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	04/15/2026

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

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was prepared in a manner to maintain nutritive value for a census of 94 residents, when the carrots' recipe was not followed. This failure decreased the facility's potential to maintain the nutritive value of the food being served.Findings:A review of Resident 58's admission Record, indicated Resident 58 was admitted to the facility in 2025.A review of Resident 58's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/5/26, indicated Resident 58 had no memory impairment.A review of Resident 50's admission Record, indicated Resident 50 was admitted to the facility in 2026.A review of Resident 50's MDS, dated [DATE], indicated Resident 50 had no memory impairment.A review of Resident 119's admission Record, indicated Resident 119 was admitted to the facility in 2026. A review of Resident 119's MDS, dated [DATE], indicated Resident 119 had no memory impairment.During an interview on 4/12/26 at 9:01 a.m. with Resident 58, Resident 50, and Resident 119, all residents stated food was not flavored and tasted bad.During a concurrent observation and interview on 4/14/26 at 10:14 a.m. with [NAME] 1 in the kitchen, [NAME] 1 was observed cooking carrots on the stove. [NAME] 1 stated she placed just carrots in the pan.During an observation on 4/14/26 at 11:05 a.m. [NAME] 1 removed the carrots from the stove and cooked it for 50 minutes. [NAME] 1 then drained the carrot juice in the sink, added a half cup of lemon juice, eight ounces (oz, a unit of measurement) of melted butter, and sprinkled on some parsley, garlic and herb on the cooked carrots. [NAME] 1 did not add salt to the cooked carrots. A review of the facility's document titled, Recipe: Fresh Carrots, dated 2026, indicated the cooking time for fresh carrots was 10-20 minutes and to add margarine, lemon juice and seasonings such as salt, parsley and other seasoning after cooking. The recipe indicated using one tablespoon of salt for 96 servings of carrots.During a concurrent interview and record review on 4/15/26 at 9:12 a.m. with Dietary Supervisor (DS), the recipe for carrots was reviewed. DS confirmed the cooking time for carrots was 10 to 20 minutes.During an interview on 4/15/26 at 9:32 a.m. with Nursing Consultant (NS), NS stated following the recipe for cooking was important since it helped dietary staff to cook food for residents and to maintain its nutritive guideline and diet balance.

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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in a sanitary manner for a census of 94 residents, when:1. Opened and expired food items were available for use and not labeled; and2. The dishwasher's temperature log for April 2026 had no temperature and chlorine monitoring for breakfast and lunch for two days.These failures had the potential to result in foodborne illnesses among vulnerable residents.Findings:1. During a concurrent observation and interview on 4/12/26 at 8:23 a.m. with [NAME] 1 in the walk-in refrigerator, the following items were stored opened without labeling: a pancake waffle syrup, almond extract bottles, whipped cream bag and a browning seasoning sauce bottle. A lime juice bottle with expiration date 4/9/26 and two thickened lemon flavor water containers with best by date 12/5/25 and 2/25/26 were also found. [NAME] 1 confirmed the opened food items were not labeled and stated it should have been labeled with open date and best by date or expiration date. [NAME] 1 further stated there should not be any expired food item.2. During a concurrent interview and record review on 4/12/26 at 8:51 a.m. with the Dietary Supervisor (DS), the dishwasher temperature log for April 2026 was reviewed. DS confirmed there was no temperature and chlorine monitoring for breakfast and lunch on 4/10/26 and 4/11/26. DS stated the dishwasher temperature log should have been monitored for each shift (breakfast, lunch, and dinner) daily. During an interview on 4/15/26 at 9:32 a.m. with Nursing Consultant (NC), NC expected dietary staff to follow the dishwasher monitoring of temperature and chlorine level of 50 to 100 parts per million (ppm, a unit of measurement) and to monitor it daily before each meal, breakfast, lunch, and dinner. A review of the facility's policy titled, Labeling and Dating of Foods, dated 2023, indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 94 residents, when: 1. Licensed Nurse (LN) 1 did not sanitize a reusable tray between Resident 114 and Resident 115's wound treatment; 2. LN 2 did not wear the required personal protective equipment (PPE, wearable gear like gowns, gloves and masks to protect individuals from physical, chemical, and airborne dangers in workplaces) while repositioning a resident on enhanced barrier precautions (EBP, an infection control method); 3. Certified Nurse Assistant (CNA) 1 and CNA 2 did not wear proper PPE when assisting a resident on neutropenic precautions (used to protect residents from getting infections because their immune system cannot properly fight bacteria); and 4. CNA 4 did not wear N95 mask (an approved respirator to seal tightly around the nose and mouth, filtered at least 95% of airborne particles) while providing care for Resident 43 with coronavirus disease (COVID 19, a contagious virus disease spread through the air). These failures decreased the facility's potential to prevent cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another) and spread of infections among staff and residents.Findings: 1. A review of Resident 114's clinical record indicated Resident 114 was admitted to the facility in April 2026 with diagnoses including left foot open wound and acute osteomyelitis (a sudden, severe infection of the bone typically caused by bacteria) of left ankle and foot. A review of Resident 115's clinical record indicated Resident 115 was admitted to the facility in January 2026 with a diagnosis of cutaneous abscess (a painful tender lump filled with pus due to a bacterial infection) of right foot. During an observation on 4/12/26 at 9:16 a.m., LN 1 prepared supplies for Resident 114's wound dressing treatment at the medication cart. LN 1 placed the supplies on a reusable tray, placed the tray on Resident 114's bed and changed Resident 114's left foot wound dressing. LN 1 finished Resident 114's dressing and returned the tray back to the medication cart without sanitization. LN 1 was then observed preparing wound treatment supplies for Resident 115. LN 1 placed the supplies on the same unsanitized tray, placed the tray on Resident 115's bed and changed Resident 115's right foot dressing. LN 1 then returned the tray back to the medication cart without sanitization. During an interview on 4/12/26 at 9:54 a.m. with LN 1, LN 1 confirmed she did not sanitize the reuseable tray between Resident 114 and Resident 115's wound dressing treatments. LN 1 stated not sanitizing the tray between resident care could have increased the cross contamination and infection control risk. During an interview on 4/13/26 at 1:23 p.m. with Infection Preventionist (IP), IP stated all multiple use items such as reusable trays should be sanitized between each resident. IP further stated cross contamination could occur if items were not properly sanitized between each resident's care. During an interview on 4/13/26 at 2:05 p.m. with Director of Nursing (DON), DON expected nurses to sanitize equipment when used across multiple residents and between each use. DON stated not sanitizing the equipment increased the risk of cross contamination and spread of infection among residents. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, dated 10/2018, indicated, An infection prevention and control program (IPCP) is established and maintained (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection . 2. A review of Resident 103's admission Record, indicated Resident 103 was admitted to the facility in March 2026 with multiple diagnoses including post cervical spine fusion (a surgical procedure performed from the back of the neck to stabilize the cervical spine) and right knee pain. A review of Resident 103's Order Summary Report (OSR), dated 3/23/26, indicated Resident 103 was on EBP due to a right knee wound. A review of Resident 103's care plan, dated 3/23/26, indicated EBP should be implemented when giving high risk care activities to Resident 103 due to his right knee wound. During a concurrent observation and interview on 4/13/26 at 8:10 a.m. with LN 2 inside Resident 103's room, Resident 103 requested assistance to reposition his right leg in bed. LN 2 responded by lifting Resident 103's right leg, adjusting the two pillows placed under it, and then moving the leg into a new position. LN 2 confirmed she was not wearing a gown while assisting Resident 103. During an interview on 4/15/26 at 10 a.m. with the IP, IP stated staff should follow infection prevention and control practices for resident safety and to prevent the spread of infection among residents. A review of the facility's policy titled, Enhanced Barrier Precautions, dated 8/2022, indicated, Enhanced Barrier Precautions (EBPs) are used as an infection prevention and control interventions to reduce the spread of multi-drug-resistant organisms to residents . EBPs employs targeted gown and glove use during high contact resident care activity. 3. A review of Resident 112's admission Record, indicated Resident 112 was admitted to the facility in April 2026 with diagnoses including acute and chronic respiratory failure with hypoxia (occurs when the lungs cannot properly pass oxygen into the blood or fail to remove carbon dioxide waste from the blood) and interstitial pulmonary disease (a condition that cause inflammation and scarring in the lung tissue surrounding the air sacs). A review of Resident 112's OSR, dated 4/15/26, indicated Resident 112 had an order for neutropenic precautions and was receiving mycophenolate mofetil (medication that acts as an immunosuppressant). During an observation on 4/12/26 at 12:13 p.m. outside Resident 112's room, CNA 1 was passing lunch trays. CNA 1 went into Resident 112's room without wearing a gown, gloves, and mask. During an observation on 4/12/26 at 12:15 p.m., CNA 2 entered Resident 112's room and provided assistance while wearing a pair of gloves and a mask. During an interview on 4/12/26 at 12:18 p.m. with CNA 2, CNA 2 confirmed she was wearing a mask and gloves. CNA 2 stated she did not wear a gown because she only helped Resident 112 brushing their teeth and to set up the lunch tray. CNA 2 further stated wearing a gown was unnecessary. During an interview on 4/15/26 at 8:46 a.m. with IP, IP expected staff to always wear a mask, gown, and gloves when assisting residents on neutropenic precautions. IP further stated wearing proper (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PPE was important to prevent the resident on neutropenic precaution from getting sick. A review of the facility's policy titled, Isolation – Categories of Transmission-Based Precautions, revised 9/2022, indicated, Neutropenic precaution . These precautions are practically important for . individuals receiving immunosuppressant medications . PPE: Gloves, gown, surgical masks . 4. A review of Resident 43's admission Record, indicated Resident 43 was admitted to the facility in 2026 with a diagnosis of COVID 19. During a concurrent observation and interview on 4/13/26 at 11:07 a.m. with CNA 4 inside Resident 43's room, CNA 4 and another CNA were transferring Resident 43 from bed to chair and assisting with activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). CNA 4 was wearing a surgical mask, gown and gloves. CNA 4 confirmed she should have used N95 mask instead of a surgical mask. During an interview on 4/15/26 at 9:07 a.m. with the IP, IP stated she expected staff to wear N95 mask, gloves, gown, and face shield or goggle when assisting with ADLs care for a resident with COVID 19. IP stated without N95 mask, staff could increase the chance of cross contamination to other residents. A review of the facility's policy titled, Coronavirus Disease (COVID-19) – Using Personal Protective Equipment, dated 5/2023, indicated, An N95 respirator (or equivalent or higher- level respirator) is donned before entry into the resident room or care area.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure an alleged violation of abuse was reported immediately for two of 27 sampled residents (Resident 41 and Resident 52), when the Department did not receive a report of the alleged violation after the abuse incident's occurrence.This failure decreased the facility's potential to protect vulnerable residents and provide a safe environment.Findings:A review of Resident 52's admission Record, indicated Resident 52 was admitted to the facility in December 2025 with a diagnosis of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). A review of Resident 41's admission Record, indicated Resident 41 was admitted to the facility in March 2026 with diagnoses including difficulty in walking and generalized muscle weakness. A review of Resident 41's Minimum Data Set (MDS- a federally mandated assessment tool), dated 3/26/26, indicated Resident 41's Brief Interview for Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 15 out of 15 with good memory.During an interview on 4/12/26 at 9:13 a.m. with Resident 41, Resident 41 stated Resident 52 hit him with a wheelchair several times and attempted to punch him.A review of Resident 52's Progress Notes, dated 3/7/26, documented by Licensed Nurse (LN) 4, indicated Resident 52 had an episode of verbal aggression towards roommate (Resident 41). Resident 52 was getting out of the room when he reversed the wheelchair and bumped into Resident 41's chair. Resident 52 became verbally aggressive towards Resident 41 when Resident 41 told him to stay away to avoid the accident. The notes further indicated Resident 52 tried to punch Resident 41.A review of Resident 41's Census List, dated 4/15/26, indicated prior to 3/7/26 Resident 41 and Resident 52 were roommates and on 3/7/26 Resident 41 was moved to a different room.During an interview on 4/13/26 at 3:04 p.m. with Certified Nurse Assistant (CNA) 3, CNA 3 stated Resident 52 was upset and Resident 41 happened to be in the hallway. CNA 3 further stated Resident 52 was a little aggressive towards Resident 41.During an interview on 4/15/26 at 9:25 a.m. with LN 4, LN 4 stated she was passing medication when she heard Resident 52 talking very loud towards Resident 41 and stating, get out of my way. LN 4 further stated Resident 52 tried to punch Resident 41.During a concurrent interview and record review on 4/13/26 at 3:37 p.m. with Director of Nursing (DON), Resident 52's progress note, dated 3/7/26, was reviewed. DON stated based on the progress note the incident was considered reportable. DON further stated the incident was not reported and should have been reported.During an interview on 4/15/26 at 11:42 a.m. with Administrator (ADM), ADM expected staff to report to him, as an abuse coordinator, any alleged abuse or suspected abuse. ADM stated alleged abuse, or suspected abuse should have been reported to officials within two hours. A review of the facility's policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised 9/2022, indicated, If resident abuse . is suspected, the suspicion must be reported immediately to the administrator and to other officials . within two hours of an allegation involving abuse .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide services consistent with professional standards of quality for one of 27 sampled residents (Resident 104), when Resident 104's psyllium husk (a bulk forming laxative used to treat constipation and cholesterol management) powder order was not prescribed or administered in accordance with the manufacturer's guidelines.This failure increased Resident 104's potential to have unmet health needs.Findings:A review of Resident 104's admission Record, indicated she was admitted to the facility in March 2026 with a diagnosis of constipation with unspecified intestinal obstruction.During an observation on 4/13/26 at 4:35 p.m. with Licensed Nurse (LN) 3, LN 3 prepared medications for Resident 104 including psyllium husk powder. LN 3 placed a teaspoon (tsp. unit of measurement) of psyllium husk powder in a small cup and added an unspecified amount of water. After mixing the medications, LN 3 administered it to Resident 104, who remarked that the drink was too sweet. A review of Resident 104's Order Summary Report (OSR), dated 3/27/26, indicated an order for psyllium husk powder to be administered two times daily for constipation. The order did not specify the amount of liquid to be mixed with each tsp. of powder, as required by the manufacturer's instructions.A review of the manufacturer's instruction for the administration of psyllium husk powder found on the back of the canister indicated, put one serving [a tsp.] into an empty glass and fill glass with eight ounces (oz. unit of measurement) of water. Stir briskly and drink promptly.During a concurrent interview and record review on 4/13/26 at 4:46 p.m. with LN 3, Resident 104's OSR, dated 3/27/26, and the manufacturer's instructions found on the back of the canister were reviewed. LN 3 stated she did not measure the amount of water used when mixing the powder. LN 3 further stated since the order did not specify the quantity of water required, she used 100 milliliters (ml-unit of measurement) of water every time she prepared it.During an interview on 4/15/26 at 10 a.m. with the Director of Nursing (DON), DON stated nurses must verify orders were accurately written and consult with the doctor or pharmacy consultant when necessary to clarify instructions to ensure specific guidelines were followed, therefore reducing the risk of adverse reactions or medication errors among residents.A review of the facility's policy titled, Administering Medications, revised in 4/2019, indicated, medications are administered in a safe manner as prescribed, the individual administering should check the label three times for right medication and right method of administration before giving the medication. If medication has been identified as having potential consequences to the resident, the person preparing or administering will contact the prescriber and discuss the concerns.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and secured for a census of 94 residents, when Licensed Nurse (LN) 3 left medications unattended on top of the medication cart.This failure increased the residents' potential for unauthorized access to medications.Findings:During an observation on 4/13/26 at 4:35 p.m. with LN 3 during medication pass, LN 3 was inside a resident's room administering medications. LN 3 left medications on top of medication cart D unattended. The items included two bubble packs, one bottled liquid medication and one canister of powdered medication.During a concurrent observation and interview on 4/13/26 at 4:42 p.m. with the Director of Nursing (DON), DON acknowledged that medications were left unsecured on top of medication cart D while LN 3 was in a resident's room administering medications. DON stated LN 3 should have locked the medications in the cart before going into the resident's room to prevent unauthorized access and ensure resident safety.During an interview on 4/13/26 at 4:46 p.m. with LN 3, LN 3 confirmed she forgot to put away the medications left on top of the cart after preparing them. LN 3 stated she should have secured the medications inside the cart before entering the resident's room.A review of the facility's policy titled, Medication Labeling and Storage, revised in 2/2023, indicated, The facility stores all medications and biologicals under . applicable federal and state requirements . The nursing staff is responsible for maintaining medication storage . Medications are stored in an orderly manner in cabinets, drawers, carts .