STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on interview and record review, the facility failed to complete the Minimum Data Set (MDS, an assessment tool used to guide care) Admission Assessment within 14 calendar days after admission for two in a census of 38 (Resident 9 and Resident 21). This failure had the potential to delay care planning and the delivery of care that would have been identified in the admission assessment. Findings: 1. Resident 9 was admitted to the facility on [DATE], with diagnoses including dementia and cognitive communication deficit. Review of Resident 9's MDS Assessment, dated 12/15/23, indicated the comprehensive Admission Assessment was completed on 1/10/24, 28 calendar days after admission. 2. Resident 21 was admitted to the facilty on 1/4/24 with diagnoses including altered mental status. Review of Resident 12's MDS Assessment, dated 1/6/24, indicated the comprehensive admission assessment was completed on 1/29/24, 26 calendar days after admission. During a concurrent interview and record review of the MDS assessments for Resident 9 and Resident 21 on 6/6/24 at 9:40 a.m. with the Director of Nursing (DON), the DON acknowledged that Resident 9 and Resident 21's Admission Assessments were completed more than 14 days from their admission and were submitted late. A review of the facility's Policy and Procedure (P&P) titled, MDS Completion and Submission Timeframes, revised 7/2017, stipulated, .Facility will conduct and submit resident assessments in accordance with current federal and state submission . Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual.

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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44971 Based on observation, interview and record review, the facility failed to develop a comprehensive person-centered care plan for one of 15 sampled residents (Resident 491), when the care plan did not address Resident 491's dialysis (a procedure to remove waste products from the blood when the kidneys stop working properly) care and interventions. This failure decreased the facility's potential to address the residents' individualized and specific needs. Findings: A review of an admission record indicated Resident 491 was admitted to the facility in May 2024 with diagnoses including dependence on renal (kidney) dialysis and end stage renal disease. During a concurrent observation and interview on 6/4/24 at 8:38 a.m. with Resident 491 in her room, Resident 491 had a tube connected to her left abdominal area. Resident 491 stated she had peritoneal dialysis (a treatment for kidney failure that uses the lining of abdomen to filter the blood) tube, went yesterday to dialysis, and was scheduled for dialysis on Monday, Wednesday, and Friday. A review of Resident 491's Minimum Data Set (MDS; an assessment tool), dated 5/22/24, indicated Brief Interview of Mental Status (BIMS) score was 13 of 15 with good memory. MDS further indicated hemodialysis (a treatment to filter wastes and water from blood) was performed on Resident 491 on admission and peritoneal dialysis was performed while she was residing in the facility. A review of Resident 491's Order Summary Report, dated 6/4/24, indicated Resident 491 was scheduled for dialysis every Monday, Wednesday, and Friday. During a concurrent interview and record review on 6/4/23 at 3:09 p.m. with Licensed Nurse 1 (LN 1), Resident 491's medical record was reviewed. LN 1 stated Resident 491 had dialysis and confirmed there was no care plan for dialysis. During an interview on 6/4/24 at 3:14 p.m. with the Assistant Director of Nursing (ADON), ADON confirmed Resident 491 had no care plan for dialysis. ADON stated nurses should have developed a care plan for dialysis; otherwise, the person-centered care plan interventions might not be followed and implemented for this specialized service. A review of the facility's policy titled, Comprehensive Person-Centered Care Plans, dated 12/16, indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on observation, interview, and record review, the facility failed to provide services which meet professional standards of quality of care for one of 15 sampled residents (Resident 290) when Resident 290 was allowed to wear a left leg/knee immobilizer without a physician's order. This failure resulted in Resident 290's use of a leg/knee immobilizer without a required physician's order. Findings: A review of Resident 290's Admission Record indicated she was admitted ,d+[DATE] with diagnoses including left tibial plateau fracture (fracture in the upper part of the shinbone) after a ground level fall. During an intial tour observation on 6/3/24 at 10:30 a.m., Resident 290 was observed lying in bed wearing a left leg/knee immobilizer. During a concurrent observation and interview on 6/4/24 at 2:32 p.m. with the Physical Therapist (PT) while doing therapy with Resident 290, the PT stated a leg/knee immobilizer should be worn at all times as ordered from the hospital to prevent the knee from bending or flexing. During a concurrent interview and record review of the Order Summary Report (OSR) dated 6/2024 for Resident 290 on 6/4/24 at 2:35 p.m. with Licensed Nurse 6 (LN 6), LN 6 verified the OSR did not include an order for the use of a leg/knee immobilizer. During a concurrent interview and record review of the same OSR on 6/4/24 at 2:39 p.m. with the Director of Rehab (DOR), the DOR confirmed the order for Resident 290's use of a leg/knee immobilizer was not in the physician's order. The DOR also mentioned the admitting nurse should have written a physician order as ordered from the hospital. During an interview on 6/5/24 at 10:28 a.m. with the Assistant Director of Nursing (ADON), the ADON stated she was the nurse who admitted Resident 290, ADON further stated she had forgotten to write the immobilizer order after clarifying it with the doctor at the hospital. The ADON acknowledged she should have recorded the order right away to prevent inaccuracy in the delivery of care to residents. Review of the facility's Policy and Procedure (P&P) titled, Medication and Treatment Orders, revised 7/2016, the P&P indicated, Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 48694 Based on observation, interview, and record review, the facility failed to maintain nail care for one of 15 sampled residents (Resident 25) when, Resident 25's fingernails on both hands were long and packed with a brownish-black substance. This failure decreased the facility's potential to maintain residents' nail care and prevent infection. Findings: A review of an admission record indicated Resident 25 was admitted to the facility in May 2024 with diagnoses including dementia (impaired ability to remember, think, or make decisions). During a concurrent observation and interview on 6/3/24 at 12:20 p.m. with Certified Nurse Assistant (CNA) 4 in the Resident 25's room, Resident 25 was observed with long fingernails packed with a brownish-black substance on both hands. The CNA 4 agreed fingernails on both hands were long and dirty. The CNA 4 stated to inform the Licensed Nurse and the Activities Aide (AA) to take care of Resident 25's fingernails. During an interview on 6/5/24 at 2:20 p.m. with AA, the AA stated she can trim resident's nails as per CNA's request, but she was not aware that Resident 25 had long and dirty fingernails. During an interview on 6/5/24 at 2:26 p.m. with Licensed Nurse (LN) 4, the LN 4 stated today she took care of Resident 25 and he was discharged to home. LN 4 also stated she was not aware of long and dirty nails. During an interview on 6/5/24 at 2:29 p.m. with CNA 5, the CNA 5 stated she took care of Resident 25 on 6/5/24 and noticed long and dirty fingernails on both hands. The CNA 5 also stated she forgot to inform the Licensed Nurse. During a review of undated care plan titled, Activities of Daily Living (ADL), indicated Resident 25 was self-care deficient, and facility did not initiate a nail care plan. During an interview on 6/6/24 at 8:59 a.m. with Assisting Director of Nursing (ADON), the ADON stated the CNAs cannot trim nails without consulting LN or AA and the CNAs should have performed daily hand hygiene for Resident 25. She also stated if nails cannot be trimmed as per diagnoses or doctor's orders then CNAs should have cleaned the dirty nails with soapy warm water and wash cloth. She stated dirty nails were source of infection. Review of the facility's policy and procedure (P&P) titled, Care of Fingernails/Toenails, dated 2010, the P&P indicated, .Nail care includes daily cleaning . soak in the warm soapy water for approximately five (5) minutes . Rinse the hand or foot that was soaked in soapy water with clear, warm water. Dry the hand or foot with towel .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45770 Based on observation, interview, and record review, the facility failed to ensure one of 15 sampled residents (Resident 2) received care in accordance with professional standards when Resident 2's physician order to float heels when in bed was not implemented. This failure decreased the facility's potential to prevent skin breakdown. Findings: A review of Resident 2's Admission Record indicated she was admitted on ,d+[DATE] with diagnoses including muscle weakness and age-related physical debility. In a concurrent observation and interview during the inital tour on 6/3/24 at 9:15 a.m., Resident 2 stated she had a good sleep and was ready to get up, was still in bed in her nightgown and feet observed to have edema (swelling). Review of Resident 2's Order Summary Report (OSR), dated 8/30/23, indicated an order to ensure heels are floated when in bed every shift for skin breakdown prevention. In a concurrent observation, interview, and record review on 6/4/24 at 7:50 a.m. with Licensed Nurse 4 (LN 4), Resident 2 was observed lying in bed, LN 4 confirmed Resident 2's feet/heels were not floated. LN 4 also acknowledged there was an active order for heels to be floated when in bed to prevent skin breakdown. In an interview on 6/5/24 at 10:28 a.m. with the Assistant Director of Nursing (ADON), the ADON stated she expected nursing staff to follow the physician's order to properly care for the residents. If the resident refused the order, the doctor should have been informed and educated the resident and the refusals should have been care planned. A review of the facility's Policy and Procedure (P&P) titled, Medication and Treatment Orders, revised 7/2016, the P&P stipulated all orders for medications and treatments will be consistent with the principles of safe and effective order writing and implementation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 45770 Based on observation, interview, and record review, the facility failed to ensure one of 15 sampled residents (Resident 15) had access to vision services when Resident 15 was not assisted in obtaining prescription eyeglasses. This failure resulted in Resident 15 not having eyeglasses to maintain good vision. Findings: A review of an Admission Record for Resident 15 indicated she was admitted in 7/23 with diagnoses including cataracts (cloudy area in the lens of the eye) and syncope (fainting). In a concurrent observation and interview on 6/3/24 at 9:45 a.m. with Resident 15, observed Resident 15 was lying in bed, squinting while watching television. A magnifying glass was on top of her table; Resident 15 stated she used it for reading. Resident 15 further mentioned the facility was supposed to provide a pair of new eyeglasses to her and she's been waiting for it for a long time. A review of Resident 15's Minimum Data Set (MDS, an assessment tool used to guide care), dated 4/19/24, indicated Resident 15 needed corrective lenses to maintain vision. In an interview on 6/5/24 at 10:10 a.m. with Social Worker (SW), the SW stated Resident 15 loves watching television and acknowledged she needed to use eyeglasses to be able to watch properly. SW confirmed Resident 15 was in need of a new pair of eyeglasses, but she hasn't provided it yet. In an interview on 6/5/24 at 10:28 a.m. with the Assistant Director of Nursing (ADON), the ADON stated part of resident's care was to provide vision services, the SW should have facilitated the resident's referrals for an appointments and provided what the resident needed to be able to function properly. A review of the facility's Policy and Procedure (P&P) titled, Referrals, Social Services, revised 12/2008, the P&P indicated social services personnel shall coordinate most resident referrals. Referrals for medical services must be based on resident needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 44971 Based on observation, interview and record review, the facility failed to ensure staffing information was posted on a daily basis at the beginning of each shift for a census of 38, when staffing information was not posted on weekend and at the beginning of weekdays' morning shifts. This failure decreased the facility's potential to post staffing information on a daily basis for residents and visitors. Findings: During an observation on 6/3/24 at 7:39 a.m. the facility's Daily Staffing, dated 5/31/24, was posted beside the main entrance door. During an observation on 6/4/24 at 9:35 a.m. the facility's Daily Staffing, dated 6/3/24, was posted bedside the main entrance door. During an observation on 6/5/24 at 9:45 a.m. the facility's Daily Staffing, dated 6/4/24, was posted bedside the main entrance door. During an interview on 6/5/24 at 11:10 a.m. with the Staffing Coordinator (SC), SC confirmed the facility's Daily Staffing for 6/1/24 and 6/2/24 were not posted over the weekend and she posted the Daily Staffing on 6/3/24, 6/4/24, and 6/5/24 after 9:30 a.m. during weekdays. SC stated the receptionist should have posted the weekend staffing; otherwise, residents and visitors will not be able to find out the number of staff providing care and the census. SC further stated the morning shift started at 6 a.m. and she should have posted staffing within two hours of the beginning of the day shift. During an interview on 6/5/24 at 1:04 p.m. with the Assistant Director of Nursing (ADON), ADON stated the receptionist should have posted staffing over the weekend and the SC should have posted it early in the morning; otherwise, residents and visitors will not know the staff ratio and number of staff taking care of them. A review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, dated 7/16, indicated Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of the day shift .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49821 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 38 when two opened Emergency drug kits found in the medication room had not been replaced by the pharmacy according to the facility policy. This failure had the potential for residents not receiving necessary medications on time or drug diversion. Findings: During an inspection of medication room [ROOM NUMBER] on 6/3/24 at 11:28 a.m., two e-kits (emergency kit, a box containing emergency medications) were observed to be previously opened and used, but still not replaced by the pharmacy. E-kit #53 was an e-kit containing controlled medications (drugs with higher risk of addiction and high potency) was accessed on 5/29/24 at 9 p.m. E-kit # 49 was an e-kit containing oral medications was first accessed on 5/30/24 followed by 6/1/24, and 6/2/24. During an interview on 6/3/24 at 11:36 a.m. with Licensed Nurse 1, LN 1 confirmed that both e-kits had been used, but still not replaced by the pharmacy. LN 1 confirmed e-kit #49 was first accessed on 5/30/24. LN 1 confirmed e-kit #53 was first accessed on 5/29/24 and pharmacy was not notified to replace it. During interview on 6/5/24 at 9:03 a.m. with the assistant Director of Nursing (ADON), the ADON confirmed that if e-kits were accessed multiple times before they were replaced, there might not be certain drugs available when needed. ADON also acknowledged that staff should have followed up with the pharmacy to replace the e-kits with the next delivery. ADON stated that the pharmacy delivers medications two times per day so there were many opportunities to replace the e-kits. During a review of the facility's policy and procedure titled Emergency Medications, dated 4/2007, indicated, Medications .used from the emergency medication kit must be replaced upon the next routine drug order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 45770 Based on interview and record review the facility failed to ensure two of 15 sampled residents (Resident 2 and Resident 3) were free from unnecessary medication when: 1. Resident 2's anti-anxiety medication (a medication used to help reduce symptoms of worry, fear, and panic) was prescribed without a stop date; and, 2. Resident 3's use of an antibiotic medication (medicines that treat bacterial infections in humans) was continued without adequate indication. These failures increased the risk of Resident 2 and Resident 3 to receive unnecessary medications. Findings: 1. A review of Resident 2's Admission Record indicated Resident 2 was admitted in 8/2023 with diagnoses including anxiety disorder. A review of an Order Summary Report (OSR) of Resident 2, dated 5/2/2024, indicated an order for hydroxyzine hydrochloride (an anti-anxiety medication) 25 milligrams (mg, unit of measurement) every 8 hours as needed (PRN) for anxiety with restlessness, there was no stop date written. A review of Resident 2's Medication Regimen Review (MRR) for 5/2024 the Pharmacy Consultant (PC) recommended the doctor to add a stop date for the anti-anxiety medication order. There was no documented revision applied to the anti-anxiety medication order. A review of Resident 2's Medication Administration Report (MAR) indicated for the whole month of 5/2024 Resident 2 received the anti-anxiety medication three times on 5/7, 5/16, and 5/20. In a concurrent interview and record review on 6/4/2024 at 9:50 a.m. with the Nurse Practitioner (NP) Resident 2's OSR, dated 5/2/2024, was reviewed, the NP confirmed that the order for anti-anxiety medication did not indicate a stop date, she also stated an end date should have been included to the order since it is an as needed order. In an interview on 6/5/2024 at 10:28 a.m. with the Assistant Director of Nursing (ADON) the ADON stated they were aware of the recommendation from the PC to add a stop date for the anti-anxiety medication order, but she's not sure if the physician was made aware of it. The ADON acknowledged that the as needed anti-anxiety medication should have been ordered for 14 days only. 2. A review of an Admission Record for Resident 3 indicated she was admitted in 5/2016 with diagnoses including cerebral infarction (a type of stroke that occurs when blood flow to the brain is disrupted). (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3's OSR dated 6/26/2023 indicated an order for ciprofloxacin hydrochloride (an antibiotic medication used to treat infections in many different parts of the body) oral tablet 250 milligrams (mg, unit of measurement) given one tablet at night as prophylaxis for recurring urinary tract infection (UTI), the duration of treatment was not included. A review of Resident 3's MRR dated 6/29/2023 the PC noted that he's aware of the new antibiotic medication order without a stop date for recurring UTI. No recommendations were noted. In a concurrent interview and record review on 6/4/2024 at 10 a.m. with the NP Resident 3's OSR was reviewed, and the NP agreed that Resident 3's antibiotic medication had been ordered for too long and should have been reviewed after her discharge from hospice care three months ago. In an interview on 6/5/2024 at 10:28 a.m. with the ADON stated the antibiotic medication order should have been reviewed accordingly for its long-term use. In a concurrent interview and record review on 6/5/2024 at 12:50 p.m. with the Infection Preventionist (IP) an Order Listing Report for the use of antibiotics was reviewed, the IP stated according to his list the last time Resident 3 had a UTI was in 6/2022, there were no other UTI infections documented after. A review of the facility's Policy and Procedure (P&P) titled Antibiotic Stewardship revised 12/2016 the P&P indicated If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: .Duration of treatment (1) Start and Stop date; or (2) Number of days therapy . A review of the facility's P&P titled Psychotropic Medication Use revised 7/2022 it indicated .PRN orders for psychotropic medications are limited to 14 days .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49821 Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed 5% for two of 10 sampled residents (Resident 241 and Resident 540) when: 1. For Resident 241, a licensed nurse administered famotidine, a medication used to treat heartburn and stomach acid reflux, not in accordance with Physician Orders. 2. For Resident 540, metoprolol succinate, a medication used to treat high blood pressure, was not available for the resident. As a result, 2 errors were identified out of 37 opportunities for error during the observation of medication administration; the facility medication error was 5.41%. Findings: 1. During an observation of medication administration on 6/3/24 at 7:52 a.m., Licensed Nurse (LN) 1 was observed to prepare and administer Resident 241's morning medications which included famotidine 10 mg (milligrams, unit of measure). LN 1 verified and administered a total of 10 pills. Reconciliation of the observation of medication administration with Resident 241's current Physician Orders indicated an order for famotidine 20 mg give 1 tablet by mouth two times a day for dyspepsia (pain or discomfort in the upper stomach). During an interview on 6/4/24 at 11:55 a.m. with LN 1, LN 1 stated Resident 241 received 2 famotidine 10 mg pills. LN 1 was unable to answer why the morning medication count was 10 pills instead of 11. LN 1 acknowledged that the morning medication count would have been 11 pills if 2 famotidine 10 mg tablets were included in the morning medication pass. During an interview on 6/5/24 at 9:03 a.m. with the Assistant Director of Nursing (ADON), the ADON stated, nurses are expected to double check and double count before giving medications, etc The ADON also acknowledged this medication error had occurred since the nurse gave only one famotidine 10 mg tablet instead of two tablets totaling the dose of 20 mg as ordered by the physician. During a review of the facility's policy and procedure titled Administering Medications, dated 12/2012, indicated, Medications must be administered in accordance with the orders .The individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 2. During an observation of medication administration on 6/3/24 at 8:06 a.m., LN 1 was observed to prepare and administer Resident 540's morning medications which did not include metoprolol succinate 25 mg. During an interview on 6/3/24 at 8:07 a.m. with LN 1, LN 1 stated she would call the pharmacy and follow up to see why the medication was not there. (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/3/24 at 11:54 a.m. with LN 1, LN 1 stated pharmacy was called and apparently, they had forgotten to send the resident's metoprolol the night before. LN1 stated that the medication would be delivered on the next delivery. During an interview on 6/5/24 at 9:03 a.m. with ADON, the ADON stated medications should be available for medication administration as prescribed by the physician. ADON further stated, I will do an in-service to let the nurses know how to follow up with pharmacy to ensure medications are available for our residents. During an interview 6/5/24 at 9:21 am with the facility's Registered Pharmacist (RPh), the RPh stated that the robot used for packaging the medication in blister packs had gotten stuck unnoticed and the metoprolol succinate prescription was not filled and sent out to facility along with other resident's medications on time. During a review of the facility's policy and procedure titled Administering Medications, dated 12/2012, indicated, Medications must be administered in accordance with the orders .The individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49821 Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly, when: 1. Six metered-dose inhalers were found with unlabeled open dates in Medication Cart A; 2. Two expired insulin vials were found in the medication refrigerator; 3. Prescription medication blister packs were found lodged in the rear gap of Medication Cart A; 4. Two expired glucometer control solutions were found in Medication Cart A; and, 5. Loose pills were found in Medication Cart A. These failures had the potential for omitting medications, medication misuse, and administering or using ineffective expired pharmaceutical products. Findings: 1. During a combined observation and interview [DATE] at 10:17 a.m. with Licensed Nurse (LN) 1, the open dates were not written on six (6) metered dose inhalers or accompanying boxes in Medication Cart A, as follows: a) Umeclidinium (an inhaled medication to relax the airways) 62.5 mcg (microgram, unit of measure) and vilanterol (an inhaled medication to control symptoms of asthma and improve lung function) 25 mcg, with an expiration date of [DATE] if unopened, had been opened without an open date, for two inhalers. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on [DATE]. A review of umeclidinium 62.5 mcg / vilanterol 25 mcg product box indicated that the inhaler should be discarded 6 weeks after opening. b) Fluticasone furoate 100 mcg inhalation powder, a medication used to help with breathing, with an expiration date of [DATE] if unopened, had been opened without an open date for two inhalers. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on [DATE]. A review of fluticasone furoate inhalation powder 100 mcg product box indicated that the inhaler should be discarded 30 days after opening. (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) Budesonide 80 mcg and formoterol fumarate dihydrate 4.5 mcg, combination of two medications used to help with breathing, with an expiration date of [DATE] if unopened, had been opened without an open date. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on [DATE]. A review of budesonide 80 mcg and formoterol fumarate dihydrate 4.5 mcg product box indicated that the inhaler should be discarded 3 months after opening. d) Fluticasone furoate 200 mcg and vilanterol 25 mcg, combination of two medications used to help with breathing, with an expiration date of [DATE] if unopened, had been opened without an open date. When asked LN 1 to provide the product's expiration date, LN 1 indicated that the opened product would expire on [DATE]. A review of fluticasone furoate 200 mcg and vilanterol 25mcg product box indicated that the inhaler should be discarded 6 weeks after opening. During an interview on [DATE] at 9:17 a.m. with LN 1, LN 1 acknowledged that she didn't know about the shorter expiration dates once these products were in use. During an interview on [DATE] at 9:03 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the inhalers should have had open date labels on them. The staff should have written the open date on each inhaler in order to know the products' true expiration dates to avoid administering expired and ineffective medications to the residents. During a review of the facility's policy and procedure titled Storage of Medication dated ,d+[DATE], indicated, The nursing staff shall be responsible for maintaining medication storage areas .in a clean, safe .manner . Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing .The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. During a review of the facility's policy and procedure titled Administering Medications dated ,d+[DATE], indicated, The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container. 2. During an observation on [DATE] at 11:26 am in the medication room, two 10 ml (milliliters, unit of measure) vials of insulin glargine and lispro (medications used to treat high blood sugar levels) were observed to be expired. According to pharmacy labels, both vials were filled on [DATE] and expired on [DATE]. During an interview [DATE] at 11:26 am with LN 2, LN 2 stated that the insulin vials' expiry dates were listed on the manufacturer's vial wrap; LN 2 stated expiration dates were ,d+[DATE] and ,d+[DATE] for glargine and lispro respectively since the vials were unused. LN 2 stated she was not aware whether the insulin vials were delivered by the pharmacy in a cold box with ice. (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON on [DATE] at 9:03, the ADON confirmed the contracted pharmacy did not deliver insulin on ice, meaning that the product's expiration date should have been 28 days after delivery of medication, whether it was kept in the medication refrigerator or room temperature. The ADON acknowledged that both insulin vials were expired and should have been removed from the active medication storage area. During a review of the facility's policy and procedure titled Storage of Medication dated ,d+[DATE], indicated, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. During a review of the facility's policy and procedure titled Administering Medications dated ,d+[DATE], indicated, The expiration/beyond use date on the medication label must be checked prior to administering. 3. During observation on [DATE] at 10:17 a.m., two (2) glucometer control solutions were found expired in Medication Cart A. Both had been opened on [DATE]. During an interview with LN 1, LN 1 stated the expiration dates were three months after date of opening. She agreed that the expiration date would be [DATE]. When asked what the significance of using expired control solutions would be, LN 1 stated that residents' glucometer readings could be inaccurate. During an interview on [DATE] at 9:03 a.m. with the ADON, the ADON stated that the glucometer control solution was expired and that this was not acceptable. During a review of the facility's policy and procedure titled, Storage of Medication dated ,d+[DATE], indicated, The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. 4. During an observation on [DATE] at 9:13 a.m. blister pack cards (cards that package medication within small plastic bubbles secured by a paper-backed foil) containing unused prescription medications were found lodged behind medication drawers in Medication Cart A. The medication cards had fallen from the drawers and wedged themselves in the bottom rear gap of the medication cart. During an interview, on [DATE] at 9:13 a.m. with LN 1, LN 1 stated she did not know they were there, but confirmed they shouldn't be there. During an interview on [DATE] at 9:07 a.m. with the ADON, the ADON acknowledged that residents might miss their medication doses due to missing blister packs; she also acknowledged medications storage areas were supposed to be kept clean. She stated that monthly inspections of the medication carts are done and that she would provide an in-service training to the nurses on checking the back of the drawers for the blister pack cards. During a review of the facility's policy and procedure titled, Storage of Medication, dated ,d+[DATE], indicated, Drugs shall be stored in an orderly manner in .drawers, carts . (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a combined observation and interview on [DATE] at 10:17 a.m. with LN 1, three (3) loose pills were found on the bottom of Medication Cart A's drawer. LN 1 confirmed that there were three loose pills retrieved from the cart. During an interview on [DATE] at 9:07 a.m. with the ADON, the ADON acknowledged that there should be no loose pills in the medication cart and medication storage areas were supposed to be kept clean. During a review of the facility's policy and procedure titled, Storage of Medication, dated ,d+[DATE], indicated, Drugs shall be stored in an orderly manner in .drawers, carts . During a review of the facility's policy and procedure titled, Administering Medications, dated ,d+[DATE], indicated, The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened shall be recorded on the container.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48860 Based on observation, interview, and record review, the facility failed to ensure the therapeutic diet menu was followed for the census of 38 during the lunch service on 6/4/2024 when: 1. Four residents (Resident 1, 5, 25, and 491) with (CCHO consistent carbohydrate) diet (a diet used in the treatment for diabetes) received one serving of fruit mix crumble cake instead of half serving for dessert; 2. One resident (Resident 2) with small portion diet, received one serving of fruit mix crumble cake instead of half serving for dessert; and, 3. One resident (Resident 5) with mechanical soft texture (a texture-modified diet that restricts foods that are difficult to chew or swallow) diet, received chopped salad with croutons instead of without croutons. These failures had the potential to result in compromising the medical and nutrition status of those five residents. Findings: 1.During an observation on lunch service on 6/4/2024 beginning at 11:45 a.m., it was noted Resident 1, 5, 25, and 491 were on CCHO diet indicated on the meal tickets (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) received one serving of fruit mix crumble cake instead of half serving for dessert. A concurrent review of the facility document titled, SUMMER MENUS: Week 1 Tuesday, dated 6/04/2024, indicated CCHO diet should receive half serving of fruit mix crumble cake. During an interview on 6/4/2024, at 1:42 p.m., the Certified Dietary Manager (CDM) acknowledged there were few residents on CCHO diet received one serving of fruit mix crumble cake instead of half serving. The CDM reviewed the menu and stated residents with CCHO diet should receive half serving of fruit mix crumble cake. 2.During an observation of lunch service on 6/24/2024 beginning at 11:45 a.m., it was noted Resident 2 with small portion diet received one serving of fruit mix crumble cake instead of half serving for dessert. A concurrent review of the facility document, titled, SUMMER MENUS: Week 1 Tuesday, dated 6/04/2024, indicated small portion diet should receive half serving of fruit mix crumble cake. During an interview on 6/4/2024, at 1:42 p.m., the CDM acknowledged there was a resident on small portion diet received one serving of fruit mix crumble cake instead of half serving. The CDM reviewed the menu and stated resident with small portion diet should receive half serving of fruit mix crumble cake. (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.During an observation of lunch service on 6/4/2024 beginning at 11:45 a.m., it was noted Resident 5 with mechanical soft texture diet received chopped salad with croutons instead of without croutons. A concurrent review of the facility document, titled, SUMMER MENUS: Week 1 Tuesday, dated 6/04/2024, indicated mechanical soft diet should receive no croutons with chop salad. During an interview on 6/4/2024, at 1:42 p.m., the CDM acknowledged there was a resident on mechanical soft texture diet received chopped salad with croutons instead of without croutons. The CDM reviewed the menu and stated resident with mechanical soft texture diet should receive chopped salad without croutons. During a follow up interview on 6/4/2024, at 1:42 p.m., the CDM stated that the cooks and dietary aid staff should follow the menu and recipe. During an interview on 6/5/2024, at 9:28 a.m., the Registered Dietitian (RD) stated CCHO diet was for residents with diabetes (a condition that happens when your blood sugar is too high) and need to consume lower carbohydrate (carbs) (food compounds as main nutrition food to release energy to the body, such as sugar, starch, etc.). She added that receiving extra carbs may potentially affect the residents' blood sugar level. The RD also stated the small portion diet was for controlling calories (a measurement of energy) intake and it may cause weight gain if not followed through. The RD stated mechanically soft texture diet was for the residents with chewing and/or swallowing issues as recommended by a speech therapist (works with people who have speech, language, or swallowing disorders). She confirmed the croutons were too hard to chew for residents on mechanical soft texture diet and was unsafe for residents with swallowing difficulty. The RD stated her expectation was the kitchen staff to follow the menu during the meal service and check the accuracy of the trays before leaving the kitchen. A review of departmental policy and procedure titled, Menu Planning, dated 2023, indicated that .The menus are planned to meet the nutritional needs of residents .The facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility .Menus are written for regular and therapeutic diets in compliance with the diet manual. A review of department document, titled, Diet Manual, dated 2023, it stated Controlled Carbohydrate Diet (CCHO) .The carbohydrates are controlled through portion control .Regular Mechanical Soft Diet .the mechanical soft diet is designed for residents who experience chewing or swallowing limitations .avoid breads with hard crusts . A review of undated facility document titled, Job Description: Dietary Aide, stated .making sure there is desserts for diabetics .Assist with tray line for breakfast and lunch, reading each card CAREFULLY for allergies, dislikes, special requests and diet types and textures. It is your responsibility to ensure trays are accurate and meets each residents individual needs. A review of undated facility document titled, Job Description: Cook, stated .Follow the menu given for the day assigned and consult with Dietary supervisor on any alternatives or changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48860 Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food serve safety when: 1. The ice machine was not clean with black and pink substances at the bottom of the ice evaporator unit (a part where water freezes to produce ice and push out from the unit) and pink slimy substances on the water curtain (a plastic cover rests over the ice evaporator where the ice dispenses); 2. There were 11 out 15 tomatoes with black and white indented spots found in dry storage; 3. There were several metal pans found stacked wet and contained food debris when stored at the clean and ready-to-use storage areas; 4. Employee's personal belonging found in the dry food storage area; and, 5. Juice dispenser was not clean with significant dust on the vent where juice dispended. Findings: 1.During an inspection of ice machine in the kitchen on 6/4/2024, at 8:39 a.m., the Outside Vendor Technician (OVT) removed the top access panel to reveal the machinery part of the ice machine. There were pink and slimy substances on the water curtain upon dissembled and could be easily wiped off with a paper towel. There were several black and pink substances found at the bottom of the ice evaporator unit. A concurrent interview with the OVT, and he stated the substances were calcium deposits and the ice machine needed to be wiped and cleaned more. A concurrent interview with the (Certified Dietary Manager) CDM, and he stated, We might have to increase the frequency of deep clean to bi-monthly. During an interview with the Registered Dietitian (RD) on 6/5/2024, at 9:28 a.m., she stated the ice machine should be clean and well maintained to prevent any bacterial growth. She added, It could have potential safety concerns for the patients when not completely maintained or cleaned. The RD stated, It appears to be a concern and we will take actions. A review of undated departmental document, titled, Ice Machine Sanitation Log, it indicated the maintenance technician was responsible to clean and sanitize the ice machine monthly and the last service was completed on 5/2/2024. (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of undated ice machine manual, titled, [Manufacturer's brand] Installation, Use, & Care Manual, it stated, .Removes mineral deposits from areas or surfaces that are in direct contact with water .use nylon brush or cloth to thoroughly clean the following ice machine areas .Evaporator plastic parts - including top, bottom, and sides .Ice machine cleaner is used to remove lime scales and mineral deposits. Ice machine sanitizer disinfects and removes algae and slime. According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-602.11 Equipment Food-Contact Surface and Utensils, it stated equipment like ice makers and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms (a living thing that is so small it must be viewed with a microscope, such as bacteria or algae). 2. An observation of the dry storage in the kitchen on 6/3/2024, at 10:05 a.m., and a concurrent interview conducted with the CDM. There were 11 out of 15 tomatoes were found covered with black and white indented spots stored on the shelf of the metal rack. The CDM confirmed and stated, they were rotten with discoloration and should be thrown away. During an interview with the RD on 6/5/2024, at 9:28 a.m., she stated the produce in the dry storage should be fresh and not spoiled. The RD acknowledged the tomatoes were not fresh and should be thrown and not to be used for cooking. She stated her expectation with the staff had to make sure the deliveries were fresh and not spoiled, and they should check the produce for freshness daily. A review of department policy and procedure, titled, Storing Produce dated 2023, indicated .Check boxes of fruit and vegetables for rotten, spoiled, items. One rotten tomato, apple, or potato in a box can cause the rest of the produce to spoil faster. Throw away spoiled items. 3. During an initial kitchen tour observation on 6/3/2024, at 9:16 a.m., there were several metal pans with conditions as followed: -Six of quarter (1/4) sheet and four of one-eighth (1/8) sheet metal pans were stacked wet, and - Three of 1/4 sheet and three of 1/8 sheet metal pans found with food debris after cleaned and sanitized. A concurrent interview with the CDM, he confirmed there were food debris and wetness found on the metal pans stated above. The CDM stated the metal pans should be left to dry on the air-dried rack for two hours or longer before stored away and should not be dirty. During an interview on 6/5/2024, at 9:28 a.m., the RD stated the dishes and pans should be cleaned and completely air-dried before stored away to avoid bacteria growth. She added pans should not have food debris and kept clean. A review of departmental policy and procedure, titled, Dish Washing, dated 2023, it stated, All dishes will be properly sanitized through the dishwasher .the dishes should be air dried in racks before stacking and storing . A review of departmental policy and procedure, titled, Sanitation, dated 2023, it stated, .All utensils, counters, shelves, and equipment shall be kept clean . (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 B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an observation in the dry storage room on 6/3/2024, at 10:05 a.m., there was a disposable cup with liquid located on the lower level of the metal rack where a box of oranges was stored; and a reusable grocery bag was on the box of oranges. A concurrent interview with the CDM, he stated the soda and the grocery bag belonged to the staff and there was no designated area for staff belongings separate from the kitchen food storage. During an interview on 6/5/2024, at 9:28 a.m., the RD stated it was not appropriate for the staff to store their belongings or food next to the food in the dry storage area. A review of departmental policy and procedure, titled, Employee Personal Items, dated 2023, it indicated, Personal items brought in by staff outside will not be kept in the kitchen. 5. An initial kitchen tour on 6/3/24, at 8:43 a.m., observation of the juice dispenser machine and a concurrent interview with the CDM was conducted. There was significant dust found on the vent where the juice dispended. The CDM confirmed and stated the juice machine needed to be cleaned and the maintenance was responsible to clean the vent. During an interview on 6/5/2024, at 9:28 a.m., the RD acknowledged and stated the juice dispenser should be clean and well maintained to prevent any bacterial growth. She added, It could have potential safety concerns for the patients, when not completely maintained or cleaned. She added, It appears to be a concern and we will take actions. A review of departmental policy and procedure, titled, Sanitation, dated 2023, it indicated, .All utensils, counters, shelves, and equipment shall be kept clean .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555889	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Manor Senior Residence	6101 Fair Oaks Boulevard 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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40841 Based on observation, interview, and record review, the facility failed to follow infection control practices for one of 15 sampled residents (Resident 32) when the Certified Nursing Assistant 3 (CNA 3) did not apply a face shield (a device to protect the eyes and face) while assisting Resident 32 with meal in the Coronavirus-19 Disease (COVID-19, an infectious disease caused respiratory illness) unit. This failure had the potential to spread infection in the facility. Findings: Review of Resident 32's Admission Record, indicated Resident 32 was admitted to the facility in 2024 with diagnoses including COVID-19. During an observation on 6/3/24 at 12:25 p.m. in Resident 32's room with CNA 3, the CNA 3 entered Resident 32's room, a COVID-19 positive room. The CNA 3 put on N-95 mask (a respiratory protective mask to provide efficient filtration of airborne), gown, and gloves. The CNA 3 assisted Resident 32 with meal and did not use any face shield or goggles. There was a visible sign by the wall of the room with instructions to don (put on) face shield and N-95, hand hygiene before entering room, and don gown and gloves. During an interview on 6/3/24 at 12:32 p.m. with CNA 3 and Licensed Nurse 5, both staff members confirmed the Personal Protective Equipment (PPE) requirement in the COVID-19 unit was N-95 mask, gloves, gown and googles/face shield. During an interview on 6/6/24 at 9:06 a.m. with the Infection Preventionist (IP), the IP stated the PPE requirement in the COVID-19 unit for staff members are N-95 mask, gown, gloves, and google or face shield. Review of the facility's policy titled, Coronavirus Disease (COVID-19)-Using Personal Protective Equipment, dated 5/2023, indicated, When caring for a resident with suspected or confirmed SAR-CoV-2 [COVID-19] infection, personnel who enter the room of the resident . use .N95 or equivalent or higher-level respirator, gown, gloves, and eye protection [goggle or face shield].