STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056178	A. Building B. Wing	11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manresa Healthcare Center	919 Freedom Blvd Watsonville, CA 95076

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure kitchen personnel were properly trained on checking the dishwasher sanitizer, when the manufacturer's instruction of the test strip was not followed. This failure had the potential to spread food-borne illness to everyone who consumed food from the kitchen. Findings: During an observation with subsequent interview, in the kitchen, with the dietary aide (DA), on 9/24/2025 at 9:43 a.m., the DA demonstrated how he checks the chlorine sanitizer for the dishwasher. The DA dipped the test strip into standing water, on dishware that was just run through the dishwasher, for 10 seconds and confirmed that was how long he let it sit in the water, then compared it to the color patches printed on the vial where the test strips were stored. During a review of the test strip container instructions, it indicated to Dip and remove quickly, Blot immediately with paper towel, Compare to color chart at once. When DA was asked if he followed those directions, he stated he did not, and re-did the test following the instructions on the vial.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 stacked, clean food service equipment was air dried prior to stacking them. This failure had the potential of any one consuming food prepared in the kitchen contracting a food-borne illness. Findings: During the initial tour of the kitchen, with the registered dietician (RD) and certified dietary manager (CDM), on 9/22/2025 at 9:45 a.m., there were observed to be over 10 steam pans, 3 cookie sheets, and 3 muffin tins, in the dry storage area, stacked wet on shelves. At that time, both the RD and CDM had acknowledged they were stacked wet. Both also stated the facility had ordered new drying racks, and they were still waiting on them. The RD asked to have all of the wet food service equipment re-washed and air dried. A review of the facility's, undated, Policy and Procedure (P&P), titled Dishware, Utensils, and pans Drying Policy, indicated Dishware such as; utensils, pots, and pans should be air dried after cleaning and sanitizing. 1. After sanitization, items should be placed on clean, sanitized racks or shelves in an inverted position to drain.2. Items should not be nested or stacked until fully dry.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:An incorrect isolation precaution (a set of practices used in healthcare settings to prevent the spread of germs from one person to another) signage was posted outside Resident 61's entrance door.CNAs were helping more than one resident at a time to eat, without using hand hygiene between different residents. These failures had the potential to spread infections to residents, staff, and visitors.Findings: 1.During an observation outside Resident 61's room on 09/22/2025 at 2:08 p.m., signage posted at Resident 61's entrance door indicated an Enhanced Standard Precaution (ESP, Wear gowns and gloves while performing the following high-contact tasks associated with the greatest risk for multidrug-resistant organisms' [MDRO] contamination of HCP hands, clothes, and the environment). During a review of Resident 61's clinical records indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including other asthma chronic lung condition that causes inflammation and narrowing of the airways, leading to recurrent episodes of wheezing, shortness of breath, chest tightness, and coughing) and other fatigue. During a review of Resident 61's Physician's order indicated an order for contact isolation (measures taken to prevent the spread of germs through direct or indirect contact with a patient or their environment) r/t (related to) c-diff (Clostridioides difficile, a serious bacterial infection that often causes diarrhea and severe stomach pain). During a follow-up observation on 9/23/26 at 8:56 a.m., outside Resident 61's entrance, the ESP signage is still posted at Resident 61's entrance door. During an interview on 9/23/25 at 12:43 p.m., with Certified Nursing Assistant (CNA) B, she stated Resident 61 is on Enhanced Barrier Precaution (EBP, infection control measures, used primarily in long-term care facilities, that involve wearing gloves and gowns during high-contact resident care activities to prevent the spread of multidrug-resistant organisms (MDROs) and other infections.) CNA further stated only need to wear PPE when doing care. During a concurrent observation and interview on 9/23/25 at 1:53 p.m., outside Resident 61's entrance door with Registered Nurse (RN) B, she stated Resident 61 is on contact precautions. RN B confirmed ESP signage was posted at Resident 61's entrance door. During a concurrent interview and record review on 9/23/25 at 2:02 p.m., with the Director of Nursing (DON), the DON reviewed Resident 61's physician's order and confirmed an order for contact isolation r/t c-diff dated 9/17/25. The DON further stated Resident 61 had 3 episodes of loose bowel movement on 9/21/25 and 2 loose bowel movement on 9/22/25. During an interview on 9/23/25 at 2:43 p.m., with Infection Preventionist (IP) C, she stated residents with contact isolation should have signage posted contact isolation. She further stated contact isolation need to wear gown before entering the room even without touching anything inside the room. During a review of the facility's policy and procedures titled, Isolation-Categories of Transmission-Based Precaution, revised December 2023, indicated, .Contact Isolations.7. Staff and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visitors wear gloves (clean, non-sterile) when entering the room. 2. During a Dining Observation on 9/22/2025 at 12:42 PM, certified nursing assistant A (CNA A) was observed helping two residents eat at the same time. Then CNA A grabbed the juice cup of a third resident, without using any hand hygiene. During a Dining Observation on 9/22/2025 at 12:45 PM, CNA D, while helping one resident to eat, touched the cup of a second resident without using any hand hygiene. During a Dining Observation on 9/22/2025 at 12:56 PM, CNA E helped two residents, at the same time, to eat, without using any hand hygiene between them. During an interview with CNA A on 9/22/2025 at 1:05 PM, stated she had used a different hand for each resident she had helped to eat. Did not comment on touching the cup of a third resident. During an interview with CNA E on 9/22/2025 at 1:09 PM, stated that while she helped two residents to eat, she did not use hand hygiene between them, wasn't able to. CNA E stated she should have used hand hygiene. During an interview with CNA D on 9/22/2025 at 1:10 PM, she stated she did not use hand hygiene before or after touching cup of 2nd res. CNA D stated she should have used hand hygiene.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure two out of 17 residents (Resident 10 and Resident 12) had an order from the physician allowing the administration of medications listed as allergies in the residents' medical records. This failure had the potential to create adverse outcomes for the affected residents.Findings:1. During a review of Resident 10's Facesheet dated 9/25/25, document indicated, Resident 10 had an allergy to the medication Atorvastatin (medication used to lower cholesterol in the blood).During a review of Resident 10's Medication Review Report dated 6/1/24-6/30/24 indicated, an order for the medication Atorvastatin Calcium Oral Tablet 20 MG [milligram] (Atorvastatin Calcium) to give 20 mg by mouth one time a day for hyperlipidemia [elevated blood fats including cholesterol] Start Date 6/1/24.During a review of Resident 10's Medication Administration Record (MAR) dated 6/1/24-6/30/24 indicated, Resident 10 was administered Atorvastatin each day for a total of 30 administrations at 2000 (8 p.m.) from 6/1/24-6/30/24.During a review of Resident 10's MAR dated 7/1/24-7/31/24 indicated, Resident 10 was administered Atorvastatin each day for a total of 31 administrations at 2000 from 7/1/24 to 7/31/24.During a review of Resident 10's Medication Review Report dated 10/1/24-10/31/24 indicated, an order for the medication Atorvastatin Calcium Oral Tablet 20 MG [milligram] (Atorvastatin Calcium) to give one tablet by mouth at bedtime related to hyperlipidemia . Start Date 10/6/24.During a review of Resident 10's MAR dated 10/6/24-10/31/24 indicated, Resident 10 was administered Atorvastatin each day for a total of 25 administrations at 2000 from 10/6/24 to 10/31/24.During an interview on 9/25/25, at 1:08 p.m. with Consultant Pharmacist (CP), CP stated Resident 10 had a listed allergy and she should have not receive Atorvastatin. There should have been a note from the physician that Atorvastatin was okay to give.During a review of Resident 10's Medical Record, Record indicated, no note from physician or staff to indicate Atorvastatin was okay to give prior to 6/1/24.During an interview on 9/26/25, at 10:54 a.m., with the Director of Nursing (DON) DON stated Resident 10 received Atorvastatin in June, July and October. DON stated, Resident 10 should have not be given a medication with a listed allergy. 2. During a review of Resident 12's Facesheet dated 9/24/25, document indicated, Resident 12 had an allergy to Acetaminophen (medication used for pain relief or fever reduction).During a review of Resident 12's Medication Review Report, dated 6/19/24 indicated, Resident 12 had an order for Acetaminophen Oral Tablet 325 MG (Acetaminophen) to give two tablets by mouth every 4 hours as needed for mild pain or temp > [greater than] 100 [degrees Fahrenheit] . Start Date 6/19/24.During a review of Resident 12's MAR dated 7/1/25-7/31/25 MAR indicated, Resident was administered Acetaminophen on 7/25/25 at 1557 (3:57 p.m.).During an interview on 9/25/25, at 1:08 p.m. with Consultant Pharmacist (CP) CP stated Resident 12 had a listed allergy and should have not receive that medication. There should have been a note from the physician that the medication was okay to give.During a review of Resident 12's Medical Record, Record indicated, no note from physician or staff to indicate Acetaminophen was okay to give prior to 7/25/25.During an interview on 9/26/25 with DON at 10:54 a.m., DON stated, Resident 12 received Acetaminophen in July of this year. DON stated, Resident 12 should not be given a medication with a listed allergy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free from unnecessary medication for one of 15 sampled residents (Resident 3) when Resident 3 received Acyclovir (an antiviral medication) without a clear indication. This failure had the potential for unnecessary medication administration for Resident 3.Findings: During a review of Resident 3's clinical record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including bilateral (both) primary osteoarthritis (a common joint disease that causes pain, stiffness, and loss of mobility) of the knees. During a review of Resident 3's physician's order, dated 7/31/25, indicated an order for Acyclovir oral tablet 400 milligrams (mg, unit of measurement) to give one tablet by mouth two times a day for prophylaxis (action taken to prevent disease, especially by specified means or against a specified disease) . During a concurrent interview and record review on 9/25/25 at 9:56 p.m., with the Director of Nursing (DON), the DON reviewed Resident 3's physician's order and confirmed Resident 3 was on Acyclovir for prophylaxis. The DON stated Acyclovir indication was for prophylaxis. The DON further stated she will ask the doctor regarding what Resident 3's Acyclovir was a prophylaxis for. During a review of Resident 3's Consultant Pharmacist's Medication Regimen Review (a comprehensive evaluation of a patient's medication therapy to ensure all drugs are necessary, effective, and safe), dated 7/31/25, it indicated, . with Acyclovir for Shingles (a viral infection that causes a painful rash) prophylaxis? During the phone interview on 9/25/25 at 1:28 p.m., with the Consultant Pharmacist (CP), she stated when she reviewed the medications of Resident 3 on July 2025, she caught the order of Acyclovir for prophylaxis and wanted to clarify it. The CP further stated antibiotics and antivirals should have a clear indications. During a review of the facility's policy and procedures titled, Medication Therapy, revised December 2023, it indicated, Policy Statement 1. Each Resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks. Policy Interpretation and implementation. 3. Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the Consultant Pharmacist) will review an individual's current medication regimen, to identify whether: a. There is a clear indication for treating that individual with the medication .