his meal tray for lunch on 12/16/25. The CDM stated Resident 7's gravy was a preference to add moisture to his food and more palatable or he will not eat his food. The CDM stated the cook should have made sure it was added to Resident 7's meal tray, but it was missed and the licensed nurse who checked the meal tray did not notice the gravy was missing and the certified nursing assistant did not check the meal tray before it was served to Resident 7. During a phone interview on 12/19/25 at 10:40 a.m. with the Registered Dietitian (RD), the RD stated gravy was ordered for residents to encourage them to eat and makes them happy. The RD stated not having gravy could make Resident 7 less likely to eat his food which could result in weight loss. The RD stated Resident 7's order for gravy was a preference and dietary staff should make sure resident food preferences were followed. During a review of facility's policy and procedure (P&P) titled, Resident Nutrition Services, dated 12/09, the P&P indicated, .Nursing personnel will ensure that residents are served the correct food tray. Prior to serving the food tray, the Nurse Aide/Feeding Assistant must check the tray card to ensure that the correct food tray is being served to the resident .If an incorrect meal has been delivered, nursing staff will report to the Food Service Manager . During a review of facility P&P titled, Resident Food Preferences, dated 11/08, the P&P indicated, .Upon the resident's (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission, or within twenty-four (24) hours after his/her admission, the Dietitian or the nursing staff will identify a resident's food preferences . The Dietitian will discuss resident food presences with the resident . The Dietitian and nursing staff, assisted by the physician, will identify any nutritional issues or dietary restrictions that might affect the facility's efforts to accommodate resident preferences . The resident's clinical record . will document the resident's likes and dislikes and special dietary instructions . The nursing staff will inform the kitchen about resident requests .		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. Based on observation during the survey period of 12/16/25 through 12/19/25, the facility failed to ensure each bedroom accommodated no more than four residents per room for four of 19 rooms (rooms 1, 2, 5, and 6). This failure had the potential for residents to not have reasonable privacy or adequate space. Findings: During the initial tour on 12/19/25 at 9:13 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. Room Number Number of Beds 1 52 55 5 6 5 Recommend waiver continue in effect. _____ HFES Signature Date Request waiver continue in effect. _____ Facility Administrator Signature Date		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 12/19/2025
NAME OF PROVIDER OR SUPPLIER Manning Gardens Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2113 E. Manning Avenue Fresno, CA 93725	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review during the survey period of 12/16/25 through 12/19/25, the facility failed to provide the minimum of at least 80 square feet per resident for eight of 19 multiple resident rooms (rooms 1, 2, 5, 6, 9, 10, 11, and 12). This failure had the potential for residents to not have reasonable accommodations for privacy or adequate space for care to be rendered. Findings: During a concurrent observation and interview on 12/19/25 at 9:33 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 of 80 square feet per resident as required by the regulation. There was 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. Room Beds Square Feet 1 5 356.92 5 398.55 5 345.56 5 384.09 3 232.710 3 239.011 3 239.712 3 239.4 Recommend waiver continue in effect. _____ HFES Signature Date Request waiver continue in effect. _____ Facility Administrator Signature Date		