

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 03/19/2026
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 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>Based on interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1)'s Responsible Party (RP, person responsible for making health care decisions), was informed and consented to the use of psychotropic medication (medication that alters perception, mood, consciousness and behavior) prior to administration of the medication. This failure deprived Resident 1's responsible party RP of the right to make an informed decision regarding Resident 1's care and resulted in Resident 1 receiving seven doses of a psychotropic medication against the RP's wishes. Findings: A review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnoses which included unspecified intellectual disabilities (condition that limits intelligence and disrupts abilities necessary for independent living). A review of Resident 1's clinical document titled, Nurse Note, dated 2/27/26, at 5:16 PM, indicated, .Resident was seen by psych NP [mental health nurse practitioner]. Orders below were noted & carried out by author. Start Buspirone [psychotropic medication for anxiety]. BID [twice daily] for anxiety disorder. A review of Resident 1's electronic health record (EHR) did not indicate informed consent was obtained for the medication. A review of Resident 1's clinical document titled, MEDICATION ADMINISTRATION RECORD [MAR], dated 2/1/26-2/28/26, indicated, .busPIRone [sic]. Give 1 tablet by mouth two times a day for anxiety m/b [manifested by] repetitive physical movement. The MAR further indicated that the medication had been administered on 2/28/26 at 9 AM and 9 PM. A review of Resident 1's MAR dated 3/1/26-3/31/26, indicated, Resident 1 received doses of buspirone as follows: 3/2/26 at 9 AM 3/9/26 at 9 PM 3/10/26 at 9 AM and 9 PM 3/11/26 at 9 AM During an interview on 3/19/26, at 1:58 PM, with Licensed Nurse (LN) 2, LN 2 stated informed consent was required prior to administering buspirone to Resident 1 due to the nature of the medication and all the side effects it could cause. LN 2 confirmed informed consent had not been obtained from Resident 1's RP prior to administering the medication. LN 2 stated when the facility did contact the RP, the RP stated they did not want Resident 1 to receive the medication. During an interview on 3/19/26, at 2:57 PM, with the Director of Staff Development (DSD), the DSD stated when an order was received for a psychotropic medication that staff were required to obtain informed consent from the resident or their RP before the medication was added to the MAR. The DSD further stated the resident, and their RP had the right to make informed decisions about their care. During a review of an undated facility policy titled, Resident Rights, the policy indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be notified of his or her medical condition and of any changes in his or her condition. be informed of, and participate in, his or her care planning and treatment. During a review of an undated facility policy titled, Psychotropic Medication Use, the policy indicated, .Residents will not receive medications that are not clinically indicated to treat a specific condition. Residents, families and/or the representative are involved in the medication management process .The IDT [interdisciplinary team, healthcare team who assess and coordinate care] must obtain a resident/representative written informed consent for treatment using psychotherapeutic drugs.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to ensure a clean, comfortable, and home-like environment for a census of 99 when: 1. Shower room [ROOM NUMBER] contained black discoloration on the flooring tiles and in the cracks where the floor met the wall, the shower head and handle contained areas of white discoloration, the emergency call light string had brown and pink discoloration and was stuck to the wall, the metal container that held the soap had orange rust on the right side, 2. The baseboard on the hallway shared by station 1, station 2 and the kitchen, was pulling away from the wall and was compacted with dust and debris, the baseboard appeared water damaged; and, 3. The plastic protective covering on the wall in room [ROOM NUMBER] behind bed B, was peeling away from the wall with gaps containing dust. The vinyl baseboard was cracked and peeling away from the wall and contained dust and debris. These failures had the potential to negatively affect the residents' physical and psychosocial well-being. Findings: 1. During a concurrent observation and interview on 3/19/26, at 11:50 AM, in shower room [ROOM NUMBER], with certified nurse assistant (CNA) 1, CNA 1 confirmed the shower room was used to bathe residents. CNA 1 further confirmed there were dark black stains on the flooring, the grout, and in the cracks where the wall and floor met. CNA 1 confirmed there were white stains on the shower head and the shower handle, brown/pink discoloration on the string connected to the call light, and rust on the soap container holder. CNA 1 stated the shower room was dirty, and it should not be. During a concurrent observation and interview on 3/19/26, at 1:26 PM, in shower room [ROOM NUMBER] with the Director of Maintenance (DOM) the DOM scraped the black substance on the floor and between the flooring cracks with a knife. The DOM stated the substance appeared to be mildew. The DOM further stated the white stains on the shower head and handle appeared to be hard water stains. The DOM confirmed there appeared to be rust on the soap holder and it should be replaced. The DOM stated the call light string appeared to be mildewed and stuck to the wall and should be replaced. The DOM further stated the mildew in the shower room was not good for the residents' health. 2. During a concurrent observation and interview on 3/19/26, at 1:16 PM, in the hallway shared by station 1, station 2 and the kitchen with the Maintenance Assistant (MA), the MA stated due to budget constraints the facility had been waiting on materials to fix the baseboard. The MA further stated the kitchen's dish room was behind the wall and a leak in the garbage disposal caused moisture to get into the wood. The MA confirmed there was an accumulation of dust and cobwebs where the baseboard was pulling away from the wall and that the area was difficult to clean. During a concurrent observation and interview on 3/19/26, at 1:20 PM, in the hallway shared by station 1 and 2 and the kitchen with the DOM, the DOM stated the wall and baseboard had been like that for approximately 6 months. The DOM further stated they would replace the whole lower section of the wall and the baseboard. The DOM stated it was not good for the residents to breath in the dust and debris. 3. During a concurrent observation and interview on 3/19/26, at 1:30 PM, in room [ROOM NUMBER] with the DOM, the DOM confirmed the protective wall covering and the baseboard behind bed B were pulling away from the wall and accumulating dust and debris. The DOM stated the dust accumulation was not good for the resident. During an interview on 3/19/26, at 2:42 PM, with the DOM, the DOM stated the maintenance department provided books at each station for staff to indicate needed repairs. The DOM further stated maintenance staff checked the books three times per day. The DOM stated his staff performed weekly rounds in the resident rooms to determine if repairs were needed. The DOM further stated the area in room [ROOM NUMBER] behind bed B may have been missed due to the resident being in bed when his room was checked. During an interview on 3/19/26, at 3:03 PM, with the Infection Preventionist (IP), the IP stated the mildew in shower room [ROOM NUMBER] could get residents sick. TH IP further stated there was risk of residents getting sick from (continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>breathing dust and debris in the hallway and in room [ROOM NUMBER]. During an interview on 3/19/26, at 4:09 PM, with the Administrator (ADM), the ADM acknowledged the findings that were observed earlier in the facility with the DOM. During a review of an undated facility policy titled, Homelike Environment, the policy indicated, .Residents are provided with a safe, clean, comfortable and homelike environment.The facility and staff management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.clean, sanitary and orderly environment. During a review of an undated facility policy titled, Maintenance Service, the policy indicated, .Functions of the maintenance personnel include.maintaining the building in good repair and free from hazards.The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>