STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555083	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manzanita Healthcare Center	5318 Manzanita Avenue Carmichael, CA 95608

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) did not develop a pressure injury or pressure sore (PI, a localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) when they failed to follow and implement preventative interventions that included to turn and re-position frequently, monitor and assess for signs of skin breakdown, and, to use pressure relieving devices(s) for her chair and bed as outlined in their Care Plan Report (CP), titled Skin integrity care plan and Skin assessment and prevention of pressure injuries policy and procedures (P&P). This failure resulted in Resident 1 to have developed facility acquired pressure injuries (PI that developed while a resident in the facility due to lack of assessment and treatment) and had the potential to have caused complications such as pain and sepsis (a life-threatening blood infection). Findings:During a review of Resident 1's admission Record, (AR), the AR indicated that Resident 1 was admitted to the facility in November 2022 with diagnoses that included Type 2 Diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and Psoriasis (skin disease, rash with itchy, scaly patches). During a review of Resident 1's Minimum Data Set (MDS a federally mandated resident assessment tool) dated 8/5/25, Section C, Cognitive Patterns (mental processof acquiring knowledge and understanding) showed a score of 5 out of 13 which suggested severe cognitive impairment. During a review of Resident 1's MDS, dated [DATE], Section GG Functional Abilities, indicated, Resident 1 needed Substantial/maximal assistance (resident unable to perform these activities without full help from others), with toileting hygiene, upper and lower body dressing, roll left and right, sit to lying, lying to sitting on side of bed, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident 1 was completely Dependent, with the facility staff for Shower/bathe self, and Putting on/taking off footwear. During a review of Resident 1's MDS, dated [DATE], Section H, Bladder and Bowel, indicated, Resident 1 was Always incontinent (unable to control) of bowel movements and urine. During a review Resident 1's MDS, dated [DATE], Section M, Skin Condition indicated, Resident 1 was at risk of developing pressure ulcers/injuries, and the facilitydocumented B. Pressure reducing device for bed. C. Turning/repositioning program for Resident 1 under Skin and Ulcer/Injury Treatments. During a review of Resident 1's Care Plan Report (CP), dated 5/3/24, with a focus of altered skin integrity had interventions that included: Monitor for any signs of skin breakdown (sore, tender, red, or broken areas), Pressure relieving device(s) for chair and bed, Turn and re-position frequently, and Weekly Skin Checks refer to weekly summary as indicated. During a review of Resident 1's Braden Scale, (BS, assessment tool for predicting pressure ulcer risk) dated 8/5/25, the BS showed Resident 1's Braden Scale score was indicative of-at risk for developing a pressure ulcer. During the review of the facility's policy and procedures (P&P), titled Skin assessment and prevention of pressure injuries, dated 2001, it indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. 1. Repeat the risk assessment weekly and upon any changes in condition. Mobility/Repositioning 1. Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team (professionals from various disciplines who work in (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555083	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manzanita Healthcare Center	5318 Manzanita Avenue Carmichael, CA 95608

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 0686 Level of Harm - Actual harm Residents Affected - Few	collaboration to address a patient with multiple physical and psychological needs) . Monitoring 1. Evaluate, report ad document potential changes in the skin. During a review of Resident 1's Order Summary Report, (OSR), contained current orders at time of transfer to the hospital, the OSR did not indicate a physician's order to reposition Resident 1 frequently and did not have physician's order for a pressure-relieving mattress or device for her chair as indicated in her care plan with a focus on Altered Skin Integrity, the facilities P&Ps titled Skin assessment and prevention of pressure injuries, and the MDS section M. During a phone interview with Resident 1's Responsible Party (RP, person in charge of decision making) on 11/5/25, at 9:43 a.m., the RP stated, Resident 1 was brought to the Emergency Department (ED, name of the hospital) on 8/17/25. She was unresponsive and had low blood pressure. The RP further stated the Emergency physician discovered Resident 1 had severe stage III (Full-thickness loss of skin. Dead and black tissue may be visible) wounds on her bottom, We were never told about the open wounds. The RP further stated he visited Resident 1 in the facility [name of the facility] every week and stayed for a couple of hours at Resident 1's bedside. RP also stated that his sister visited Resident 1, and she was not told by the facility that Resident 1 had stage III wounds on her bottom. RP also had indicated in the complaint that, She had been complaining about pain on her bottom for months. Additionally, when she had a doctor appointment on August 4, 2025, and was transferred to the medical transport, she was in extreme pain and distress, unable to sit up in her wheelchair, lying over the arm of her wheelchair, barely able to stay in it. During a review of Resident 1's record from [name of the hospital] ED (emergency department) titled Wound Care Note (WCN), dated 8/18/25, the WCN indicated thefollowing: . Location: Sacrum (triangular bone in the lower back between hip bones) . Wound Category: Pressure yes.Unstageable x (when unable to determine stage of ulcer due to physician being unable to see the base of the wound) . Additional wound: Location: Left ischium (above the back side of the thigh and beneath the buttocks. A pressure injury can develop here when you sit too long without shifting your weight) . Wound Category: Pressure yes. Stage 3 x. Non-pressure Additional wound: Location: Right ischium. Wound Category: Pressure yes. Pressure Injury: Stage 2 x (Partial-thickness loss of skin, presenting as ashallow open sore or wound) .Pain: Yes. During a review of Resident 1's record from [name of the hospital] ED titled Physician Note (PN), dated 8/19/25, the PN indicated, Unstageable pressure injury sacrum, stage II pressure injury right ischium, stage III pressure injury left ischium.This wound was present on admission. Category: Other Wounds. Location: Sacrum. Discovery Time: 08/17/2025 21:18. During an interview and record review with Medical Records Asst (MRA), and Licensed Nurse 1 (LN 1) on 11/6/25 at 11:44 a.m., MRA found Resident 1's Shower Day Skin Inspection, (SDSI, with a drawing of a naked human body, anteriorly and posteriorly to mark and label skin changes noted during a shower) sheets were dated 8/2/25, 8/7/25, 8/9/25, 8/11/25, 8/13/25, 8/14/25. LN 1 confirmed the SDSI sheets were Resident 1's shower sheets. LN 1 stated the Certified Nursing Assistant (CNAs) should mark (with an x or shading) and label the SDSI sheets of their observations during a shower. The process would then have the CNAs informing the nurse of any unusual or new redness or sores. The process then should be that the nurse would assess the resident's skin areas as identified by the CNAs. The LNs should then collaborate with the Treatment Nurse (TN). LN 1 confirmed this did not happen. During a continued interview and record review with LN 1 and MRA on 11/6/25 at 11:44 a.m., LN 1 stated Resident 1's SDSI sheet dated 8/11/25 was marked as open area at the posterior buttocks (back of the bottom) and SDSI sheet dated 8/16/25 was circled and marked Red at the posterior buttocks. LN 1 stated that the remainder of the SDSI sheets were all marked with shading at the posterior buttocks area but were not labeled with words such as open or red as it should have been. LN 1 stated that nurses should have assessed, documented and informed the Treatment Nurse (TN) of Resident 1's changes in her skin as indicated on the shower sheets. LN 1 further stated that if redness and open skin areas were left untreated, they could get infected and result in possible pressure sores. LN 1 continued to say that the nurses are also expected to complete Resident 1's Weekly Nursing Summary (WNS) assessments to evaluate skin changes, and other health status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555083	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manzanita Healthcare Center	5318 Manzanita Avenue Carmichael, CA 95608

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 0686 Level of Harm - Actual harm Residents Affected - Few	changes. LN 1 stated that the last completed WNS was 7/31/25, and that the nurses did not conduct the WNS for Resident 1 for the month of August 2025. LN 1 emphasized the importance of completing the WNS assessment to capture Resident 1's health decline or change of condition. The MRA confirmed that she did not have copies of the WNS assessment sheets. During an interview with LN 3 on 11/12/25 at 12:39 p.m., LN 3 acknowledged that she signed Resident 1's SDSI sheets however she cannot recall the dates. LN 3 said she doesn't perform skin assessments unless the CNA reported to her that there was a difference between resident's current skin condition from the previous skin assessment. LN 3 continued to say, CNA 2 wrote down open area on 8-11-25 in the SDSI sheet. LN 3 stated if there is an open skin on the sacrum area and it is not treated, it could get infected and may lead to a pressure sore as it was on the boney part of the human body. During an interview with LN 2 on 11/6/25 at 1:05 p.m., LN 2 stated Resident 1 was dependent on staff with her Activities of Daily Living (ADL, refers to basic self-care tasks like bathing, dressing, and eating) needs. Resident 1 was unable to turn to her side without the help from the staff, and the facility staff used the Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place) to transfer Resident 1 to bed, wheelchair, and shower chair. LN 2 confirmed she signed Resident 1's SDSI sheets dated 8/9/25 and 8/14/25. LN 2 stated that although it was not labeled with words indicating the problem, the SDSI sheets were marked with black ink at the posterior buttocks which indicated an issue with that area. LN 2 verbalized, a signed SDSI sheet meant that she was aware of Resident 1's skin changes, and LN 2 should have assessed and documented her findings and informed the TN. However, LN 2 was not sure if she had assessed Resident 1's skin as the process (after identifying skin abnormality on the shower sheet) required. During an interview with CNA 1 on 11/6/25 at 1:33 p.m., CNA 1 acknowledged she gave showers to Resident 1 on 8/2/25, 8/7/25, 8/9/25, 8/13/25, 8/14/25. CNA 1 stated that Resident 1 was unable to turn to sides, recline on her bed without the assistance from the nursing staff. CNA 1 admitted that she saw redness and a rash on 8/2/25, 8/7/25, 8/9/25, 8/13/25, 8/14/25 to Resident 1's skin on her posterior buttocks as she marked on the SDSI sheet. However, CNA 1 stated she did not label with words her markings on the SDSI sheets, I should have labeled it, so they [nurses] know what I saw. During an interview with the Director of Nursing (DON) on 11/6/25 at 1:51 p.m., the DON acknowledged that CNA 1 and CNA 2 gave showers to Resident 1 as indicated on the SDSI sheets. The DON further acknowledged LN 2 and LN 3 signed the SDSI sheets acknowledging they received and reviewed the reports for Resident 1. The DON stated the facility's process was for the nurses to review the SDSI sheets, assess and document the resident's skin as reported by the CNA on the SDSI sheets, and then the nurse should collaborate with the TN for further physician order/treatments. The DON confirmed that all SDSI sheets (on 8/2/25, 8/7/25, 8/9/25, 8/13/25, 8/14/25) indicated an unusual finding on posterior buttocks of Resident 1. The DON further stated that these assessments/findings were not documented in the resident's chart such as on the Treatment Administration Record (TAR, tool nurses use to document and manage wound care treatments) and progress notes as the process indicated. The DON stated the expectation is for the nurses to physically check the resident's skin for any skin change as indicated on the SDSI sheets. The DON further confirmed that there were no WNS done for Resident 1 for August 2025, and said, there should be WNS completed by the nurses for Resident 1 every week. This tool would help nurses identify early signs of changes in skin condition. The DON stated that if the process was not followed when a sore or redness was identified then an open sore left untreated, could get worse and become infected. During an interview with CNA 2 on 11/12/25 at 1:18 p.m., CNA 2 stated Resident 1 was incontinent with urine and bowel, and needed help in changing her briefs, and assistance in taking a shower. CNA 2 further stated Resident 1 cannot walk, and needed assistance to turn to sides, CNA 2 used the Hoyer lift to bathe and transfer Resident 1. CNA 2 acknowledged that she noted an open skin tear and redness to Resident 1's posterior buttocks and indicated it on the SDSI sheets. CNA 2 continued to say that she informed LN 3 about her observations of Resident 1's skin condition as documented on SDSI sheets. During an interview with the TN on 11/12/25 at 1:41 p.m., the TN stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555083	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manzanita Healthcare Center	5318 Manzanita Avenue Carmichael, CA 95608

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 0686 Level of Harm - Actual harm Residents Affected - Few	that she was familiar with Resident 1 and emphasized that if an open area or skin tear was left untreated, it could get infected, grow and may progress to a pressure sore or unstageable sore. The TN continued to say that Resident 1 should have been repositioned every two hours, checked her skin integrity regularly, placed a cushion on Resident 1's wheelchair to help prevent pressure, and placed a pressure-relieving mattress especially to bed bound or bedridden residents. During a review of Resident 1's TAR, dated 8/1/25 - 8/31/25, the TAR did not have documentation of treatments regarding wound care on the residents bottom or a repositioning or turning protocol. During the review of the facility's policy and procedures, titled Bath/Shower, dated 2001, indicated, The purpose of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition the resident's skin. During the review of the facility's policy and procedures, titled Care Plans, Comprehensive Person-Centered, (CPCPC), dated 2001, the CPCPC 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. 9. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change.10. The interdisciplinary team review and updates the care plan: a. when there has been a significant change in the resident's condition.