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	01/02/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs for one out of three sampled residents (Resident 1), when Resident 1's call light (device used to contact staff for assistance) was not within Resident 1's reach.This deficient practice placed Resident 1 at increased risk for unmet care needs, delayed staff response, and potential for accidents or injury.Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses including senile degeneration of the brain (age-related changes in the brain that cause memory and thinking problems), parkinson's disease with dyskinesia (a brain condition that causes shaking, slow movement, stiffness, and balance problems, along with extra, uncontrolled movements that are often caused by Parkinson's medications), unspecified dementia (memory and thinking problems that interfere with daily life), chronic obstructive pulmonary disease (a long term lung disease that makes it hard to breathe), palliative care (care focused on comfort and relief from pain or symptoms during serious illness), depressive disorder, fracture right femur (break in the right thigh bone).During a concurrent observation and interview on 1/2/26, at 10:30 AM, with Resident 1, in Resident 1's room, Resident 1's call light was observed hanging from the left-side of the bed rail down to the floor. Resident 1 stated that she could not find her call light and that without the call light, staff would not be able to come right away if help was needed.During a concurrent observation and interview on 1/2/26, at 10:45 AM, with Certified Nurse Assistant (CNA) 1, in Resident 1's room, CNA 1 confirmed the call light was not in the proper place because it was hanging from the left side of the bed rail to the floor. CNA 1 stated that if Resident 1 tried to reach the call light, Resident 1 could fall. During a concurrent observation and interview on 1/2/26 at, 10:52 AM, with Licensed Nurse (LN) 1, in Resident 1's room, LN 1 confirmed the call light was not within Resident 1's reach because it was hanging from the left side of the bed rail to the floor. LN 1 stated that Resident 1 would not be able to get help right away if the call light was not within reach, which created a safety risk and could result in a fall.During an interview on 1/2/26, at 4:23 PM, with the Director of Nursing (DON), the DON stated that residents' call lights should always be within a resident's reach. The DON further stated that if a call light was not within reach, the resident was at risk for a fall. Review of Resident 1's Care Plan, revised on 12/12/25, in the section titled, Focus, indicated, . Unwitnessed fall. In the section titled, Interventions, indicated, .Keep call light within reach.Review of Resident 1's Care Plan, initiated on 12/17/25, in the section titled, Focus, indicated, .Fracture to right femur. In the section titled, Interventions, indicated, .Keep call light within reach.Review of the facility policy and procedure (P&P) titled, Answering the Call Light, revised 9/2022, indicated, .Ensure the call light is accessible to the resident when in bed.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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. Based on interview, and record review, the facility failed to submit a summary of investigation of an alleged unusual incident/injury report to the Department within five (5) working days, as required, following a fracture incident for one of three sampled residents (Resident 1).This failure placed Resident 1 at potential risk for further injury. Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility in 2025 under hospice care (comfort focused care for people who are seriously ill) with diagnoses including senile degeneration of the brain (age-related changes in the brain that cause memory and thinking problems), parkinson's disease with dyskinesia (a brain condition that causes shaking, slow movement, stiffness, and balance problems, along with extra, uncontrolled movements that are often caused by Parkinson's medications), unspecified dementia (memory and thinking problems that interfere with daily life), chronic obstructive pulmonary disease (a long term lung disease that makes it hard to breathe), palliative care (care focused on comfort and relief from pain or symptoms during serious illness), depressive disorder, fracture right femur (a break in the right thigh bone).Review of Resident 1's UNUSUAL INCIDENT/INJURY REPORT, dated and submitted to the Department on 12/16/25 by the Director of Nursing (DON), indicated that on 12/12/25 at 1:40 AM, Resident 1 was found sitting on the floor with no visible injury noted upon assessment. The UNUSUAL INCIDENT/INJURY REPORT, further indicated that on 12/15/25, Resident 1 underwent an X-ray (an imaging test that takes pictures of bones) due to right hip pain, which revealed a subacute fracture of the right femoral neck (healing or not new break in the upper part of the thigh bone near the hip).Review of Resident 1's X-ray results, dated 12/15/25, indicated, .SIGNIFICANT FINDINGS.RIGHT Hip X-Ray.Subacute fracture of the right femoral neck.During an interview on 1/2/26, at 9:38 AM, with the DON, the DON stated that she forgot to submit the summary of investigation of an alleged unusual incident/injury involving Resident 1 to the Department. The DON further stated that she was aware of the requirement to submit the report within five (5) working days.During a subsequent interview on 1/2/26, at 4:23 PM, with the DON, the DON stated that the purpose of the summary of the investigation for an alleged unusual incident or injury was to identify the root cause of the incident, share findings with staff through in-service education, and plan and implement appropriate interventions. The DON further stated that without the summary of investigation, interventions for the reported incident would not be implemented. Review of an undated facility policy and procedure (P&P) titled, Accidents and Incidents-Investigating and Reporting, indicated, .The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident.