

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Manzanita Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40841</p> <p>Based on observation, interview, and record review, the facility failed to maintain respect and dignity for one of 22 sampled residents (Resident 439), when Resident 439's bilateral buttocks' sides were exposed in the hallway during transfer.</p> <p>This failure decreased the facility's potential to maintain Resident 439's respect and dignity.</p> <p>Findings:</p> <p>A review of an admission record indicated Resident 439 was admitted to the facility in 2024 with a diagnosis of panic disorder (a frequent and unexpected panic attack).</p> <p>During a concurrent observation and interview on 2/3/25 at 9:54 a.m. with Resident 439's daughter, Certified Nursing Assistant 3 (CNA 3) was wheeling Resident 439 on a shower chair in the hallway. Resident 439's bilateral buttocks' sides were not covered by the gown and were exposed to other residents, staff members, and Resident 439's daughter. Resident 439's daughter stated there was a respect and dignity issue when Resident 439's body was exposed.</p> <p>During an interview on 2/6/25 at 9:34 a.m. with the Director of Nursing (DON), DON stated staff should have covered Resident 439 with a blanket when transferred in the hallway; otherwise, Resident 439 will feel bad if left exposed to the public.</p> <p>A review of the facility's policy titled, Dignity, dated 2/2021, indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>40841</p> <p>Based on observation, interview, and record review, the facility failed to provide an appropriate communication method for one of 22 sampled residents (Resident 70), when Licensed Nurse 7 (LN 7) was unable to find a communication board to communicate with Resident 70.</p> <p>This failure decreased the facility's potential to address Resident 70's basic needs.</p> <p>Findings:</p> <p>A review of an admission Record indicated Resident 70 was admitted to the facility in 2024 with diagnoses including speech and language deficits.</p> <p>During a concurrent observation and interview on 2/4/25 at 8:53 a.m. with Resident 70 in her room, Resident 70 was unable to verbalize her needs and was using body language and gestures.</p> <p>During a concurrent observation and interview on 2/4/25 at 2:21 p.m. with LN 7 in Resident 70's room, LN 7 was unable to communicate with Resident 70 and started searching for the communication board inside Resident 70's room. LN 7 confirmed there was no communication board inside Resident 70's room and stated there should have been a communication board to help Resident 70 communicate with staff.</p> <p>During an interview on 2/6/25 at 9:29 a.m. with the Director of Nursing (DON), DON stated the communication board or chart should have been kept inside Resident 70's room to help her expressing her basic needs.</p> <p>A review of the facility's policy titled, Accommodation of Needs, dated 3/2021, indicated, In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed toward assisting the residents in maintaining independence . interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication .</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51387</p> <p>Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 96 residents, when:</p> <ol style="list-style-type: none"> 1. Controlled drug (medication that may be abused or cause addiction) record form was not filled out and signed immediately at the time of medication administration for Resident 445; and 2. Unused or expired, controlled drugs were not destroyed according to the facility's policy. <p>These failures had the potential for diversion or misuse of residents' controlled medications.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent inspection of medication cart A on [DATE] at 11:14 a.m. with Licensed Nurse 4 (LN 4), a controlled drug count for Resident 445's hydromorphone (a medication used for pain), two milligrams (mg; unit of measure) was inaccurate. There were 10 tablets of hydromorphone two mg in the medication bubble pack and the controlled drug log indicated there should be 11. <p>During an interview on [DATE] at 11:15 a.m. with LN 4, LN 4 stated she gave Resident 445 hydromorphone earlier and forgot to sign the medication control count sheet after giving the medication to the resident. LN 4 acknowledged the medication control count sheet needed to be completed at the time of medication administration.</p> <p>During an interview on [DATE] at 2:41p.m. with Director of Nursing (DON), DON stated the medication control count sheet needed to be completed at time of medication administration.</p> <p>A review of the facility's policy and procedure (P&P) titled, Controlled Substances Policy, revised in 2019, indicated, Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift . Upon administration: a. The nurse administering the medication is responsible for recording: (1) name of resident receiving the medication; (2) name, strength and dose of the medication; (3) time of administration; (4) method of administration; (5) quantity of the medication remaining; and (6) signature of nurse administering medication.</p> <ol style="list-style-type: none"> 2. During an inspection of the unused and expired controlled medications storage area on [DATE] at 9:55 a. m. in the DON's office, it was discovered upon removing the lid on the container used to store destroyed controlled medication, that pills of various sizes, shapes and colors were identifiable, legible and not destroyed. The method being used by the facility to render the medications destroyed entailed placing them in a container of liquid. <p>During an interview on [DATE] at 9:56 a.m. with DON, DON acknowledged that the pills in the controlled medication storage container were identifiable, and not destroyed.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>51387</p> <p>Based on observation, interview, and record review, the facility failed to keep one of 22 sampled residents (Resident 64) free of unnecessary psychotropic medication (drug prescribed to affect the mind, emotions or behavior), when Resident 64 was receiving divalproex sodium (a psychotropic medication indicated for seizure treatment and mood disorders) for an inadequate indication.</p> <p>This failure increased Resident 64's potential for unwanted adverse effects such as sedation and falls.</p> <p>Findings:</p> <p>A review of an admission record indicated Resident 64 was 78-years old, admitted in May 2024 to the facility from an acute care hospital with diagnoses including worsening disease of the nervous system, anxiety, depression, and dementia (a progressive state of decline in mental abilities) with behavioral disturbance.</p> <p>A review of Residents 64's Care Plan, dated 5/16/24, indicated Resident 64 was at risk for fall and injury related to her diagnoses.</p> <p>A review of Resident 64's Minimum Data Sets (MDS-an assessment tool), dated 5/23/24, 8/23/24, and 11/23/24, indicated a Brief Interview of Mental Status (BIMS) score of four out of 15 with severely impaired cognition. MDS assessments further indicated Resident 64 exhibited no indicators of psychosis, such as hallucinations (sensory experience of something not present); delusions (an impression or belief not based on reality); or verbal or physical behavioral symptoms directed toward others.</p> <p>A review of Resident 64's active physician orders, dated 2/5/25, indicated the following psychotropic medications:</p> <ol style="list-style-type: none"> 1. divalproex sodium oral capsule delayed release sprinkle 125 milligrams (mg; a unit of measure). Give two capsules by mouth two times a day for dementia with behavioral disturbances manifested by hallucination. 2. divalproex sodium oral capsule delayed release sprinkle 125 mg for dementia. Give three capsules by mouth in the evening for dementia with behavioral disturbances. <p>A review of Resident 64's Medication Administration Record (MAR), dated 2/6/25, indicated Resident 64 was administered divalproex sodium 625 mg daily divided in multiple doses continuously in the morning and evening from 5/17/24 to 2/6/25 (still receiving currently), over a period of almost a year.</p> <p>A review of a letter from the Department of Health Care Services, dated 5/14/24, indicated Resident 64 did not have a serious mental illness.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/5/25 at 10:40 a.m., Resident 64 was awake, eyes open, lying in bed, looking forward, television on, appeared calm, and not in distress.</p> <p>During an interview on 2/5/25 at 10:42 a.m. with Home Health Aide 1 (HHA 1) with Yolo Hospice, HHA1 stated she worked with Resident 64 every Wednesday, felt safe caring for her, was not a danger to herself or others, and never saw her combative or hallucinating. HHA 1 further stated when she assisted Resident 64 for shower she sometimes could tell Resident 64 did not like water or was startled by it when turned on. HHA 1 also added when talking to Resident 64, she would not respond in a manner that signaled an understanding or ability to answer questions and seemed confused.</p> <p>During an interview on 2/5/25 at 10:50 a.m. with Certified Nursing Assistant 3 (CNA) 3, CNA 3 stated she routinely provided care four days a week to Resident 64, felt safe caring for her, was not a danger to herself or others, was very confused and sleepy, said few things sometimes, but was mostly very confused, did not yell out, was not combative, and guarded herself when her briefs needed change. CNA 3 further stated it took Resident 64 two hours to consume her breakfast because she fell asleep during her meal and dropped her fork and spoon, and did not usually eat her lunch because by the time she received it, she just have finished her breakfast. CNA 3 also added Resident 64 did not know how to use the call light, needed frequent assessment, monitoring and attendance to needs, and her room was located at the end of the hall.</p> <p>During an interview on 2/5/25 at 10:58 a.m. with Licensed Nurse 6 (LN 6), LN 6 stated she felt safe caring for Resident 64 and was not a danger to herself or others.</p> <p>During an attempt to interview the facility's Consultant Pharmacist (CP) on 2/5/25 at 11:44 a.m., the department was unable to get a hold of the CP.</p> <p>During an interview on 2/5/25 at 4:19 p.m. with Medical Doctor (MD), MD stated Resident 64 was prescribed divalproex sodium for dementia and behaviors, did not know if divalproex sodium was approved by Food and Drug Administration (FDA) as indicated for dementia with or without behaviors.</p> <p>A review of divalproex's manufacturer Prescribing Information (PI), last revised in 10/2011, did not indicate divalproex sodium was for treatment of dementia. PI further indicated divalproex was associated with the following side effects including but not limited to an increased risk of falls, headaches, drowsiness, dizziness, vision problems, insomnia (inability to sleep), and abnormal thinking.</p> <p>During an interview on 2/5/25 at 4:30 p.m. with the Director of Nursing (DON), DON was unable to explain why the facility's MD and CP had not reassessed Resident 64 for the unnecessary use and unapproved indication of divalproex to treat dementia.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Psychotropic Medication Use, revised in 2022, indicated, Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record . Medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medication are not prescribed or administered as a substitution for another psychotropic medication unless there is a documented clinical indication consistent with clinical standard of practice . Categories of medications which affect brain activity such as antihistamines, anti-cholinergic medications, and central nervous system medications that are prescribed as a substitute for an adjunct to a psychotropic medication are monitored and managed as psychotropic medications . When determining whether to initiate, modify, or discontinue medication therapy, the IDT [Interdisciplinary team] conducts an evaluation of the resident. The evaluation will attempt to clarify whether: . a particular medication is clinically indicated to manage the symptoms or condition.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>51387</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed five percent (%; unit of measure) for two of five sampled residents (Resident 140 and Resident 36).</p> <p>1. Licensed Nurse 2 (LN 2) administered Resident 140's extended release (ER) isosorbide mononitrate (medication used to treat chest pain) 30 milligrams (mg; unit of measure) tablet not in accordance with physician order, when LN 2 crushed the ER tablet and released the medication all at once instead of gradually over time. This error had a potential to lead to an overdose or severe side effects.</p> <p>2. LN 2 administered Resident 140's delayed release (DR) pantoprazole (a medication used to treat indigestion) 40 mg tablet not in accordance with physician order, when LN 2 crushed the DR tablet and released the medication all at once instead of gradually over time. This error had a potential to lead to an overdose or severe side effects.</p> <p>3. LN 2 omitted administering Resident 140's physician ordered medication, amlodipine (a medication used to treat high blood pressure and heart disease) five mg tablet. This omission had the potential to lead to an increase in blood pressure, and/or an adverse outcome to Resident 140.</p> <p>4. LN 3 did not administer Resident 36's scheduled ordered dose of 180 mg of simethicone (a medication used to treat abdominal bloating) due to the facility's failure to attain and have available the physician ordered dosage of the medication. This failure had the potential to lead to pain and/or discomfort to Resident 36.</p> <p>As a result, four errors were identified out of 28 opportunities, during the observation of medication administration. The medication error rate was 14.29%.</p> <p>Findings:</p> <p>1. During an observation of medication administration on 2/3/25 at 8:35 a.m., LN 2 was observed to prepare and administer Resident 140's morning medications which included one isosorbide mononitrate extended release 30 mg tablet. LN 2 was observed to crush six medication tablets.</p> <p>Reconciliation of the observation of medication administration with Resident 140's current physician orders indicated an order for isosorbide mononitrate ER 30 mg tablet to be given by mouth daily at 8 a.m. The order did not contain instructions to crush the medication.</p> <p>A review of Resident 140's isosorbide mononitrate ER 30 mg pharmacy label, stated Do Not Crush.</p> <p>2. During an observation of medication administration on 2/3/25 at 8:35 a.m., LN 2 was observed to prepare and administer Resident 140's morning medications which included one pantoprazole delayed release 40 mg tablet. LN 2 was observed to crush six medication tablets.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reconciliation of the observation of medication administration with Resident 140's current physician orders indicated an order for pantoprazole delayed release 40 mg to be given by mouth daily at 7 a.m. The order did not contain instructions to crush the medication.</p> <p>During an interview on 2/3/25 at 3:15 p.m. with LN 2, LN 2 stated it was not an acceptable practice to crush delayed release medications without an order. LN 2 acknowledged that the medication was not ordered to be crushed.</p> <p>During an interview on 2/4/25 at 10:05 a.m. with the Director of Nursing (DON), DON stated extended or delayed release medications were not supposed to be crushed.</p> <p>3. During an observation of medication administration on 2/3/25 at 8:35 a.m., LN 2 was observed to prepare and administer Resident 140's morning medications which did not include Resident 140's amlodipine five mg tablet.</p> <p>Reconciliation of the observation of medication administration with Resident 140's current physician orders indicated an order for amlodipine five mg to be given by mouth daily.</p> <p>A review of Resident 140's Medication Administration Record (MAR), dated 2/3/25, indicated amlodipine five mg tablet was given at 8 a.m.</p> <p>During an interview on 2/3/25 at 3:15 p.m. with LN 2, LN 2 acknowledged only six oral medications were administered to Resident 140. If amlodipine five mg was administered, it would have been seven oral medications administered to Resident 140. LN 2 stated medications should have been administered as prescribed by the physician.</p> <p>During an interview on 2/4/25 at 10:05 a.m. with the DON, DON stated I have already heard about the amlodipine not being given to one of our residents. DON further stated medications were to be administered as ordered and Resident 140 should have received her amlodipine as prescribed.</p> <p>4. During an observation of medication administration on 2/3/25 at 9:46 a.m., LN 3 was observed preparing Resident 36's morning medications, which did not include simethicone 180 mg capsule since the medication was unavailable.</p> <p>During an interview on 2/3/25 at 9:50 a.m. with LN 3, LN 3 stated she did not have the correct dose of simethicone in the medication cart to administer it to Resident 36.</p> <p>Reconciliation of the observation of medication administration with Resident 36's current physician orders indicated an order for simethicone 180 mg capsule by mouth after meals for gas.</p> <p>During an interview on 2/4/25 at 10:05 a.m. with the DON, DON stated the correct dose of medication was not available to be administered which required staff to contact the physician and revise the order accordingly. DON acknowledged that the ordered medication should have been available for LN 3 to administer it to Resident 36.</p> <p>A review of the facility's policy and procedure titled, Administering Medications Policy, revised in 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including required time frame.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>51387</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly, when:</p> <ol style="list-style-type: none"> 1. A medication was stored in the refrigerator, not according to manufacturer's specification; 2. A medication was stored at room temperature, not according to manufacturer's specification; and 3. A discontinued medication was not removed from the medication storage room and was still accessible to the staff. <p>These failures had the potential for medication misuse, drug diversion, medication ineffectiveness, and medication administration errors.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During an inspection on 2/4/25 at 9:37 a.m. of the facility's medication storage room, a discontinued, unopened medication, cyanocobalamin 1,000 micrograms/milliliters (mcg/ml; a unit of measure) was found stored in the refrigerator, not according to manufacturer's required storage parameters. <p>A review of the manufacturer's package insert with a revised date of 2017, cyanocobalamin 1,000 mcg/ml, indicated to be stored between 68 degrees (a unit of measure) - 77 degrees Fahrenheit (scale of temperature).</p> <p>During an interview on 2/4/25 at 9:42 a.m. with the Director of Nursing (DON), DON acknowledged that cyanocobalamin was found stored outside the manufacturer's required temperature range, and that all medications should have been stored at the required temperature range.</p> <p>A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage Policy, dated 2023, indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls.</p> <ol style="list-style-type: none"> 2. During an inspection on 2/4/25 at 10:41 a.m. of the facility's medication cart A, a medication, acidophilus probiotic dietary supplement was found stored at room temperature in the medication cart, not according to manufacturer's required storage parameters. <p>A review of the manufacturer's labeled sticker on the container, revised 2024, acidophilus probiotic dietary supplement was required to be refrigerated, with labeled instructions to Refrigerate After Opening the container.</p> <p>During an interview on 2/4/25 at 9:42 a.m. with the DON, DON acknowledged that all medications should have been stored at the required temperature range.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's P&P titled, Medication Labeling and Storage Policy, dated 2023, indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls . Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location.</p> <p>3. During an inspection on 2/3/25 at 9:46 a.m. of the facility's medication storage room, a discontinued medication, clonidine 0.2 milligrams (mg; unit of measure), was found stored under the sink on the floor.</p> <p>During a concurrent observation and interview on 2/4/25 at 9:47 a.m. with the DON, in the facility's medication storage room, DON acknowledged the tube of clonidine found under the sink on the floor, was a discontinued medication for a discharged resident, and stated discontinued medications should have been given to her for destruction by the facility staff.</p> <p>A review of the facility's P&P titled, Medication Labeling and Storage Policy, dated 2023, indicated, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . medications are stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer . to prevent the possibility of mixing medications of several residents.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Manzanita Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5318 Manzanita Avenue Carmichael, CA 95608	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50750</p> <p>Based on observation, interview, and record review, the facility failed to ensure the nutritive value of food was maintained, when broccoli was cooked for over two hours prior to lunch meal service.</p> <p>This failure had the potential of leading to nutrient deficiency for the 96 residents receiving facility prepared meals.</p> <p>Findings:</p> <p>During an observation on 2/4/25 at 9:48 a.m., in the kitchen, [NAME] 1 poured frozen broccoli into a pan and placed it into the convection oven to cook.</p> <p>During an observation on 2/4/25 at 12:22 p.m., in the kitchen, lunch meal service started. Observation of the broccoli showed a light green color, with a soft, limp texture when served.</p> <p>During the lunch meal on 2/4/25 at 1:15 p.m., two test trays were placed on the final meal cart (a regular diet and a pureed texture). The two test trays were picked up at 1:30 p.m. Food items tasted were: Regular pork with gravy, pureed pork with gravy, regular seasoned broccoli, pureed seasoned broccoli, and polenta. The broccoli was extremely soft (mushy) when tasted by five surveyors.</p> <p>During an interview on 2/5/25 at 11 a.m. with Registered Dietitian (RD), RD stated the cook was expected to put the vegetables in the oven last, and if vegetables were cooked for a long period of time, vitamins and minerals from the vegetables would be dead.</p> <p>A review from Ohio State University (SNAP_Ed_newsletter_broccoli">https://fcs.[NAME].edu>SNAP_Ed_newsletter_broccoli), indicated that overcooked broccoli loses nutrients.</p> <p>A review from Arkansas Cooperative Extension Service (news>fcs>fruits-veggies">https://www.uaex.uada.edu>news>fcs>fruits-veggies), indicated that broccoli had nutrients including carotenoids and fiber. Known for its anti-cancer properties, broccoli has tons of nutrients including vitamins A and C, fiber, folic acid, calcium, and potassium. Avoid overcooking because discoloration will occur, as well as strong flavors are likely to develop. For best flavor, cooked broccoli should be crisp.</p> <p>During an interview on 2/5/25 at 5:04 p.m. with Dietary Manager (DM), DM stated broccoli have been usually cooked 30 minutes before the start of meal service.</p> <p>During a review of Recipe: Seasoned Broccoli, dated 2024, indicated, Cooking Time: 10-20 minutes . Boil or steam broccoli until tender . Do not overcook, will turn brown and mushy .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50750</p> <p>Based on observation, interview, and record review, the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food service safety, when:</p> <ol style="list-style-type: none"> 1. Three baking sheets, one frying pan, one container for scoops, stove knobs, convention oven, and mixer were found dirty; 2. Ten pans, two frying pans, and blender were stored wet; 3. Pipes under three-compartment sink found rusted and dirty, floors were discolored with white and gray buildup, and counter had a white discolored area; 4. Yellow cutting board found with two deep grooves of about one and a half to two inches in length; 5. Four bulk storage containers were found with lids not closed tightly; and 6. Fan in dish machine area was found with black build-up on the blades. <p>These failures had the potential to lead to food borne illness for the 96 residents eating facility prepared meals.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During the initial kitchen tour on 2/3/25 at 8:31 a.m., three baking sheets were found stacked under the steam table with dark brown to black colored buildup in the corners and up the sides; a small frying pan was observed with dark brown/black colored buildup covering approximately 50% of the pan surface; a gray container holding clean scoops was found with a wet, yellow gel like substance inside; stove knobs were sticky, with visible food residue; and the convention oven was covered with food spills and food splatters on the inside. <p>During an interview on 2/3/25 at 8:47 a.m. with Dietary Manager (DM), DM acknowledged baking sheets and small frying pan were old and stated he would discard. He confirmed the gray container with scoops had yellow residue inside next to the clean scoops. DM concurred the stove knobs and convention oven were dirty; he stated the cooks were to clean the stove knobs and oven every meal and scheduled for deep cleaning weekly.</p> <p>During a concurrent observation and interview on 2/3/25 at 9:07 a.m. with DM, a mixer that appeared ready to use, contained food residue stuck to the surface. DM concurred and stated the mixer had batter buildup.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy titled, Sanitization, dated November 2022, indicated, in bullet 2. All utensils, counters, shelves and equipment are kept clean . free from breaks, corrossions, open seams, cracks and chipped areas that may affect their use or proper cleaning . 3. All equipment, food contact surfaces and utensils are cleaned and sanitized . 8. When cleaning fixed equipment (e.g mixers .) the removable parts are: a. washed and sanitized and non-removable parts cleaned with detergent and hot water .</p> <p>A review of the United States Food and Drug Administration (FDA) Food Code 2022, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, . (C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>2. During the initial kitchen tour on 2/3/25 at 8:31 a.m., three half steam table pans, seven small steam table pans, and two frying pans were observed stored. These pans had water droplets on their inner and outer surfaces.</p> <p>During an interview on 2/3/25 at 8:47 a.m. with DM, DM acknowledged the pans were wet and stated pans needed to be fully dried before storing to avoid bacteria growth.</p> <p>During the same initial kitchen tour on 2/3/25 at 9:01 a.m., a covered blender was stored and appeared ready to use. When lid was removed, approximately half a tablespoon of clear liquid was observed at the bottom of the blender.</p> <p>During an interview on 2/3/25 at 9:07 a.m. with DM, DM confirmed blender had liquid residue inside.</p> <p>A review of the 2022 US FDA Food Code section 4-901.11, indicated, Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow.</p> <p>3. During a concurrent observation and interview within the initial kitchen tour on 2/3/25 at 8:44 a.m. with DM, the pipes underneath the three-compartment sink were found rusted and dirty. The floor under the three-compartment sink was discolored with white and gray buildup, and the counter next to the three-compartment sink had a white discolored area. DM acknowledged and was unsure why there were buildup and discoloration.</p> <p>A review of the facility's policy titled, Sanitization, dated November 2022, indicated, in bullet 1. All kitchens, kitchen areas and dining areas are kept clean .</p> <p>A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, .(C) Nonfood-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>4. During a concurrent observation and interview on 2/3/25 at 9:05 a.m. with DM, a yellow cutting board was found with two deep grooves of about one and a half to two inches in length. DM acknowledged the yellow cutting board had two deep grooves.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy titled, Sanitization, dated November 2022, indicated, in bullet 2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrossions, open seams, cracks and chipped areas that may affect their use or proper cleaning . 12. Plastic ware . that cannot be sanitized or are hazardous because of chips, cracks . are discarded. Damaged or broken equipment that cannot be repaired is discarded .</p> <p>A review of the US FDA 2022 Food Code, section 4-501.12, titled, Cutting Surfaces, indicated, Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.</p> <p>5. During an observation on 2/3/25 at 9:14 a.m., in the dry storage area, four bulk storage containers containing sugar, flour, brown rice and panko were found with the lids not closed tightly, but resting on the containers.</p> <p>During a follow-up observation on 2/3/25 at 11:44 a.m., in the dry storage area, four bulk storage containers remained with lids not closed tightly.</p> <p>During an interview on 2/3/25 at 11:45 a.m. with DM, DM confirmed the lids on the four bulk storage containers were not closed tightly and stated he expected the lids to be fully sealed.</p> <p>During an interview on 2/5/25 at 10:58 a.m. with Registered Dietitian (RD), RD stated if lids were not tightly closed on the containers it could allow moisture, pests, or bacteria to enter the food products.</p> <p>A review of the US FDA 2022 Food Code, section 3-305.13, titled, Vended Time/Temperature Control for Safety Food, Original Container., 1/18/23 version, indicated, The possibility of product contamination increases whenever food is exposed . Once the original seal is broken, the food is vulnerable to contamination.</p> <p>6. During an observation on 2/3/25 at 11:33 a.m., the fan in the dishwashing area directed over the clean drying dishes was observed with dust buildup of approximately an inch covering the tips of the blades.</p> <p>During a concurrent observation and interview on 2/4/25 at 9:21 a.m. with DM, DM was shown a photo of the fan in the dishwashing area from 2/3/25. DM acknowledged the fan was dirty and said he would have it cleaned.</p> <p>A review of the facility's policy titled, Sanitization, dated November 2022, indicated, in bullet 1. All kitchens, kitchen areas and dining areas are kept clean . 2. All utensils, counters, shelves and equipment are kept clean .</p> <p>A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, .(C) Nonfood-Contact Surfaces of Equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>50750</p> <p>Based on interview and record review, the facility failed to provide a resident refrigerator and microwave for a census of 96 to ensure safe food storage and reheating of food for later consumption.</p> <p>This failure had the potential to prevent residents from enjoying favorite foods, reduced resident food options, and potentially lead to weight loss.</p> <p>Findings:</p> <p>During an interview on 2/5/25 at 12:13 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated outside food would be checked against the diet order before it would be given to the resident. If a resident had left over food, it could not stay in the room for more than two hours before the facility would discard it. CNA 1 further stated that they do not refrigerate food for residents, because there was not a refrigerator and microwave for resident use.</p> <p>During an interview on 2/5/25 at 12:18 p.m. with Licensed Nurse 1 (LN 1), LN 1 stated they advised family members against bringing perishable foods as the facility did not store or re-heat resident food.</p> <p>During an interview on 2/5/25 at 12:37 p.m. with CNA 2, CNA 2 stated residents were allowed to keep food in their rooms up to 24 hours, and after that it would be discarded. CNA 2 further stated facility did not store and re-heat resident food.</p> <p>During an interview on 2/5/25 at 5:25 p.m. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), ADON stated refrigerator and microwave were not available for residents' use. DON concurred that there had never been a resident refrigerator or microwave as long as she had worked for the facility.</p> <p>A review of the facility's policy titled, Foods Brought by Family/Visitors, dated March 2022, indicated, in bullet 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food . b. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator . 8. Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours are discarded .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40841</p> <p>Based on observation, interview, and record review, the facility failed to follow infection control practices for three of 22 sampled residents (Resident 441, Resident 69, and Resident 290), when:</p> <ol style="list-style-type: none"> 1. Licensed Nurse 6 (LN 6) did not change gloves during wound care treatment for Resident 441; 2. LN 6 did not follow proper handwashing and glove changing procedures during wound treatment for Resident 69; and 3. Resident 290's midline (a thin, flexible tube inserted into a vein in the upper arm and used to administer medicines and fluid directly into blood) dressing on left upper arm (LUA) was soiled and not changed for nine days. <p>These failures decreased the facility's potential to prevent spread of infections among vulnerable residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 441's Admission Record, indicated Resident 441 was admitted to the facility in 2024 with a diagnosis of sepsis (harmful microorganisms in the blood or other tissues that could potentially lead to malfunction of the organs, shock, and death). <p>A review of Resident 441's Order Summary Report, dated 2/6/25, indicated Resident 441 had a left buttock wound. The order further indicated to cleanse the wound using wound cleaning solution and gauze, apply skin prep and vacuum transparent drape to peri wound skin, fill with black foam and bridge to anterior portion of thigh area, cover with drape, apply wound-assisted closure (VAC; a suction device dressing to apply negative pressure to a wound), and change dressing three times per week.</p> <p>During a concurrent observation and interview on 2/5/25 at 11:41 a.m. with LN 6 inside Resident 441's room, LN 6 was providing wound VAC treatment for Resident 441. LN 6 placed two trash bags right next to Resident 441's buttock wound and beside the clean field wound supplies on the bed. LN 6 removed multiple times the outer transparent drape (dressing) and discarded it in the trash bag, touched the soiled dressing in the trash bag, and then touched Resident 441's wound dressing using the same gloved hand. LN 6 did not perform hand hygiene or changed gloves after touching the soiled dressing in the trash bag. LN 6 confirmed no hand hygiene was performed and soiled gloves were not changed and stated it might lead to cross contamination and wound infection.</p> <p>During an interview on 2/6/25 at 9:34 a.m. with the Director of Nursing (DON), DON stated LN 6's infection control and cross contamination issue might impact Resident 441's wound healing.</p> <p>A review of the facility's policy titled, Handwashing/Hand hygiene, dated 8/2019, indicated, Use an alcohol-based hand rub . or, alternatively, soap . and water . before handling clean or soiled dressing, gauze pads .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled, Personal Protective Equipment - Gloves, dated 2001, indicated, Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin. The use of disposable gloves is indicated . when handling soiled linen or items that may be contaminated .</p> <p>Surveyor: [NAME], [NAME]</p> <p>2. A review of Resident 69's Admission Record, indicated she was admitted to the facility on [DATE] with a diagnosis of severe sepsis with septic shock (widespread infection in the body causing organ failure and dangerously low blood pressure).</p> <p>A review of Resident 69's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/18/24, indicated she had a stage three pressure ulcer (injury to skin and underlying tissues resulting from prolonged pressure on the skin) on her tailbone with full thickness tissue loss and visible fat deposits.</p> <p>A review of Resident 69's Care Plan, revised 1/24/25, indicated she was being monitored and treated for skin/wound care due to increased size in her tailbone pressure ulcer.</p> <p>During an observation on 2/5/25 at 9:30 a.m., LN 6 prepared for Resident 69's wound care treatment. LN 6 used her gloved hands to wash Resident 69's unclean pressure ulcer with disinfectant (a chemical that destroys bacteria) and gauze, then continued to wear the contaminated gloves to apply medicated cream and dressing covers to the pressure ulcer.</p> <p>During an interview on 2/5/25 at 10:34 a.m. with LN 6, LN 6 stated she was aware of the need to wash hands and change gloves after switching from a contaminated to a clean body site. LN 6 stated that by not following proper hand hygiene protocol during wound care, Resident 69's risk of infection would increase.</p> <p>During an interview on 2/5/25 at 4:43 p.m. with the Infection Prevention nurse (IP), IP stated nurses should follow the facility's hand hygiene measures when providing wound care to prevent the growth of bacterial infections among residents.</p> <p>A review of the facility's policy titled, Handwashing/Hand Hygiene, revised August 2019, indicated, All personnel shall follow the handwashing/hand hygiene procedures to prevent the spread of infections to . residents. The policy further indicated, Use an alcohol-based hand rub . or soap and water . Before and after direct contact with patients . Before moving from a contaminated body site to a clean body site.</p> <p>A review of the facility's policy titled, Personal Protective-Gloves, revised July 2009, indicated, The use of disposable gloves is indicated during all cleaning of blood, body fluids, and decontaminating procedures . Gloves shall be used only once and discarded.</p> <p>48694</p> <p>3. A review of Resident 290's Admission Record, indicated Resident 290 was admitted to the facility in January 2025 with multiple diagnoses including sepsis and acute kidney failure (a sudden loss of kidney function; filtering waste from blood as urine).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 2/3/25 at 10:42 a.m. with Resident 290, a midline dressing was observed on Resident 290's LUA with a see-through dressing dated 1/25/25. Dark colored drainage was noted around the insertion site through the dressing. Resident 290 stated nurses used this line daily to give him antibiotics (a medicine used to treat an infection).</p> <p>A review of Resident 290's Order Summary Report, dated February 2025, indicated an order to change Resident 290's LUA midline dressing weekly and as needed if soiled.</p> <p>During an interview on 2/4/25 at 11:09 a.m. with LN 8, LN 8 confirmed Resident 290's LUA midline dressing was dated 1/25/25 and stated the dressing was soiled and should have been changed on the seventh day 2/1/25.</p> <p>During an interview on 2/4/25 at 11:20 a.m. with DON, DON stated staff did not follow the physician order and the facility's policy to change Resident 290's midline dressing. DON further stated staff should have changed Resident 290's midline dressing weekly or as needed to prevent a central line-associated bloodstream infection.</p> <p>A review of the facility's policy titled, Central Venous Catheter Care and Dressing Change, revised in March 2022, indicated, . Change the dressing . at least 7 days . and immediately if the dressing or site appear compromised .</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50750</p> <p>Based on observation, interview, and record review, the facility failed to maintain equipment in safe operating condition, when:</p> <ol style="list-style-type: none"> 1. The Walk-in freezer was found with ice build-up on ceiling, floor, door, walls, and fan unit indicating potential temperature changes; 2. The dish machine's required minimum temperatures were not reached; and 3. The convection oven was not achieving the desired food temperature for the pork at or above 165 degrees Fahrenheit (F, a unit of measurement). <p>These failures had the potential of leading to food borne illness for the 96 residents eating facility prepared meals.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 2/3/25 at 8:51 a.m. with Dietary Manager (DM) in the walk-in freezer, the walk-in freezer was observed with ice build-up on the fan unit, ceiling, and pieces of ice on the floor. DM stated maintenance was in earlier removing ice build-up in the freezer which may be the cause of the ice on the floor. During an observation on 2/3/25 at 11:38 a.m., in the walk-in freezer, the ice on the floor had been cleaned up. Ice build-up was still observed covering the ceiling, walls, and boxes on the racks. During a concurrent observation and interview on 2/4/25 at 8:57 a.m. with Environmental Services Director (ESD), in the walk-in freezer, the walk-in freezer was observed with ice build-up on ceiling, walls, and boxes. ESD acknowledged ice build-up and stated the ice on the floor on 2/3/25 was from him loosening the ice build-up elsewhere in the freezer. During a follow-up observation on 2/4/25 at 4:19 p.m., in the walk-in freezer, the walk-in freezer showed high condensation and poor visibility. The ice build-up was greater than the earlier observation, and a two-and-a-half-inch drip had developed over the door. During a subsequent interview on 2/4/25 at 4:20 p.m. with DM, DM acknowledged there was ice build-up in the freezer and confirmed that ice build-up in the freezer was not okay. During an interview on 2/5/25 at 10:50 a.m. with Registered Dietitian (RD), RD stated ice build-up in walk-in freezer could affect the quality of the food and possibly cause freezer burn. <p>Facility unable to provide original walk-in freezer manual and referred surveyors to [NAME] Refrigerated Boxes as being like the freezer in use.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555083	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Manzanita Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the service manual at [NAME] Refrigerated Boxes, Inc. Revised: 5/2013 (http://www.ballyrefboxes.com/bally_walk-incooler_freezer.asp), indicated in Routine Maintenance, that; D. Heater wires should be checked for proper function. Feel for warmth around the door frames on hinged entrance doors and pressure relief port doors, if applicable. Note: Condensation or Ice buildup around doors may indicate leakage or heater failure. Contact a serviceman immediately . F. Inspect refrigeration units frequently for proper function of evaporator & [and] condenser fan motors, drain pan heaters, defrost controls, and drain line heaters. Condensate water must never be permitted to drip on the Walk-In floor. Drain pan or drain line heater failure will result in ice buildup and Evaporator damage. Refer to the Refrigeration System Instructions for proper drain pan and condensate drain line instructions .</p> <p>2. During a concurrent observation and interview on 2/3/25 at 9:24 a.m. with Dietary Aide 1 (DA 1), DA 1 demonstrated the dishwashing process. DA 1 explained the dish machine sanitized using high temperatures (150 F for wash cycle and 180 F for rinse cycle) and showed the temperature gauges that needed to be monitored. During multiple wash cycles, the wash temperature gauge did not move beyond 135 F. During the rinse cycle the temperature gauge did not reach the minimum temperature of 180 F.</p> <p>During a concurrent observation and interview on 2/3/25 at 9:30 a.m. with DM, DM ran another batch of dishes through the dish machine. During this cycle the wash temperature gauge reached 140 F, and the rinse temperature gauge reached 176 F. DM confirmed both cycles did not meet proper temperatures and stated he would contact the dish machine repair company to get it checked.</p> <p>During a follow up observation on 2/3/25 at 1:57 p.m., the dish machine was being used to clean/sanitize lunch dishes. DA 2 was asked to run a dish machine cycle. During the wash cycle, the wash temperature gauge did not reach the minimum temperature of 150 F and during the rinse cycle the temperature gauge did not reach the minimum temperature of 180 F.</p> <p>A review of the facility's policy titled, Sanitization, dated November 2022, indicated, in bullet 5. Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitization are: a. High-Temperature Dishwasher (Heat Sanitization): (1) Wash temperature (150-165 F); and (2) Rinse Temperature (180 F) .</p> <p>3. During a concurrent observation and interview on 2/4/25 at 11:52 a.m. with [NAME] 1 and DM, prior to lunch meal service, the hot food temperatures were checked. The temperature of the pork entrees (regular texture, mechanical soft, and pureed) were all below 165 F. [NAME] 1 and DM confirmed the temperature and placed the pork entrees back into the convection oven.</p> <p>The textured pork entrees (mechanical soft and pureed) were removed from the convection oven and checked again at 12:04 p.m. [NAME] 1 and DM found the temperature at 142 F. DM placed the mechanical soft and pureed texture pork on the stove and was able to reach 165 F or above within a few minutes.</p> <p>The regular pork entree was removed from the convection oven at 12:12 p.m., and the temperature was at 159 F. DM placed the regular pork on the stove, and at 12:18 p.m. the pork temperature was at 170 F.</p> <p>During an interview on 2/5/25 at 4:38 p.m. with [NAME] 2, [NAME] 2 stated the convection oven was not reaching the higher temperatures for the dinner meal on 2/4/25. He further stated a repair company came to fix the convection oven after the dinner meal service.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy titled, Sanitization, dated November 2022, indicated, in bullet 2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use .</p> <p>A review of the United States Food and Drug Administration (FDA) Food Code 2022 section 4-501.11 for Good Repair and Proper Adjustment indicated (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) Equipment . shall be kept . in accordance with manufacturer's specifications. The FDA Food Code 2022 further indicated that Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk .</p>