

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056216	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2025
NAME OF PROVIDER OR SUPPLIER Guardian Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>(continued on next page)</p>

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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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to ensure the use of supplemental oxygen was provided in accordance with professional standards of practice for two out of three sampled residents who received oxygen therapy (Resident 2, and Resident 3) when, oxygen in use signage was not posted at Resident 2's, and Resident 3's doorway. This failure had the potential to result in negative impacts on the health and safety of Resident 2, Resident 3, other residents in the facility, staff, and visitors.</p> <p>Findings: a. Review of Resident 2's admission RECORD indicated Resident 2 was admitted to the facility with diagnoses which included chronic atrial fibrillation (a persistent, long term irregular heart rhythm with symptoms including shortness of breath). Review of Resident 2's current order summary report indicated an active physician order dated 12/17/25 for oxygen therapy at 2 L/min (liter per minute, a unit of measure) via nasal cannula (two prongs that fit into the nostrils to deliver supplemental oxygen), to be administered as needed for shortness of breath, labored breathing. During an interview on 12/19/25 at 3:16 p.m., Licensed Nurse (LN) 3 stated Resident 2 was prescribed oxygen at 2 liters per minute via concentrator (a medical device that delivers concentrated, purified oxygen) as needed for shortness of breath. LN 3 further stated Resident 2 had diagnosis of atrial fibrillation and orthostatic hypotension (a form of low blood pressure that happens when standing after sitting or lying down), which required oxygen use for episodes of shortness of breath. During an observation on 12/19/25 at 3:11 p.m., Resident 2 was observed in a lying position in bed with an oxygen concentrator positioned on the floor to the right side of his bed; however, no Oxygen in Use signage was observed posted on Resident 2's doorway. During an observation on 12/23/25 at 8:40 a.m., Resident 2 was observed in his room receiving oxygen without Oxygen in Use signage posted on Resident 2's doorway. During a concurrent observation and interview at Resident 2's room on 12/23/25 at 8:50 a.m., Certified Nurse Assistant (CNA) 3 confirmed Resident 2 was receiving oxygen at 2 liters per minute via concentrator and confirmed that no oxygen in use signage was posted on his doorway. CNA 3 explained the importance of oxygen in use signage, stating it was necessary to prevent fire hazards and to alert staff, residents, and visitors that oxygen was being used in the room. During an interview on 12/23/25 at 10:26 a.m., LN 2 stated the purpose of posting oxygen in use signage was to alert nursing staff that the resident was receiving oxygen, to ensure resident safety and prevent fire hazards. LN 2 stated it was the responsibility of nursing staff to post oxygen in use signage when there was an active physician order for oxygen therapy. LN 2 further stated that nursing staff were expected to ensure oxygen in use signage was posted on the doorway of any resident receiving oxygen at the facility. b. Review of Resident 3's admission RECORD indicated Resident 3 was admitted to the facility with diagnoses which included unspecified combined systolic and diastolic congestive heart failure (a condition where the heart struggles to pump blood effectively, affecting both its ability to squeeze and relax), and chronic total occlusion of coronary artery (a complete blockage of a heart artery caused by severe buildup, leading to reduced blood flow, shortness of breath, chest pain, and fatigue). Review of Resident 3's current order summary report indicated an active physician order dated 11/24/25 for oxygen therapy at 2 L/min via nasal cannula, to be administered as needed for shortness of breath and/or comfort. During an observation in Resident 3's room on 12/19/25 at 3:14 PM Resident 3 was noted lying in his bed while receiving oxygen therapy at 2 L/min via an oxygen concentrator. No oxygen in use signage was observed posted on Resident 3's doorway. During a concurrent observation and interview on 12/19/25 at 3:16 p.m., in Resident 3's room Licensed Nurse (LN) 3 confirmed that Resident 3 was receiving oxygen at 2 L/min via an oxygen concentrator for shortness of breath. During a subsequent observation on 12/23/25 at 8:40 a.m., no oxygen in use signage was observed posted on Resident 3's doorway. During a concurrent observation and interview at Resident 3's room on 12/23/25 at 8:50 a.m., Certified Nurse Assistant (CNA) 3 confirmed that no Oxygen in Use signage was posted on Resident 3's room doorway. CNA 3 also confirmed that Resident 3 was receiving oxygen via an oxygen concentrator. CNA 3 explained that Oxygen in Use signage should be posted to alert staff, visitors, and residents that oxygen was in use in the room to maintain safety and prevent potential fire hazards. During an interview on 12/23/25 at 10:49 a.m., the Director of Staff Development (DSD) confirmed that nurses were responsible for posting oxygen in use signage on residents' doorways when oxygen was being used to prevent fire hazards and to meet residents' needs. During a concurrent interview and record review on 12/23/25 at 2:26 p.m., with the Assistant Director of Nursing (ADON) the facility provided policy and procedure (P&P) titled Oxygen Administration, revised September 2022 was reviewed. The ADON</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review the facility failed to provide food storage, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 93 residents who ate facility prepared meals when:1. Four sheet pans (sheet pan, a flat, rectangular metal pan with a raised rim on all four sides, used in ovens for baking, roasting, and broiling foods) were found with dark brown build-up; and,2. A food item (pie) in the freezer was not labeled with a use-by date and expiration date.These failures had the potential to expose 93 residents to foodborne illnesses (illnesses caused by the ingestion of contaminated food or beverages).Findings: 1. During a concurrent observation and interview conducted during the initial tour of the kitchen with the Dietary Supervisor (DS) on 12/19/25 at 10:47 a.m., a stack of four large sheet pans was observed stored in the clean rack, stacked on top of one another. Dark brown buildup was noted on the raised rims of all four sheet pans. The DS confirmed the finding. The DS stated that some of the sheet pans were old and required more thorough scrubbing. The DS further stated it was not acceptable when sheet pans were not washed properly, as residents consuming food prepared on those sheet pans could potentially be exposed to foodborne illness. The DS stated that he expected staff to scrub the sheet pans properly; however, his expectations were not met by dietary staff.During an interview on 12/19/25 at 12:16 p.m., the Dietary Aide (DA) stated that if dishes and pans were not completely cleaned, old food particles could come off into food, and residents could become ill from consuming contaminated food.During a concurrent observation and interview of the sheet pans conducted on 12/19/25 at 12:49 PM the Dietary Supervisor Assistant (DSA) stated that bacteria and mold could grow on those sheet pans and that anyone consuming food cooked on those pans could potentially develop foodborne illnesses. The DSA also stated that she checked all dishes, including sheet pans, and she did not know how she missed those items.During an interview on 12/19/25 at 1:07 p.m., the Dietary [NAME] (DC) explained the dishwashing process, and stated that all remaining food items were first removed from dishes, including sheet pans. The DC stated all dishes and pans were then scrubbed thoroughly with soap and water to ensure no food build up remains, rinsed with water, and placed in the dishwasher, and after washing, dishes were air-dried and then placed on the clean racks. The DC stated that when sheet pans were noticed to not be properly clean, the entire process would be repeated to ensure the items were clean and safe for use. The DC further stated that if food particles remain on dishes or pans, it would be unsafe for residents to consume food prepared and cooked in those items and could cause residents to become ill. During an interview on 12/23/25 at 2:26 p.m., the Assistant Director of Nursing (ADON) stated that it was not acceptable for dishes to be inadequately cleaned and that there was a risk of foodborne illness associated with consuming food prepared using improperly cleaned dishes.Review of the facility provided policy and procedure (P&P) titled, Sanitation, dated 2023 indicated, .The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving, and storing of food. PROCEDURE. 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair. The facility's P&P was not followed. According to the Food and Drug Administration (FDA) Food Code 2022, Section 4-601.11, Equipment, Food-Contact Surfaces required, . EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. 2. During a concurrent observation and interview conducted on 12/19/25 at 10:42 a.m., during the initial kitchen tour with the Dietary Supervisor (DS), an opened box of (brand name) pie was observed with an open date of 12/11/25; however, it did not have a use-by (the last day a food is recommended for consumption, meaning you should not eat it after this date) date, or expiration date. The item was located on the left side shelf inside the freezer near the door. The DS confirmed the finding and stated the pie had been left over from Christmas dinner held several days prior. The DS acknowledged that the pie should have been labeled with a use-by date and that the date was missing. The DS further stated that serving food past its use-by date was unsafe and could result in foodborne illness, posing a risk to residents and anyone consuming the product.During an interview on 12/19/25 at 1:07 p.m., the Dietary [NAME] (DC) stated that all food items stored in kitchen storage areas and other food preparation locations were required to be labeled with an open date, preparation date, use-by date, and expiration date to ensure residents' safety.During an interview on 12/23/25 at 2:26 PM, the Assistant Director of Nursing (ADON) stated food items should be labeled properly with all dates. ADON</p>		