STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056216	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guardian Care and Rehabilitation Center	410 Eastwood Ave Manteca, CA 95336

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to report a change in condition and/or medical treatment to the physician and the Responsible Party (RP, the person responsible to direct the care of a loved one admitted into a nursing facility) for one of four residents (Resident 4) when: 1. Resident 4 refused her medications on multiple days; 2. Resident 4 refused fingerstick blood sugar monitoring (FSBS, poking a finger to apply a drop of blood to a test strip. The test strip is inserted into a small electronic device which measures blood sugar levels) tests on multiple days; and 3. Resident 4 refused her physical therapy treatments on multiple days. These failures resulted in Resident 4 ' s physician and RP being uninformed of a change in condition, and did not allow for the RP to participate in medical decisions and/or treatment options. These failures also had the potential for a decline in function for Resident 4. Findings: 1. A review of Resident 4 ' s ADMISSION RECORD indicated that Resident 4 was admitted to the facility with diagnoses which included intertrochanteric fracture of the right femur (broken right hip), diabetes mellitus (a chronic condition that affects the way the resident ' s body processes blood sugar), and delusional disorders (a serious mental health condition in which the resident cannot tell what is real from what is imaginary). Further review of Resident 4 ' s ADMISSION RECORD indicated that Resident 4 ' s son was her RP. During an interview with Resident 4 ' s RP on 3/4/25, at 3:55 p.m., the RP stated that the facility staff did not notify the family that the resident was refusing medications and FSBS tests on multiple occasions until she was discharged on [DATE]. A review of Resident 4 ' s Physician Progress Notes, dated 12/10/24, indicated a communication by fax to Resident 4 ' s primary physician indicated that Resident 4 refused her morning medications. A review of Resident 4 ' s Physician Progress Notes, dated 12/15/24, indicated a communication by fax to Resident 4 ' s primary physician indicated that Resident 4 refused her medications. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4 ' s Physician Progress Notes, dated 12/30/24, indicated a communication by fax to Resident 4 ' s primary physician indicated that Resident 4 refused some of her medications. A review of Resident 4 ' s Progress Notes, dated 1/2/25, indicated Resident 4 refused her medications and told the staff that her daughter-in-law said not to take any medications. A review of Resident 4 ' s Progress Notes, dated 1/6/25, indicated Resident 4 refused her medications and was encouraged to take her medications. A review of Resident 4 ' s Progress Notes, dated 1/12/25, indicated Resident 4 refused her medications and FSBS test. Resident 4 ' s Progress Note further indicated that a change in condition form was completed, and a message was left for the RP to call back. A review of Resident 4 ' s Weekly Assessments, dated 2/5/25, indicated Resident 4 continued to refuse medications and FSBS tests. A review of Resident 4 ' s Progress Notes, dated 2/13/25, indicated the RP was notified that Resident 4 refused medications prior to discharge. During an interview on 3/5/25, at 1:30 p.m., with Licensed Nurse (LN) 1, LN 1 stated that if a resident refused medications, she would provide education to the resident regarding the medication and offer the medication to the resident again. LN 1 stated that she would also notify the RP. LN 1 stated that she would document the resident ' s refusal of medication in the nurses ' notes or progress notes. LN 1 stated that she would also document the notification of the RP and the physician. During a concurrent interview and record review on 3/5/25, at 2:53 p.m., Resident 4 ' s 12/24 Medication Administration Record (MAR, a document listing medications and monitoring parameters) was reviewed with LN 2. LN 2 stated that Resident 4 usually took her medications, but occasionally she refused them. LN 2 confirmed that Resident 4 refused nine doses of her oral medications for treating diabetes, refused 12 doses of Ezetimibe (medication to lower cholesterol (a type of fat) in the blood), refused eight doses of Ducosate (medication to prevent constipation), refused 11 doses of Atorvastatin (medication to lower cholesterol), refused 10 doses of a medication for a fungal infection to her foot, refused eye drops two times, refused 18 doses of Senna (medication to prevent constipation), refused Vitamin D3 (dietary supplement) one time, refused 16 doses of Apixaban (an anticoagulant medication which makes your blood flow through your veins more easily to prevent blood clots and a stroke) refused nine doses of Olanzapine (medication used to treat the resident ' s delusional disorder), and refused 51 doses of Midodrine (medication given for low blood pressure (when the force of the blood moving through your blood vessels when your heart beats is too low)). During a concurrent interview and record review on 3/5/25, at 2:53 p.m., Resident 4 ' s 1/25 MAR was reviewed with LN 2. LN 2 confirmed that Resident 4 refused 18 doses of Glipizide (an oral medication used to treat diabetes), refused 19 doses of Sitagliptin (an oral medication used to treat diabetes), refused 21 doses of Atorvastatin, refused 18 doses of Ducosate, refused 17 doses of Lipitor, refused 18 doses of antifungal medication for a fungal infection to her foot, refused 18 doses of Senna, refused two doses of Vitamin D3, refused 18 morning doses and 25 evening doses of Aphixiban, and refused 13 morning doses 17 afternoon doses and 14 evening doses of Midodrine. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/5/25, at 2:53 p.m., Resident 4 ' s 2/25 MAR was reviewed with LN 2. LN 2 confirmed that Resident 4 refused 13 doses of Glipizide, refused 13 doses of Sitagliptin, refused 10 doses of Atorvastatin, refused five doses of Ducosate, refused six doses of Ezetimibe, refused six doses of antifungal medication for a foot infection, refused 10 doses of Senna, refused five morning doses and 10 afternoon doses of Aphixiban, and four morning doses, six afternoon doses, and seven evening doses of Midrodrine. LN 2 acknowledged that Resident 4 refused multiple medications during the past three months. LN 2 stated that when a resident refused medications, LNs documented refusal in the nursing progress notes and notified the RP. LN 2 stated that LNs documented notification of the RP in the progress notes. LN 2 stated that LNs notified the RP to see if the RP could convince the resident to comply and take the medications. LN 2 stated that a noncompliant (a resident who failed or resisted cooperating with their treatment plan) care plan was created for residents that refused medications. LN 2 stated that the risks for Resident 4 not taking her medications were elevated blood sugar, elevated cholesterol, fatty liver (elevated levels of fat in the liver), blood clots that could cause cardiac arrest (cause the heart to stop beating), low blood pressure, and increased signs and symptoms of disease processes. During a concurrent interview and record review on 3/6/25, at 8:13 a.m., Resident 4 ' s MARs, dated 12/24 through 2/25, were reviewed with Resident 4 ' s primary MD (Medical Doctor). The MD stated that Resident 4 was noncompliant and refused medications and physical therapy. The MD stated that on 11/30/24 she did not think that Resident 4 had the capacity to make decisions because she was lethargic and only alert to her name. The MD stated that it could have been due to medications given during surgery and after surgery. The MD stated that on 12/3/24, she felt that Resident 4 could make her own decisions because she was more alert. The MD stated that she knew that Resident 4 had a RP. The MD stated that she thought that the LNs told the RP about Resident 4 ' s refusal of medications. The MD stated that she visited the facility once a week. The MD stated that the LNs never told her that Resident 4 refused that many medications. The MD stated that if she knew, she would have called the RP. The MD stated that there was no documentation in the binder where nurses would place issues with residents for the MDs to follow up regarding Resident 4 ' s refusal of medications. The MD stated that the risks of Resident 4 missing that many medications were that her diabetes would not be controlled, her cholesterol levels would not be controlled, and she would be at risk for a blood clot. During a concurrent interview and record review on 3/6/25, at 11:07 a.m., Resident 4 ' s MARs, dated 12/24 through 2/25, were reviewed with Nurse Practitioner (NP) 1. NP 1 stated that she saw Resident 4 the beginning of January or February in 2025. NP 1 stated that she was aware of Resident 4 ' s refusal of medications. NP 1 stated that she was not sure if the RP was informed that Resident 4 refused her medications, or if the RP was informed of the number of doses of medications that Resident 4 refused. NP 1 stated that the staff were good at reporting to the residents ' RPs. NP 1 stated that the risks of Resident 4 not taking her medications were diabetic coma (a life-threatening disorder that happens when a resident ' s blood sugar is too high causing the resident to become unconscious (passed out; asleep unaware)) and low blood pressure. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/25 at 2:16 p.m., Resident 4 ' s MARs, dated 12/24 through 2/25, were reviewed with the Director of Nursing (DON). The DON stated that her expectations were that if a resident refused medications, the LNs would notify the MD right away, document in a CIC form (Change of Condition), create a noncompliant care plan for the resident, and notify the resident ' s RP. The DON stated that when the resident refused medications it was a CIC. The DON acknowledged that Resident 4 ' s RP should have been notified that there were multiple refusals of medications. The DON stated that the CIC should have also been addressed in the nurses ' weekly summary notes in Resident 4 ' s electronic medical record (EMR). During an interview on 3/6/25, at 12:37 p.m. with LN 3, LN 3 stated that if a resident had a pattern of refusing medications, she would let the NP on call know and notify the RP. LN 3 stated that she would document the notifications to the NP and the RP in the progress notes of the resident ' s EMR SBAR (SBAR; situation background assessment recommendation, a clinical communication tool) form. During an interview on 3/6/25 at 2:25 p.m. with the DON, the DON stated that there were not any SBAR sheets for Resident 4 located in Medical Records. The DON stated that there should have been a CIC for each time Resident 4 refused medications. The DON confirmed that facility policy was not followed. A review of an undated P&P titled, Administering Medications, the P&P indicated, .21. If a drug is .refused . the individual administering the medication shall document refused .on the EMAR (electronic medication administration record) .Immediate notification of MD must be done for crucial medications that has potential to have a negative effect on resident ' s health . 2. A review of Resident 4 ' s Progress Notes dated 1/12/25, indicated, Resident 4 refused her FSBS test. The Progress Note further indicated that a change in condition form was completed, and a message was left for the RP to call back. During a concurrent interview and record review on 3/5/25, at 2:53 p.m., Resident 4 ' s MAR, dated 12/24 through 2/25, was reviewed with LN 2. LN 2 confirmed Resident 4 ' s 12/24 MAR indicated Resident 4 refused FSBS tests 10 times. LN 2 confirmed Resident 4 ' s MAR, dated 1/25, indicated Resident 4 refused 11 FSBS tests before breakfast, 25 FSBS tests before lunch, 22 FSBS tests before dinner, and 24 FSBS tests at bedtime. LN 2 confirmed Resident 4 ' s MAR, dated 2/25, indicated, Resident 4 refused six FSBS tests before breakfast, 10 FSBS tests before lunch, 12 FSBS tests before dinner, and 11 FSBS tests before bedtime. During an interview on 3/6/25 at 2:16 p.m. with the facility Director of Nursing (DON), the DON acknowledged that Resident 4 ' s RP should have been notified that there were multiple refusals of FSBS tests. The DON stated that the CIC should have also been addressed in the nurses ' weekly summary notes in the resident ' s electronic medical record (EMR). The DON acknowledged that facility policy was not followed. 3. A review of Resident 4 ' s Physician Order Summary indicated that Resident 4 had orders for physical therapy five times a week. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/25, at 11 a.m., with the Physical Therapist (PT), the PT Resident 4 came to the facility after surgery for a leg fracture. The PT stated that Resident 4 had a history of a mental disorder. The PT stated that Resident 4 made up stuff and made excuses to not do her physical therapy. The PT stated that Resident 4 refused her physical therapy a lot. The PT stated that Resident 4 was never able to do five physical therapy sessions a week. The PT stated that he did not call Resident 4 ' s RP about her refusals. The PT stated that Resident 4 refused her physical therapy more than she participated in her physical therapy. The PT stated that when Resident 4 refused her physical therapy, the PT informed her nurse of the refusal. During an interview on 3/6/25 at 2:09 p.m. with the Physical Therapy Director (PT Dir) and the Director of Nursing (DON), the PT Dir stated that there was no specific policy on what to do if a resident refused physical therapy. The PT Dir stated that if a resident refused physical therapy, the PT would ask the resident two to three times if they wanted physical therapy and if they continued to refuse, the PT notified the resident ' s nurse. The PT Dir stated that PT continued to ask the residents if they wanted physical therapy as long as they had an order for physical therapy, and notified the residents ' nurses each time residents refused. The DON stated that if the residents refused physical therapy and the nurses were notified, the nurses should have notified the residents ' RPs. During an interview on 3/6/25 at 2:25 p.m. with the DON, the DON stated that there were not any SBAR sheets for Resident 4 located in Medical Records. The DON stated that there should have been a CIC for each time Resident 4 refused physical therapy. The DON confirmed that facility policy was not followed. During an interview on 3/6/25 at 2:45 p.m. with the PT Dir in the PT Dir ' s office, the PT Dir acknowledged that Resident 4 refused physical therapy 13 times. A review of an undated policy and procedure (P&P) titled, Change in a Resident ' s Condition or Status, the P&P indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status .Policy Interpretation and Implementation .1. The nurse will notify the resident ' s attending physician or physician on call when there had been a(an): .f. refusal of treatment or medications two (2) or more consecutive times .3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Intract SBAR Communication Form .8. The nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status .