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	11/13/2025

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. (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

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(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	**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 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