| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555889 | A. Building<br>B. Wing | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain Manor Senior Residence | 6101 Fair Oaks Boulevard<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(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 |
|---|---|---|---|
| | 555889 | A. Building<br>B. Wing | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain Manor Senior Residence | 6101 Fair Oaks Boulevard<br>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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one out of five sampled residents (Resident 3) received treatment and care in accordance with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 3's alarm bracelet was not monitored for placement and functionality.This failure had the potential for an ineffective wandering management of Resident 3 and risk for Resident 3's further elopement occurrences.Findings: A review of Resident 3's clinical record indicated Resident 3 was admitted November of 2024 and had diagnoses that included Alzheimer's disease (a progressive disease that destroys memory and other important mental functions causing memory loss and confusion), dementia (impairment of the ability to remember, think, or make decisions that interferes with everyday activities, and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).A review of Resident 3's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 5/14/25, indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 3 out of 15 which indicated Resident 3 had a severely impaired cognition (mental process of acquiring knowledge and understanding). During a concurrent observation and interview on 7/16/25 at 12:36 p.m. with Resident 3, in the facility's dining area, Resident 3 was observed wearing a black alarm bracelet on his left wrist. Resident 3 stated it was for staff to monitor his location. Resident 3 further stated he doesn't remember when he started wearing the alarm bracelet.A review of Resident 3's Care Plan Report, undated, indicated, The resident [Resident 3] is an elopement risk/wanderer r/t [related to] Disoriented to place, impaired safety awareness, Dementia/Alzheimer's, exit seeking episode noted 6/30/25, 7/1/25 .Interventions .WANDER ALERT guard Device.A review of Resident 3's Wandering Risk Assessment, dated 7/2/25, indicated Resident 3 was high risk for wandering.A review of Resident 3's active physician's order, dated 7/2/25, indicated, Wander guard [alarm bracelet] to alert staff of attempts to leave facility unattended. Check for placement. every shift.A review of Resident 3's active physician's order, dated 7/10/25, indicated, WANDERGUARD USE: CHECK FOR FUNCTIONALITY USING [NAME] MONITOR DEVICE [a device used to check if the alarm bracelet is working properly] every day shift.A review of Resident 3's Medication Administration Record (MAR- a legal document used to record medications given to the residents) and treatment administration records (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident), for the month of July 2025, did not indicate that Resident 3's alarm bracelet was being checked for placement every shift or was being checked for functionality every day shift.During a concurrent interview and record review on 7/16/25 at 3:23 p.m. with Licensed Nurse (LN) 4, Resident 3's clinical records were reviewed. LN 4 confirmed that Resident 3's alarm bracelet had no documentation that it was being checked for placement every shift or was being checked for functionality every day shift. LN 4 stated that Resident 3's alarm bracelet was placed last 7/2/25. LN 4 also stated Resident 3's alarm bracelet should be monitored for placement and functionality to make sure the alarm bracelet was working properly. LN 4 further stated that Resident 3 would be at risk for wandering if the placement and functionality of the alarm bracelet is not monitored regularly. During an interview on 7/16/25 at 3:48 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 3's alarm bracelet should always be monitored for proper placement and functionality because there would still be a risk for Resident 3's elopement if the alarm bracelet was not working properly.A review of the facility's policies and procedures (P&P) titled, Safety and Supervision of Residents, revised 7/2017, indicated, .Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Individualized, Resident-Centered Approach to Safety .4. Implementing interventions to reduce accident risks and hazards shall include the following: .d. Ensuring that interventions are implemented .5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555889 | A. Building<br>B. Wing | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain Manor Senior Residence | 6101 Fair Oaks Boulevard<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>Based on observation, interview and record review, the facility failed to ensure one out of five sampled residents (Resident 1) was free from significant medication error when Resident 1 did not receive prescribed insulin (medication used to manage blood sugar level) in accordance with the physician's order.This failure has the potential to result in Resident 1 experiencing hypoglycemia (too low blood sugar level) and other unnecessary insulin side effects which could negatively affect Resident 1's health.Findings:A review of Resident 1's clinical record indicated Resident 1 was admitted July of 2025 and had diagnoses that included diabetes mellitus (DM- a chronic condition causing too much sugar in the blood that can negatively affect health condition).A review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 7/15/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 15 had an intact cognition (mental process of acquiring knowledge and understanding). A review of Resident 1's active physician's order, dated 7/11/25, indicated, Insulin Aspart [rapid-acting insulin used to manage high blood sugar levels] Injection Solution 100 UNIT/ML [milliliters- unit of measurement] .Inject as per sliding scale [a method of managing blood sugar levels where insulin doses are adjusted based on current blood sugar reading] .subcutaneously [under the skin] with meals for DM .During an interview on 7/16/25 at 11:35 a.m. with Licensed Nurse (LN) 1, LN 1 stated she already checked Resident 1's blood sugar and had administered his insulin. LN 1 further stated that Resident 1 has not eaten but lunch will be served between 11:30 a.m. to 12 noon.A review of Resident 1's Medication Administration Record (MAR- a legal document used to record medications given to the residents), for the month of July 2025, indicated Resident 1 had a blood sugar level of 167 and was given 1 unit of insulin aspart.During an interview on 7/16/25 at 12:05 p.m. with Resident 1, Resident 1 stated his nurse already administered his insulin. Resident 1 further stated he had not eaten yet and was still waiting for his lunch meal.During a concurrent observation and interview on 7/16/25 at 12:51 p.m. with LN 3, in Resident 1's room, LN 3 was observed delivering Resident 1 his lunch meal. LN 3 confirmed that observation.During an interview on 7/16/25 at 2:10 p.m. with LN 1, LN 1 confirmed that Resident 1's insulin aspart was administered too early. LN 1 stated that Resident 1's insulin aspart should have been administered with meals as per the doctor's order to prevent hypoglycemia.During an interview on 7/16/25 at 3:48 p.m. with the Director of Staff Development (DSD), the DSD stated she would expect staff to follow the doctor's order when administering insulin medication. The DSD further stated that the resident would be at risk for hypoglycemia if a rapid-acting insulin is not administered with meal. A review of the facility's policies and procedures (P&P) titled, Administering Medications, revised 12/2012, indicated, 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).A review of the facility's P&P titled, Insulin Administration, revised 3/2025, indicated, The type of insulin, dosage requirements, strength, and method of administration are verified with the order on the medication sheet and the physician's order before administration .Rapid-acting [insulin] .Onset [how quickly the insulin reaches the bloodstream and begins to lower blood sugar] .within 15 min [minutes] . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555889 | A. Building<br>B. Wing | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain Manor Senior Residence | 6101 Fair Oaks Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555889 | A. Building<br>B. Wing | 07/16/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mountain Manor Senior Residence | 6101 Fair Oaks Boulevard<br>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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 61 residents when:1. A shared glucometer (a device which measures blood sugar using blood from the fingertip) was not sanitized properly after use; and,2. A facility staff did not wear required personal protective equipment (PPE) when performing resident care on Resident 4 who was on enhanced barrier precaution (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use) and there was no EBP signage posted outside of Resident 4's room.These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), and potential exposure of residents and staff to germs.Findings:1. During an observation on 7/16/25 at 11:46 a.m., with Licensed Nurse (LN) 2 was observed checking a resident's blood sugar using a glucometer (True Matrix Pro) which was shared between residents. LN 2 used a lancet (a sharp piercing device) to pierce the resident's finger to get blood and then applied the blood to the test strip that was attached to the glucometer. After reading the result, LN 6 went out the room, discarded the used lancet and test strip, wiped the shared glucometer with one alcohol prep pad (pads used to clean the skin prior to bandaging, wiping off surfaces like desks, sinks and counters, and cleaning hands), and stored the glucometer in the medication cart.During an interview on 7/16/25 at 11:58 a.m. with LN 2, LN 2 confirmed that she used an alcohol wipe to clean and sanitize the used glucometer before storing it in the medication cart. LN 2 stated she thought it was okay to use alcohol prep pad in cleaning and sanitizing the used glucometer.During an interview on 7/16/24 at 3:40 p.m. with the Infection Preventionist (IP), the IP stated that shared glucometers should always be cleaned and sanitized properly using a germicidal wipe (Super Sani-Cloth Wipes) and not an alcohol prep pad. The IP also stated there would be a risk of infection issues and cross-contamination if the shared glucometer was not cleaned and sanitized properly. The IP further stated they should follow the manufacturer's recommendation in cleaning the glucometers.A review of the facility's policy and procedures (P&P) titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, revised 6/2011, indicated, d. Reusable items are cleaned and disinfected or sterilized between residentsA review of the manufacturer's instructions for True Matrix Pro blood glucose monitoring system titled, Care, Cleaning/Disinfecting and Troubleshooting, undated, indicated, To Clean and Disinfect the Meter: .2. Make sure meter is off and a test strip is not inserted. With ONLY Super Sani-Cloth Wipes [germicidal wipes] ., rub the entire outside of the meter using 3 circular wiping motions with moderate pressure on the front, back, left side, right side, top and bottom of the meter .2. A review of Resident 4's clinical record indicated Resident 4 was admitted July of 2025 and had diagnoses that included pneumonia (infection that inflames air sacs in one or both lungs), and diabetes mellitus (a chronic condition causing too much sugar in the blood).A review of Resident 4's active physician's order, dated 7/15/25, indicated, RESIDENT HAS CAPACITY TO MAKE HEALTHCARE DECISIONS.A review of Resident 4's active physician's order, dated 7/15/25, indicated, EBP (Enhance Barrier precaution) high contact resident care activities : dressing, bathing/showering, transferring [sic], providing hygiene, changing linen, changing brief or assisting with toileting, device care: .feeding tube . Wound care. every shift.A review of Resident 4's care plan, undated, indicated, The resident [Resident 4] requires tube feeding [the delivery of food and nutrients through a feeding tube directly into the stomach or part of the intestines] r/t [related to] Dysphagia [swallowing difficulties].During a concurrent observation on 7/16/25 at 11:58 a.m. in Resident 4's room, LN 2 was observed handling and re-connecting Resident 4's gastrostomy tube (a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) to the tube feeding formula while only wearing gloves and not wearing a gown. There was also no observed EBP signage posted outside of Resident 4's room.During an interview on 7/16/25 at 11:59 a.m. with LN 2, LN 2 confirmed that she only wore gloves when she used and re-connected Resident 4's gastrostomy tube to the tube feeding formula. LN 2 also confirmed that there was no EBP signage posted outside of Resident 4's room. LN 2 stated she does not think Resident 4 was on EBP.A review of the facility's order listing report for residents on EBP, provided by the Infection Preventionist (IP), indicated that Resident 4 was on EBP. During an interview on 7/16/24 at 3:40 p.m. with the IP, the IP stated that staff should be wearing both gloves and gown when handling and using feeding tube to protect the resident from getting infection.A review of the facility's P&P titled, Enhanced Barrier Precautions, revised |