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	08/29/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to ensure allegations of abuse were thoroughly investigated for one resident (Resident 72) in a census of 92. This failure had the potential for Resident 72 to experience further abuse, negatively affecting their physical and psychosocial well-being. Findings:A review of Resident 72's admission RECORD, indicated Resident 72 was admitted to the facility with diagnoses which included palliative care (a specialized form of medical care that focuses on improving the quality of life for people with serious or life-limiting illnesses).During a concurrent observation and interview on 8/26/25, at 2:44 PM, with Resident 72, in Resident 72's room, Resident 72 was seated in her wheelchair. Resident 72 further stated a staff member used foul language when caring for her and slapped me around a little. Resident 72 explained it had occurred recently.A review of Resident 72's clinical document titled, Progress Notes, dated 6/27/25, indicated, .resident [Resident 72] reported .that she was slapped by CNA [Certified Nursing Assistant] after 2pm on 06/25/25 .will monitor closely for physical or mental distress .During a concurrent interview and record review on 8/28/25, at 10:08 AM, with the Director of Staff Development (DSD), CNA 8's (the alleged perpetrator) employee file was reviewed. The DSD stated there were three incidents where CNA 8 was in-serviced on communication skills. The DSD explained one of the incidents was a verbal counseling on poor communication skills. The DSD reviewed CNA 8's document titled, Employee Progressive Counseling, dated 10/27/20, and 11/2/20, which indicated, .Type of Offense . Standards of Conduct .Description of Infraction .FAILURE TO PROPERLY COMMUNICATE WITH A RESIDENT. STAFF USED INAPPROPRIATE WORDS WHILE PROVIDING CARE FOR A RESIDENT .Type of Offense Quality of Work .Description of Infractions .Failure to provide the quality of care to residents as required under job descriptions for CNA per facility protocol with multiple warnings and write-ups. Staff will be suspended for 3 days for further investigation . The DSD explained following the incidents in October and November 2020, CNA 8 was placed on a Performance Improvement Plan, which indicated, .The purpose of this Performance Improvement Plan (PIP) is to define serious areas of concern, gaps in your work performance .Consequences of Further Infractions .Termination . The DSD reviewed CNA 8's third incident, which occurred 4/3/24. CNA 8's document titled, Employee Progress Counseling, dated 4/3/24, was reviewed. The document indicated, .Type of Counseling .Verbal .Description of Infraction .Poor communication skills .During an interview on 8/27/25, at 3:58 PM, with the Social Services Director (SSD), the SSD stated the investigative interviews for Resident 72's alleged abuse were all conducted by her. During a concurrent interview and policy review on 8/28/25, at 10:15 AM, with the SSD, the SSD stated Resident 72 was the only resident she interviewed. The SSD explained the staff member she interviewed on the day and shift when the alleged abuse occurred was CNA 8, the alleged perpetrator. Following review of an undated facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, the SSD stated she should have interviewed other residents and other staff members that were working on the day and shift of the alleged abuse. The SSD explained she did not feel it was a good investigation. The SSD stated she had not reviewed CNA 8's employee file. The SSD further stated she should have partnered with the DSD to review CNA 8's employee file. The SSD stated the risk to Resident 72 was further abuse. During an interview on 8/28/25, at 11:19 AM, with the Director of Nursing (DON), the DON stated other staff members on shift of the day of the alleged abuse should have been interviewed. The DON further stated other residents, in the care of CNA 8, should have been interviewed. The DON explained the importance of interviewing staff on shift from the day of the alleged abuse and other residents was to ensure a complete investigation and to prevent further incidents. The DON explained it was important to look at employee records to help in the investigation and to find out if there were similar complaints.A review of an undated facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, indicated, .All reports of resident abuse (including injuries of unknown origin) .are reported .and thoroughly investigated .The individual conducting the investigation as a minimum .interviews staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .interviews the resident's roommate, family members, and visitors .interviews other residents to whom the accused employee provides care or services .reviews all events leading up to the alleged incident .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan when:A care plan was not developed for Resident 62's face and neck swelling; and, Resident 102's care plan intervention for two person assist with activities of daily living (ADL, skills required for self-care and independent living, including bathing, dressing, toileting, transferring, continence, and feeding) care was not followed.These failures resulted in Resident 62 not having interventions and goals for his face and neck swelling and the potential for injury to Resident 102, negatively impacting Resident 62 and Resident 102's health, safety, and well-being.Findings: 1. Review of Resident 62's admission RECORD, indicated Resident 62 was admitted to the facility with diagnoses which included chronic pain (persistent pain that lasts for more than three months) and abdominal pain. During an interview on 8/27/25, at 11:25 AM, with Resident 62, Resident 62 stated he was not happy with the care he received for his face and neck swelling. Resident 62 explained staff did not do anything for the face and neck swelling. Resident 62 further explained he had to tell staff what to do, stating he directed them to get him some ice so he could put it on his face and neck. A review of Resident 62's clinical document titled, Care Plans, indicated Resident 62 did not have a care plan for his face and neck swelling. A review of Resident 62's clinical document titled, Progress Notes, dated 8/16/25, indicated, .@ [at] 0530 [5:30 AM] [Resident 62] complained of swelling with a burning sensation 3/10 [pain level on a 1-10 scale with 10 being the worst pain] to the right side of face and neck. Assessed the site. Skin color normal for ethnicity . Plan of care ongoing . During an interview on 8/28/25, at 11:11 AM, with the Director of Nursing (DON), the DON acknowledged there was not a care plan in place for Resident 62's face and neck swelling. The DON explained care plans were important so residents could get the proper treatment and a plan to resolve the issue. A review of an undated facility policy titled, Care Plans, Comprehensive Person-Centered, 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 . 2. A review of Resident 102's MDS (Minimum Data Set- a resident assessment and screening tool) Section GG (focusing on functional abilities and goals), dated 8/14/25, indicated Resident 102 required assistance of two (2) or more helpers to roll left and right. A review of Resident 102’s Care Plan initiated on 10/3/18, under the section, Focus, indicated, .the resident has Multiple Sclerosis [MS, a disease that causes breakdown of the protective covering of nerves. Multiple sclerosis can cause numbness, weakness, trouble walking, vision changes and other symptoms] affecting lower extremities. Further review of the document under the section, Interventions, indicated Resident 102 required 2 persons to assist with her ADLs. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/26/25, at 2:16 PM, with Resident 102, Resident 102 stated she was not happy with the care she received while being turned by staff. Resident 102 explained there was only one nursing aide who turned her while providing care. During a phone interview on 8/27/25, at 2:42 PM, with Certified Nursing Assistant (CNA) 3, CNA 3 confirmed that she had turned Resident 102 alone, without the assistance of another staff. During a concurrent interview and record review on 08/28/25, at 10:55 AM, with the Director of Staff Development (DSD), the DSD confirmed that CNA 3 had turned Resident 102 alone, when there should have been two CNAs providing care. The DSD stated it was important to follow Resident 102's care plan to ensure that the resident was receiving proper care, using the correct interventions, and to achieve goals for health conditions. Review of an undated facility policy titled, Repositioning, indicated, .Repositioning the Resident in Bed 1. Check the care plan…to determine resident’s specific positioning needs…and the number of staff required to complete the procedure .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview, and record review, the facility failed to provide adequate supervision and ensure an accident-free environment for one of three sampled residents (Resident 103) when, Resident 103 fell while left unsupervised and partially secured in her gurney, in a transportation vehicle during transportation to a dialysis clinic (outpatient facility that provides dialysis treatment to residents with end-stage renal disease (ESRD) or chronic kidney failure, helping to clean their blood of waste and excess fluid when their kidneys cannot) on 7/3/25.This failure potentially resulted in Resident 103 sustaining a mild compression fracture (when the bone is crushed or compressed but not completely broken) in the L3 (the third lumbar vertebra (bone) in the spine located in the lower back that supports body weight).Findings:A review of Resident 103's admission RECORD, indicated Resident 103 was admitted to the facility in 2021 with diagnoses which included chronic pain, hemiplegia and hemiparesis (weakness or paralysis on one side of the body) following cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to tissue damage or death) affecting the left non-dominant side, dependence on renal dialysis (a person's life relies on regular dialysis treatments to sustain life because their kidneys have lost most or all of their function), functional quadriplegia (a person is unable to move all four limbs due to severe disability or frailty, but without any underlying physical injury or damage to the spinal cord), and aphasia (a language disorder that affects a person's ability to communicate effectively due to damage to the area in the brain responsible for language processing).A review of Resident 103's nursing care plan, .ADLS [Activities of Daily Living; tasks necessary for basic personal care and independent living] . dated 10/21/21, indicated, .Focus: Resident has self-care deficit d/t [due to] left sided weakness .Requires 1-2-person dependent assistance [require total physical assistance from another person].Goal: Will be assisted by staff in performing ADLs which cannot be met by resident.Interventions: Monitor for any decline in ADL function.A review of Resident 103's nursing care plan, dated 6/15/25, indicated, .Focus: Resident requires safe and coordinated transport to/from medical appointments.Goal: Resident will be transported safely with no injury or adverse event.Interventions: Provide safety belts, positioning devices, and blankets as needed .A review of Resident 103's Progress Notes with the following dates and times indicated the following:1. 7/3/25, at 1 p.m., .VS WNL [vital signs such as blood pressure, heart rate, respiratory rate and temperature are within normal limits]. No new skin changes noted. Resident left to dialysis.2. 7/3/25, at 2:03 p.m., .Received call from dialysis that resident was sent to [name of hospital] due to resident having a fall in van and running a fever of 105.3. 7/3/25, at 6:36 p.m., .resident in hospital.4. 7/4/25, at 1:54 a.m., .Spoke to ER [emergency room] nurse.as per nurse resident on ATB [antibiotic; a medication used to fight off bad bacteria] for UTI [urinary tract infection; an infection in any part of the urinary system which includes the kidneys, ureters, bladder and urethra].5. 7/6/25 at 8:16 a.m. hospitalized .6. 7/7/25, at 1:28 p.m., .[General Manager (TRM 2)] expressed his plan of correction and apologized for the driver not following protocol.[name of transportation company] informed that the driver will be terminated [fired] and not following procedure of securing resident in the transport van.7. 7/18/25, at 7:14 p.m., Resident arrived at the facility around 16:22 [4:22 p.m.] via Stretcher from [hospital].DX [diagnosis] of UTI with sepsis [a serious condition in which the body responds improperly to an infection].8. 7/22/25, at 7:48 p.m., .Results received via fax. Resident is noted [with] mild compression [fracture] in L3.A review of Resident 103's emergency department (ED) records titled, ED Note - Physician, dated 7/3/25, the record indicated, .CHIEF COMPLAINT: BIBA [brought in from ambulance] from [name redacted] dialysis center. Pt [patient] resides at [name of skilled nursing facility]. Fever. HISTORY OF PRESENT ILLNESS: Patient.with history of chronic kidney disease on dialysis, nonverbal from previous CVA [cerebral vascular accident; also known as a stroke which is a medical condition where blood flow to the brain is disrupted, causing brain tissue damage] brought in by ambulance from [name of skilled nursing facility] for evaluation of fever, per report from EMS [Emergency Medical Services] patient had a maximum temperature of 102 at the facility. Patient unable to give adequate history because she is nonverbal [unable to speak] from previous CVA. There was no mention of Resident 103's fall from the gurney in the ED Note.A review of Resident 103's clinical record written by Resident 103's primary physician titled, Office Visit, dated 7/22/25, indicated .Family requesting Xray.Recent gurney [a medical stretcher on wheels for transporting residents] fall to ground patient complaining of increase pain in hip knee.Plan of care.Xray ordered.A review of Resident 103's clinical record titled, Radiology [specializes in the use of imaging techniques to diagnose and treat diseases] Interpretation, dated 7/22/25, indicated, LUMBER SPINE 2-3 View [an X-ray (imaging that takes pictures of