

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 08/29/2025
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)		
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. 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 (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 0689 Level of Harm - Actual harm Residents Affected - Few	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 the inside of your body) study of the lower back that includes two to three different images taken from specific angles]: Mild compression fracture in L3.Review of Resident 103's Nurses Note, dated 7/23/25, the record indicated, .Resident was see by MD [medical doctor] on 7/22. X-ray reviewed, resident was noted w/ [with] compression fx [fracture] on L3.MD instructed writer to f/u [follow-up] w/ [name of doctor redacted, Resident 103's primary physician] on treatment secondary to L3 compression fx findings.During an interview on 7/27/25, at 11:29 a.m., Certified Nursing Assistant (CNA) 5 stated Resident 103 was on total care (resident reliant on staff to meet all needs) on 7/3/25. CNA 5 stated during the transport to the dialysis clinic on 7/3/25, Resident 103 was secured on the gurney with two out of three safety belts. CNA 5 explained, Resident 103 was secured by two safety belts; one was around the hip and the second one around the legs. CNA 5 stated Resident 103 was not secured by the safety belt around the chest area. CNA 5 stated she did not know if Resident 103 needed to have a safety belt secured in place around the chest area. CNA 5 stated instead of sitting in the back seat of the transportation van she sat in the front seat next to the driver. CNA 5 stated during transportation inside the transportation van Resident 103 was sitting upright in the gurney with her head elevated. CNA 5 stated on the way to the dialysis clinic, when the van made a left turn, she heard a sound. CNA 5 stated she turned around to look at the back of the van and saw Resident 103's upper body was out of the gurney while Resident 103's leg was still secured in the gurney. CNA 5 stated Resident 103 had rolled halfway from the gurney to the van floor. CNA 5 stated the driver of the transportation van stopped the vehicle and both the driver and CNA 5 went to the back of the van and put Resident 103 back in the gurney. CNA 5 stated when she placed Resident 103 back in the gurney Resident 103 had no safety belt secured around her chest area. CNA 5 further stated that upon arrival at the dialysis clinic she notified Licensed Nurse (LN) 9 (nurse whom worked at the dialysis clinic) that Resident 103 fell from the gurney inside the transportation van on the way to the dialysis clinic. CNA 5 stated LN 9 took Resident 103's temperature and notified CNA 5 that Resident 103 had to go to the emergency room due to a high temperature and the fall from the gurney. CNA 5 stated she should have checked that Resident 103 had a safety belt secured in the chest area. CNA 5 stated since she sat in front of the transportation van she did not have direct visual of Resident 103. CNA 5 stated she should have had visual of Resident 103 the whole-time during transportation. CNA stated the risk of not checking the safety belts fastened resulted in Resident 103 falling from the gurney. CNA 5 stated Resident 103 could have injured her head from the fall.During an interview on 8/27/25, at 12:07 p.m., the Staffing Coordinator (SC) stated CNA 5 had notified her that Resident 103 fell out of the gurney inside the transportation van during transportation to dialysis (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	emergency room visit notes and ambulance report did not contain documentation regarding Resident 103's fall from the gurney prior to arrival at the emergency room. Review of an undated facility policy titled, Safety and Supervision of Residents, the policy indicated, .Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Resident supervision is a core component of the systems approach to safety.risk factors and environmental hazards include the following: a. Bed safety.falls.Review of an undated facility policy titled, Fall Risk Assessment, the policy indicated, .The staff will seek to identify factors that may contribute to falling .Review of an undated facility policy titled, Transportation, Diagnostic Services [medical tests, examinations, and procedures used to identify or diagnose a health condition], the policy indicated, .A member of the nursing staff, or social services, will accompany the resident to the diagnostic center when the resident's family is not available. The nursing staff must always monitor and seat next to the residents .The nursing staff must check if residents are strapped in their seats, safe and secure.Review of the facility staff job descriptions titled, Certified Nursing Assistant, dated 2003, the document indicated, .Make resident comfortable.Assist in transporting residents to/from appointments.Assist with lifting, turning, moving, positioning, and transporting residents into and out of beds, chairs, bathtubs, wheelchairs, lifts etc.Ensure that residents who are unable to call for help are checked frequently.Assist with the application of slings, elastic bandages, binders, etc. [et cetera; and other similar things].Follow established safety precautions in the performance of all duties.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to implement and maintain a comprehensive QAPI (QAPI- a data driven and proactive approach to improvement used to ensure services are meeting quality standards) program and plan when the facility did not adhere to its QAPI policy and did not provide documentation or evidence of ongoing QAPI activities. These failures had the potential to impede the facility's ability to identify and correct quality of care issues which could place the residents at risk for unmet physical, psychosocial, and overall health needs. Findings: During a concurrent interview and record review on 8/29/25, at 1:55 PM, the Administrator (ADM) reviewed the QAPI program and confirmed that they did not have an appropriate monitoring and documentation portion of the QAPI program. Review of the QAPI binder showed no evidence of detailed monitoring, follow-up, or documentation of QAPI activities. The ADM acknowledged that documentation of the QAPI program should have been completed and confirmed the program lacked sufficient details and follow-through. The ADM also acknowledged that the QAPI policy was not comprehensive, required revision, and lacked clear guidelines for implementation. Furthermore, the ADM confirmed that while the committee had been meeting on a quarterly basis, the facility was not following its QAPI policy. During a review of an undated facility policy and procedure titled, Quality Assurance and performance Improvement (QAPI) Program, indicated, .Key components of this process include: a. tracking and measuring performance. f. monitoring or evaluating the effectiveness of corrective actions/performance improvement activities, and revising as needed. 3. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan.		

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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&hellip;to determine resident&rsquo;s specific positioning needs&hellip;and the number of staff required to complete the procedure .		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure professional standards of quality care were met for 2 of 32 sampled residents (Resident 83 and Resident 10), with the potential to affect the full census of 92 when: 1. Resident 83's bilateral foot pain was not assessed for over 24 hours after the licensed nurse (LN) was notified, 2. Wounds on Resident 10's right forearm were not assessed for over 48 hours; and, 3. Staff providing resident care could not communicate in English. These failures resulted in a delayed assessment, treatment, and pain control for Resident 83 and delayed assessment and treatment for Resident 10. In addition, these failures had the potential to negatively affect Resident 83 and Resident 10's health and well-being and had the potential for all residents in the care of non-English speaking staff to have unmet care needs. Findings: 1. A review of Resident 83's admission RECORD, indicated Resident 83 was admitted to the facility with diagnoses which included type 2 diabetes (a disease in which the blood glucose or blood sugar levels are too high) with foot ulcer (an open sore or wound on the foot that results from the breakdown of skin and underlying tissues). During a concurrent observation and interview on 8/26/25, at 10:25 AM, with Resident 83, in Resident 83's room. Resident 83 stated he was concerned about his toes. Resident 83 further stated he had his toenails trimmed on 8/19/25. Resident 83 explained his toenails had been long prior to his appointment and he was starting to get feeling back in his toes. Resident 83 further explained his toes 'really hurt' and the bottom of his feet hurt also. Observation of Resident 83's feet showed two blackened nickel sized areas on each of Resident 83's great toes. Resident 83 stated he had not informed his nurse and stated it was okay for the Department to inform his nurse. During an interview on 8/26/25, at 10:30 AM, with LN 10 (Resident 83's day shift [work hours 6:30 AM to 3 PM] nurse), LN 10 was informed that Resident 83 was experiencing pain in his feet and had blackened areas on his great toes. LN 10 stated she would follow up with Resident 83. During a subsequent interview on 8/27/25, at 9:40 AM, with Resident 83, Resident 83 stated LN 10 never came in to ask him about the pain in his feet and had not spoken to him about his toes. Resident 83 explained his feet and toes were causing him constant pain, at a pain level of 7 (pain scale 1-10 with 10 being the worst pain). Resident 7 further explained the pain, especially in his great toes was keeping him awake at night. During a concurrent observation and interview on 8/27/25, at 9:46 AM, with LN 11 (Resident 83's day shift nurse), LN 11 stated if she had been informed a resident was experiencing pain she would do an assessment. LN 11 explained she would assess the site of pain, do a skin assessment and notify the physician if there were any issues. LN 11 further explained if there were any issues she would carry out any physician orders. LN 11 performed a skin and pain assessment on Resident 83 in Resident 83's room. Resident 83 informed LN 11 that he had a constant pain level of 7 and the bottom of his feet and great toes hurt. LN 11 asked Resident 83 if she could look at his feet, Resident 83 stated yes. LN 11 donned (put on) gloves, lifted the blanket and observed the blackened areas on Resident 83's great toes. LN 11 stated Resident 83 was prone to diabetic ulcers (an open sore or wound, often on the feet, that fails to heal properly due to complications of diabetes). LN 11 further stated LN's did full assessments daily and the blackened areas on Resident 83's great toes should have been noted. LN 11 stated the blackened areas looked like diabetic ulcers. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/27/25, at 9:58AM, with the Director of Nursing (DON), the DON stated her expectations were if a resident had a complaint of pain, it was the LN's responsibility to assess the resident and notify the physician if it was a new onset of pain. The DON explained the certified nursing assistants (CNA) needed to report any skin issues to the LN. During an interview on 8/27/25, at 9:59 AM, with LN 10, LN 10 stated she had not written a progress note regarding Resident 83's foot and toe pain. LN 10 stated she had not looked at Resident 83's toes on 8/26/25. A review of Resident 83's untitled clinical document from the podiatrist's (foot doctor) office, dated 8/19/25, indicated, .Plan .Check feet daily . During a joint interview on 8/27/25, at 2:54 PM, with both LN 11 and LN 12, LN 11 and LN 12 stated they should have known about the podiatry consult from 8/19/25 and should have put in the 'check feet daily' as an order and had not. During an interview, on 8/27/25, at 3:10 PM, with LN 13 (Resident 83's PM shift [work hours 2:30 PM to 11 pm] nurse on 8/26/25), LN 13 stated LN 10 had not informed her of Resident 83's new onset of pain in his feet on 8/26/25, during change of shift. During an interview on 8/27/25, at 3:14 PM, with LN 1, LN 1 stated Resident 83's new onset of pain in his feet should have been reported to the oncoming shift. LN 1 stated informing the oncoming shift was important because Resident 83's feet could have been assessed to rule out infection. LN 1 explained the risk to Resident 83 was his toes could have been infected and could have caused sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection). LN 1 stated since Resident 83's pain and blackened great toes had not been assessed and reported to anyone that there was a delay in care for Resident 83. LN 1 further stated the physician would have wanted to be informed of Resident 83's change in condition. During an interview on 8/27/25, at 3:37 PM, with the DON, the DON stated the process for getting the podiatry notes if the packet did not come back with the resident, was to call podiatry to get the report. The DON explained LNs should have followed up with the podiatry office when Resident 83's packet was not available to carry out physician's orders. The DON further explained when LN 10 was informed of Resident 83's new onset of pain and the blackened areas on his great toes, she should have assessed Resident 83 right away. The DON stated the importance was to prevent pain and infection. The DON stated Resident 83 was at high risk for infection. A review of an undated facility policy titled, Pain Assessment and Management, indicated, .The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.Acute [sudden] pain (or significant worsening of chronic [long-term] pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. 2. A review of Resident 10's admission RECORD, indicated Resident 10 was admitted to the facility with diagnoses which included depression (is a mood disorder that causes a persistent feeling of sadness and loss of interest). During an observation on 8/26/25, at 10:28 AM, with Resident 10, in resident 10's room, Resident 10 was in bed, appeared to be sleeping, wearing a short-sleeved shirt. Nine dime sized scabs were (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visible on Resident 10's right forearm. During a record review of Resident 10's Electronic Health Record (EHR), there was no documented evidence of the nine dime sized scabs on Resident 10's forearm being assessed. Further review of the record did not show any progress notes, change in condition, or care plans regarding the nine dime sized scabs on Resident 10's forearm. During a concurrent observation and interview on 8/28/25, at 2:07 PM, with Resident 10, in Resident 10's room, Resident 10 was lying in bed, wearing a short-sleeved shirt, with the nine dime sized scabs on his right forearm with noted red raised areas around the scabs. Resident 10 stated the scabs did not itch but were a little painful. Resident 10 further stated he had had the scabs for about 2 months. During an interview on 8/28/25, at 2:13 PM, with LN 13, LN 13 stated she had not asked Resident 10 about the scabs on his right forearm. During an interview on 8/28/25, at 2:14 PM, with LN 14, LN 14 stated she had observed the scabs but did not ask Resident 10 about the scabs. During a concurrent observation and interview on 8/28/25, at 2:16 PM, with the DON, in Resident 10's room, the DON confirmed the presence of the nine dime sized scabs on Resident 10's right forearm. The DON stated her expectation was for the LNs to write a progress note, do a change in condition, care plan it, and notify the physician and resident representative. The DON further stated the importance was to prevent infection and complications before the areas got worse. A review of an undated facility policy titled, Change in a Resident's Condition or Status, indicated, .Our facility promptly notifies the resident, his or her attending physician.of changes in the resident's [NAME]/mental condition and/or status.The nurse will notify the resident's attending physician.when.discovery of injuries of unknown source.significant change in the resident's physical.condition.A significant change of condition is a major decline or improvement in the resident's status that.will not normally resolve itself without intervention by staff.Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the [physician]. 3. A review of Resident 48's admission RECORD, indicated, he was admitted to the facility in late 2024. A review of Resident 48's minimum data set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) dated 7/18/25, indicated, .Section C-Cognitive Patterns.Brief Interview for Mental Status (BIMS) [a tool used to screen for cognitive impairment]. indicated, a score of 15 points which suggested that cognition was intact. During an interview on 8/26/25, at 10:01 AM, with Resident 48, Resident 48 stated not all of the CNAs who cared for him spoke English or understood what was said to them. Resident 48 stated he could not name the CNAs who did not speak English because there were too many of them. A review of Resident 36's admission RECORD, indicated, she was admitted to the facility in late 2022 with diagnoses which included chronic obstructive pulmonary disease (COPD, lung condition that causes long-term breathing difficulties). (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 36's MDS dated [DATE], indicated, .Section C-Cognitive Patterns.Brief Interview for Mental Status (BIMS). indicated, a score of 12 points which suggested a moderate cognitive impairment. During an interview on 8/26/25, at 1:06 PM, with Resident 36, Resident 36 stated the staff did not speak English and did not understand her needs. Resident 36 further stated when she required her nebulizer (machine that delivers medication in a fine mist to improve breathing status) the non-English speaking staff just looked at her and did not understand her request. A review of Resident 6's admission RECORD, indicated, he was admitted to the facility in early 2023. A review of Resident 6's MDS dated [DATE], indicated, .Section C-Cognitive Patterns.Brief Interview for Mental Status (BIMS). indicated, a score of 15 points which suggested that cognition was intact. During an interview on 8/26/25, at 3:17 PM, with Resident 6, Resident 6 stated a lot of the staff did not speak English. Resident 6 further stated the non-English speaking staff did not understand his needs. A review of a facility provided document titled, RESIDENTS COUNCIL MEETING, dated 7/29/25, indicated, .Residents had said the CNA's and Nurses continue to talk in their Language and that they can't understand the English residents what they are asking for and that the residents can't understand them. During a telephone interview on 8/27/25, at 12:32 PM, with CNA 3, CNA 3 stated, via [NAME] translator, she worked the night shift because she did not speak English. During a concurrent interview and employee file review on 8/28/25, at 10:55 AM, with the Director of Staff Development (DSD), The DSD stated CNA 3 spoke only basic English. The DSD further stated CNA 3 required a staff member to interpret for her when she had received her orientation and subsequent trainings. During a concurrent interview and record review on 8/29/25, at 8:54 AM, with the Director of Nurses (DON), the DON stated it was her expectation that all staff would be able to communicate with the residents and speak in English. The DON further stated there was a risk to the residents of unmet care needs if the staff could not communicate with them. The DON confirmed the facility's CNA job description indicated staff should be able to speak and read in English. A review of a facility job description titled, Certified Nursing Assistant, dated 2023, indicated, .The primary purpose of your job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and plan of care.Specific Requirements.Must be able to read, write, speak, and understand the English language. A review of an undated facility policy titled, STAFF COMMUNICATION, indicated, .All nursing staff must adhere to standardized communication practices that support resident safety, continuity of care, and compliance with federal, state, and facility guidelines.		

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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 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, and record review, the facility failed to ensure medications were administered to meet professional standards of practice for 1 out of 32 sampled residents (Resident 7), when Resident 7's medication Midodrine (a blood pressure medication used to treat low blood pressure) was administered outside of physician ordered parameters (standard guidelines from the physician, used to categorize a patient's blood pressure reading and determine the proper course of treatment). This failure had the potential for Resident 7 to experience hypertension (high blood pressure, can damage the arteries and increase the risk of heart disease, and other health problems). Findings: A review of Resident 7's admission RECORD, indicated Resident 7 was admitted to the facility with diagnoses which included hypotension (low blood pressure). A review of Resident 7's clinical document containing physician orders, indicated, .Order Date .12/18/24 .Midodrine .by mouth .1 tablet .two times a day .hold if SBP [systolic blood pressure - the upper number on a blood pressure reading] > [greater than] 120 . A review of Resident 7's clinical document titled, Care Plan Report, revised 7/2/25, indicated, .Focus .Resident [7] has Hypotension .On Midodrine . Goal .The resident will maintain BP [blood pressure] within acceptable range as determined by [physician] .Give medications as ordered . A record review of Resident 7's clinical document titled, Medication Administration Record, (MAR) dated 8/1/25 through 8/31/25, indicated Resident 7's medication Midodrine was administered outside of the physician ordered parameters on 16 out of 53 opportunities for the month of August 2025. During an interview on 8/29/25, at 8:23 AM, with licensed nurse (LN) 5, LN 5 stated she would administer the medication midodrine for low blood pressure. LN 5 explained the parameters for midodrine were in the physician's order. During a concurrent interview and record review on 8/29/25, at 9:32 PM, with the Director of Nursing (DON), the DON stated the order for Resident 7's medication midodrine was to be held for a SBP greater than 120. The DON reviewed the following dates of administration on Resident 7's August 2025 MAR as follows: August 2025, 9 AM administration: 8/3 122/608/10 126/788/24 124/768/25 124/728/26 128/77 August 2025, 5 PM administration: 8/10 124/728/11 126/708/13 126/628/14 122/708/15 122/808/16 134/898/17 128/768/18 122/708/19 124/688/22 126/708/24 128/78 The DON confirmed midodrine was administered to Resident 7 with the above BPs and were outside of the physician ordered parameters. The DON explained the midodrine should not have been administered for the above BP's. The DON further explained it could have caused hypertension. A review of the facility policy titled, Administration Procedures For All Medications, revised 8/2014, indicated, .Prior removing the medication package/container from the cart/drawer .Check for vital signs .prior to medication administration .Notification of Physician .Held medications for pulse, blood pressure .resulting in medications being held .		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure the provision of care and services to ensure 1 of 32 sampled residents (Resident 80) maintained his highest level of function when staff did not provide range of motion (ROM, the full movement of a joint) exercises to his extremities or hand hygiene to his contracted (shortening or hardening of muscles, tendons, or other tissue leading to a deformity and rigidity of joints) right hand.This failure had the potential for Resident 80 to experience a physical decline, worsening of right arm and hand contractures, and infection to his right hand.Findings:A review of Resident 80's admission RECORD, indicated he was admitted to the facility in early 2024.A review of Resident 80's clinical document titled, Care Plan Report, indicated, .Focus.Resident has a self care deficit. Requires 1-2 person extensive total assistance in ADL's [Activities of Daily Living, personal care tasks which include bathing, dressing, eating, and transferring in and out of bed].RUE [right upper extremity] contracture [A permanent tightening of the muscles, tendons, skin] .Goal.risk of complications due to self care deficit will be minimized with interventions.Interventions.Incorporate ROM exercises during care.Monitor/document/report.any s/sx [signs/symptoms] of immobility: contractures forming or worsening.skin breakdown.A review of Resident 80's minimum data set (MDS, a federally mandated resident assessment and screening tool which identifies care needs) Section GG-Functional Abilities, indicated, .Functional Limitation in Range of Motion.Upper extremity (shoulder, elbow, wrist, hand).1. Impairment on one side.A review of Resident 80's clinical documentation of care provided titled, Task: Incorporate ROM exercise during care every AM [morning] & PM [evening] Shift, indicated, .Amount of time spent providing Range of Motion. the document indicated: .Not Applicable. for the following dates and shifts: AM and PM shift for the dates of 8/4/25, 8/13/25, 8/15/25, 8/18/25, and 8/24/25.AM shift for the dates of 8/17/25, 8/19/25, 8/21/25, 8/22/25, and 8/23/25.PM shift for the dates of 8/6/25, 8/7/25, 8/8/25, 8/9/25, 8/10/25, 8/11/25, 8/12/25, 8/14/25, and 8/16/25.During an interview on 8/28/25, at 3:23 PM, with Certified Nurse Assistant (CNA) 10, CNA 10 stated, when she provided ROM for Resident 80, she documented the number of minutes the care was provided. CNA 10 further stated if Resident 80 refused ROM she documented Resident Refused. CNA 10 stated she documented not applicable if she did not perform ROM with Resident 80 or if he was asleep when she went in the room.During a concurrent observation and interview on 8/29/25, at 8:35 AM, with the Assistant Director of Nurses (ADON), in Resident 80's room, the ADON confirmed Resident 80's contracted right hand had a strong odor. The ADON further confirmed Resident 80's fingers were curled tightly into the palm of his hand. The ADON stated Resident 80's right hand should be clean, and a hand roll should have been in place to prevent his fingers from digging into his hand. The ADON provided hand hygiene to Resident 80, which resulted in a brown, crusty residue on the washcloth. During a concurrent interview and record review on 8/29/25, at 8:47 AM, with the ADON, the ADON confirmed Resident 80's clinical document indicated, Not Applicable for ROM over multiple days and shifts for the month of August 2025. The ADON stated that without ROM care, Resident 80 was at increased risk of contracture and limited mobility. The ADON further stated staff should have provided daily care to Resident 80's right hand, including using a splint or rolled washcloth to prevent his fingers from digging into his palm. The ADON stated Resident 80 was at risk of skin breakdown and infection if the care was not provided.A review of a facility policy titled, Activities of Daily Living (ADLs), Supporting, revised 3/18, indicated, .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.including.hygiene.mobility.Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs.A review of an undated facility policy and procedure titled, Range of Motion Exercises, indicated, .The purpose of this procedure is to exercise the resident's joints and muscles.The following information should be recorded in the resident's medical record.The date and (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time that the exercises were performed.If the resident refused the treatment, the reason(s) why and the intervention taken.Notify the supervisor if resident refuses the exercises.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview, and record review, the facility failed to ensure that physician-ordered weekly weights were completed for 1 out of 3 sampled residents (Resident 43) when Resident 43's weekly weight order was not carried out by staff. This failure resulted in Resident 43 experiencing an unmonitored 10-pound weight loss over one month (from 132 pounds on July 3, 2025, to 122 pounds on August 3, 2025), placing the resident at risk for further nutritional compromise and decline. Findings: Review of Resident 43's admission RECORD, indicated Resident 43 was admitted to the facility with multiple diagnoses including type 2 diabetes mellitus with other specified complication (high levels of sugar in the blood) and paraplegia, unspecified (inability to voluntarily move the lower parts of the body). Review of Resident 43's clinical record titled, "Order Recap Report, (summary listing of a resident's order by the physician), indicated that Resident 43's weight should be monitored weekly as ordered by the physician on 7/1/25 with a start date of 7/7/25. During a concurrent interview and record review on 8/28/25, at 10:38 a.m., with the Restorative Nurse Assistant (RNA 1), Resident 43's medical records were reviewed. RNA 1 confirmed that staff did not follow the doctors' order of monitoring and documenting Resident 43's weight every week. During a concurrent interview and record review on 8/28/25, at 11:22 a.m., with Licensed Nurse (LN 6), Resident 43's Physician orders were reviewed. LN 6 confirmed that Resident 43's medical records contained a physician's order directing staff to check the resident's weight weekly; however, there was no documentation showing the orders were completed by the staff. LN 6 stated that Resident 43's weight loss would have been prevented if the order was followed. During a concurrent interview and record review on 8/28/25, at 10:54 a.m., with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), the ADON and the DON reviewed Resident 43's medical record and validated that staff had not been checking Resident 43's weight weekly as ordered. The ADON and the DON both agreed that Resident 43's weight loss could have been prevented if the order to weigh the resident weekly was carried out by staff. Review of Resident 43's undated clinical record titled, Care Plan Report, (document that outlines a person's specific needs, goals, and the services or interventions required to meet them, ensuring consistent and coordinated care from various providers and caregivers), indicated that "Weekly Weights x 4 weeks. Review of an undated facility policy titled, Following Physician Orders, indicated, "It is the policy of this facility that all clinical staff shall carry out physician orders as prescribed. 2. Implementation. Orders must be carried out as prescribed and within the timeframe indicated."		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview, and record review, the facility failed to provide the necessary behavioral health care and services for 1 of 32 sampled residents (Resident 81) when a referral was not made to a psychiatrist (psych, a medical doctor who can diagnose and treat mental health conditions) or psychologist (psych, scientific discipline that studies mental states and processes and behavior in humans) for Resident 81 who had a behavior of food hoarding (keeping or storing food for long periods of time before consuming or discarding the food). This failure had the risk for Resident 81's behavioral health care needs being unmet. It also had the potential for Resident 81 to eat spoiled food and cause a food borne illness. Findings: A review of Resident 81's admission RECORD, indicated Resident 81 was admitted to the facility with a diagnosis of, but not limited to, inappropriate diet and eating habits. During a concurrent observation and interview on 8/26/25, at 1:49 PM, with Resident 81, Resident 81's bed was observed with multiple food trays. Resident 81 stated he was saving the food trays because he liked to eat a little from time to time. Resident 81 further stated he could not eat a lot of food and preferred to consume the food in small frequent intervals. During an interview on 8/26/25, at 2:05 PM, with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 81 would get angry when the staff took the trays out and threw out the old food in the garbage. CNA 1 further stated Resident 81 took his food trays and did not allow staff to touch them. During a concurrent observation and interview on 8/27/25, at 8:57 AM, with License Nurse 2 (LN), LN 2 stated Resident 81 preferred to independently place his food trays and return them. LN 2 further stated the CNAs always offered to take the food tray out but Resident 81 would refuse all the time. LN 2 stated that Resident 81 had been educated by staff of the risks of keeping food items at the bedside but Resident 81 asked the nurse not to educate him, stating that he knew what he was doing. LN 2 further stated Resident 81's behavior with food hoarding could possibly cause an illness and infection to Resident 81 when he consumed the food. During an observation on 8/27/25, at 9:46 AM, Resident 81 was observed sleeping in bed with a stack of trays containing drinks and small containers of food sauces at the foot of the bed. During a subsequent observation on 8/27/25, at 1:36 PM, Resident 81's meal trays were still observed on his bed. There were several sauces on his bedside table, along with glasses of milk, two of which that were dated from the previous day (8/26/25). During a concurrent interview and record review on 8/28/25, at 8:54 AM, with the Director of staff development (DSD), Resident 81's medical record was reviewed. The DSD stated Resident 81 hoarded food, and when the nursing staff tried to remove the food, he would get mad. The DSD further stated Resident 81 was educated about the behavior and the facility created a care plan for his behavior. Resident 81's care plan dated 5/4/22, was reviewed with the DSD, indicating Resident 81 had a behavior of storing/hoarding food items at bedside. The DSD stated interventions included explaining to Resident 81 the risk of keeping milk products beyond an hour could cause food poisoning and a psychiatry evaluation as indicated. During a concurrent interview and record review on 8/28/25, at 9:36 AM, with the Infection preventionist (IP), Resident 81's medical record was reviewed. The IP stated Resident 81 was noncompliant because he was refusing to let staff from taking the trays out. The IP further stated the nurse explained the risks of noncompliance of the food safety policy, and the risk of food borne illnesses. The IP stated the nursing staff continued to encourage Resident 81 to let them pick up his food trays. The IP further stated Resident 81 had a behavior of hoarding food and drinks ever since he came to the facility. The IP stated there was no psychiatric referral sent because there was no indication for Resident 81 to be seen, even if it was included in the care plan. During a concurrent interview and record review on 8/28/25, at 10:42 AM, with the Social Service Director (SSD), the SSD confirmed a psychiatric consult referral was not sent for Resident 81. During an interview on 8/28/25, at 1:11 PM, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON stated Resident 81 had a behavior of storing and hoarding food items at bedside. The DON further (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the facility staff educated Resident 81 with the risks of food hoarding and Resident 81 understood. The DON stated Resident 81 was not referred to a psychiatrist or a psychologist. The DON stated they did not speak to their medical doctor about Resident 81's behavior. A review of an undated facility policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered, indicated, .The comprehensive, person-centered care plan .b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including .which professional services are responsible for each element of care .A review of an undated facility P&P titled, Referrals, Social Services, indicated, .Social services shall coordinate most resident referrals .Referrals for medical services must be based on physician evaluation of resident need and a related physician order. A review of an undated facility P&P titled, Behavioral Health Services, indicated, .The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe medication handling practices with a resident census of 92 based on the facility's policy and standards of practice when:1. Medication delivery documents from the provider pharmacy were not consistently signed and documented upon receipt from delivery courier for accuracy and accountability of prescription medication receipt; and, 2. Non-controlled prescription (non-opioid drugs that only prescribed by a doctor) medication destruction and disposition were not consistently documented with co-signature witness by two licensed staff. These failed practices could contribute to unsafe drug handling and risk of drug diversion (drug loss due to unauthorized use). Findings:1. During a concurrent observation and interview with Licensed Nurse (LN) 15, in Station 1 medication room, on 8/26/25, at 9:32 AM, the record for medication receipts and delivery was reviewed. The white binder had sheets of delivery record from the provider pharmacy. The paper sheets titled Packing Slips, listed the name and quantity of medications delivered and a space for nurse signature. The unsigned delivery sheets included controlled medications and non-controlled(non-opioid) prescription medications. The delivery receipts were not consistently signed by a licensed staff including the narcotic medications delivery sheets. LN 15 acknowledged the findings and stated they received delivery from the pharmacy provider early mornings or late afternoons. LN 15 stated there were two sheets to sign, one given to driver and one copy goes in the binder. LN 15 acknowledged the section on the Packing Slip, indicated, By signing below you acknowledge that the items above have been received: Supervising Nurse Print name.Signature.Date.Nurse Print name.Signature.Date.During an interview with the Director of Nursing (DON), in her office, on 8/27/25, at 11:18 AM, the DON stated the medication delivery documents per policy should be signed by licensed staff receiving it.During a telephone interview with facility's consultant Pharmacist (CP), on 8/29/25, at 8:30 AM, the CP stated the standard medication delivery procedure was for the receiving nurse to verify the accuracy of delivery and accountability of prescription drug delivery.Review of the facility's policy titled, Accepting Delivery of Medications, dated 7/2016, the policy indicated, All staff shall follow a consistent procedure in accepting medications.A licensed nurse shall receive medication delivery to the facility.Before signing to accept the delivery, the nurse will reconcile the type, number, form and strength of medications in the package with the delivery ticket/order receipt .A nurse shall sign the delivery ticket indicating review and acceptance of the delivery and shall keep a copy of the delivery ticket. Both the receiving nurse and the delivery agent must sign any notation about errors. The delivery ticket shall be archived in a designated location.2. During a concurrent interview, record review, and inspection of Station 2 medication room, with LN 11, on 8/26/25, at 10:02 AM, the destruction record for prescription medications was reviewed. The destruction record indicated the discontinued prescription medications and listed the name and quantity of the medication disposed of along with a signature space for co-signers (a person that witnessed the medication destruction). The records further indicated there was no co-signature by a licensed staff for non-controlled medications destruction. LN 11 acknowledged the witness signatures were missing from the non-narcotic disposition documentation.During a telephone interview with the CP, on 8/29/25, at 8:30 AM, the CP stated two licensed nurses as witnesses needed for destruction of prescription medication. CP stated witness signatures was a safe practice for accountability and preventing risk of diversion.During an interview with the DON, in her office, on 8/27/25, at 11:18 AM, the DON stated non-controlled drug destructions are done by night shift nurses or the charge nurses and the records should be co-signed per facility's policy.Review of the facility's policy titled, Discarding and Destroying Medications, dated 7/2016, the policy indicated, Medication that cannot be returned to the dispensing pharmacy.will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances.The medication (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disposition record must contain, as a minimum, the following information: The residents name, Date medication destroyed.Quantity destroyed.Method of destruction.Signature of witnesses. Completed medication disposition record shall be kept on file in the facility.as mandated by state law governing the retention and storage of such records.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview, and record review, the facility failed to assess and review the long-term use of two medications, part of a class of drugs called Protein Pump Inhibitors (or PPI, a class of drugs that reduce stomach acid production and works by inhibiting the enzyme known as the proton pump, which is responsible for generating acids for food digestion), on two out of five residents reviewed for unnecessary medications (Resident 7 and Resident 36) based on FDA (or Food and Drug Administrations, a federal agency that addresses safety of medication use) and the manufacturer warnings on long term use of PPI medications. These failures could pose risks of adverse drug effects on vulnerable elderly residents. Findings: 1. During a review of Resident 7's electronic medical record, dated 8/27/25, the record indicated Resident 7 was admitted to the facility with multiple medical conditions including diabetes (blood sugar disease), mental health issues, epilepsy (a condition characterized by recurrent seizures when disruption of brain activity cause jerking movements and loss of consciousness), and gastro-esophageal reflux disease (or GERD, when stomach acid flows back up into the esophagus and causes heartburn) among others. The record did not indicate any history of recent or current intestinal (stomach) bleeding or complaints. Review of Resident 7's Medication Administration Record (or MAR, a document that listed medications administered), dated 8/2025, the MAR record indicated a PPI drug called pantoprazole was used to treat GERD since 2021 and was renewed on 5/2024 as follows: Pantoprazole, tablet 40 MG (or Prtonix, Acid reducing drug; MG is milligram, a unit of measure); Give 1 tablet by mouth in the morning related to GASTRO-ESOPHAGEAL REFLUX DISEASE (or GERD) WITHOUT ESOPHAGITIS (inflammation of the esophagus, the tube that connects the mouth to the stomach); Active since 5/8/2024. During a concurrent interview with Licensed Nurse (LN 1), and review of Resident 7's medical records, at Station 2, on 8/29/25, at 8:30 AM, LN 1 stated the pantoprazole was actually started in 2021 upon admission to the facility for history of stomach bleeding. LN 1 confirmed since admission there had not been any notes or concerns regarding the GERD, upset stomach or bleeding in the medical doctor or nursing notes. LN 1 stated the Medical Doctor (MD 1) saw the residents yesterday (8/28/25) with no notes or orders on pantoprazole. 2. During a review of Resident 36's electronic medical record, dated 8/27/25, the record indicated Resident 36 was admitted to the facility with multiple medical conditions including diabetes, mental health issues, heart and breathing issues including blood clot in the lungs, and gastro-esophageal reflux disease among others. The record did not indicate any history of recent or current intestinal (stomach) bleeding or complaints. Review of Resident 36's MAR, dated 8/2025, the MAR record indicated a PPI drug called omeprazole was used to treat GERD since 10/20/22 and it was renewed on 1/2025 as follows: Omeprazole Oral Capsule, .20 MG (or Prilosec, stomach acid reducing drug); Give 1 capsule by mouth in the morning related to GASTRO-ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS; Active: 1/29/25. During a concurrent interview with LN 1, and review of Resident 36's medical records, at Station 2, on 8/29/25, at 8:35 AM, LN 1 stated the omeprazole was actually started in 2022 upon admission to the facility. LN 1 confirmed since admission there had not been any notes or concerns regarding the GERD, upset stomach or bleeding in the medical doctor or nursing notes. LN 1 stated MD 1 saw the residents yesterday (8/28/25) with no notes or orders for GERD diagnosis. Phone calls to MD 1 office on 8/28/25 and 8/29/25 were not returned. During a telephone interview with the facility's Consultant Pharmacist (CP), on 8/29/25, at 11:51 AM, the CP stated he started helping the facility the previous month, July 2025. The CP was aware of FDA warnings and side effects of long-term use of the PPI including pneumonia, C. diff (or Clostridium difficile, a stomach infection), and magnesium level in body (an element that helped with healthy heart rhythm, nerves, muscles, and bone fracture). The CP confirmed no recommendation was provided to the facility or the medical doctor to reassess the long-term use of PPI on Resident 7 and Resident 36. During an interview with the Director of Nursing (DON), in her office, on 8/29/25, at 11:51 AM, the DON stated the long-term use of PPI should have (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been re-assessed since there was no complaint about stomach issues and she relied on the pharmacy and doctors to address. Review of a drug alert warning by FDA on long term use of PPI, with date range of 5/25/2010, 2/8/2012, and 8/4/2017, the FDA had issued warnings about the potential risks associated with long-term use of proton pump inhibitors (PPIs, i.e. protonix and omeprazole), including increased risk of fractures, hypomagnesemia (low magnesium level; Magnesium, a vital mineral that plays a crucial role in various bodily functions, including nerve and muscle function, bone health, and maintaining a steady heartbeat), and certain infections like Clostridium difficile (or C. Diff, a stomach infection that can lead to severe diarrhea). The FDA links were accessed on 8/29/25 via 1. https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fda-drug-safety-commur, 2. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-clostridium-difficile-assc, and 3. https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-low-magnesium-levels-i. Review of a Centers for Medicare & Medicaid Services (CMS) Medicaid Integrity Group document, dated 10/2015, titled, Proton Pump Inhibitors Use in Adults, last accessed on 8/29/25 via https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/medicaid-integrity-education/pharmacy the document indicated the FDA has issued several warnings regarding the long-term use of proton pump inhibitors (PPIs), including the risk of fractures, hypomagnesemia (low magnesium level), C. difficile infection (a type of bowel infection), and potential kidney problems. The FDA also recommends using the lowest effective dose and shortest duration of therapy. Review of Beer's criteria (Beers Criteria, also known as the American Geriatrics Society (AGS) Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, is a set of guidelines that help healthcare professionals identify medications that may be harmful or unnecessary for older adults), dated 4/2023, last accessed on 8/29/25 via https://www.americangeriatrics.org/media-center/news/many-older-adults-take-multiple-medications-updated-i and https://sbgg.org.br/wp-content/uploads/2023/05/1-American-Geriatrics-Society-2023.pdf, the document indicated, Treating GERD with a PPI for longer than 8 weeks should be avoided for most older adults. Rationale: Risk of C difficile infection, pneumonia.bone loss and fractures.Recommendation: Avoid scheduled use for >8 weeks [more than 8 weeks] unless for high-risk patients.Strength of Recommendation: highReview of the drug information for pantoprazole, accessed via DailyMed (a website by National Library of Medicine and Food and Drug Administration or FDA, a federal government entity that provides information about approved drugs), last accessed on 9/2/25 via https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=6b5ed424-2203-482f-bb85-2c97d9c356f2, the record under Warnings and precautions indicated, .Published observational studies suggest that PPI therapy like pantoprazole sodium may be associated with an increased risk of Clostridium difficile associated diarrhea, especially in hospitalized patients.Several published observational studies suggest that PPI therapy may be associated with an increased risk of osteoporosis-related fractures of the hip, wrist, or spine. The risk of fracture was increased in patients who received high dose, defined as multiple daily doses, and long-term PPI therapy (a year or longer). Patients should use the lowest dose and shortest duration of PPI therapy appropriate to the condition being treated. Patients at risk for osteoporosis-related fractures should be managed according to established treatment guidelines.Hypomagnesemia, symptomatic and asymptomatic, has been reported rarely in patients treated with PPIs for at least three months, and in most cases after a year of therapy. Serious adverse events include tetany, arrhythmias, and seizures. Hypomagnesemia may lead to hypocalcemia and/or hypokalemia and may exacerbate underlying hypocalcemia in at-risk patients. In most patients, treatment of hypomagnesemia required magnesium replacement and discontinuation of the PPI.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in one out of two medication rooms (a locked room used to store medications and supplies) and one out of four medication storage carts (a mobile cart stored medications and supplies needed for administration) with a resident census of 92 when: 1. Unlabeled discontinued prescription medication box called Kristalose (or lactulose, a laxative drug in power packet form also used to treat liver disease) was stored in the active storage areas of the medication room at Station 1. 2. Expired (outdated) medication called Dorzolamide/Timolol eye drop (DOROZOL/TIMOLOL or Cosopt, two drugs in one bottle, used to treat glaucoma, an eye disease that damages the eye nerves which leads to vision loss) was stored in the active medication storage cart at station 1B. These failed practices could contribute to unsafe medication storage and use of outdated eye drops into a resident's eye. Findings: 1. During a concurrent observation, interview, and inspection of the facility's medication room at Nurse Station 1, on 8/26/25, at 9:02 AM, accompanied by Licensed Nurse (LN) 15, an unlabeled box of prescribed medication called Kristalose (lactulose) packet box, listed as Rx only (Rx only means that the medication is for prescription use only, requiring a valid prescription from a licensed healthcare provider and dispensed by a pharmacist) was stored with active Over-The-Counter (or OTC, drug that does not require a doctor's prescription) medications. LN 15 acknowledged the findings and stated that the prescribed medications should be destroyed when residents no longer needed them. LN 15 stated she did not know who the medication had belonged to. During an interview on 8/27/25, at 11:19 AM, with the Director of Nursing (DON), the DON stated all discontinued non controlled medications (a pharmaceutical preparation that is not regulated by strict government controls which include both prescription and the over-the-counter drugs) were destructed by night shift nurses, and or the desk nurse. The DON further stated discontinued medications should not be stored with active medications in the medication storage areas. During a phone interview, on 8/29/25, at 8:30 AM, with the Pharmacy Consultant (PC), the PC stated that discontinued non-controlled prescribed medications should be destroyed by 2 nurses and should not be stored in active storage areas in the medication room. Review of the facility's policy titled, MEDICATION ORDERING, RECEIVING AND STORAGE, revised on July 2016, indicated, . DISCARDING AND DESTROYING MEDICATIONS. Medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by the resident, and/or medications left by residents upon discharge) will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals. Policy Interpretation and Implementation. 2. Non-controlled. will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. Review of the facility's policy titled, Medication Ordering and Receiving From Pharmacy . Medication Labels, revised in August 2014, indicated . Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels. Procedures. G. Medication labels are not altered, modified, or marked in any way by nursing personnel. 2. During a concurrent observation, interview, and inspection of the facility's medication storage cart 1B at Nurse Station 1, on 8/26/25, at 9:38 AM, accompanied by LN 15, the eye drop medication called COSOPT was found to be outdated (or expired; no longer should be used) with expiration date of 8/17/25. LN 15 acknowledged the finding and stated that the outdated medication should be removed from the active medication storage cart and should not be used for any resident. During an interview, on 8/26/25, at 10:02 AM, in the medication storage room, at Nurse Station 2, LN 11 stated expired and outdated medications should be removed from active medication storage carts and disposed of in the pharmaceutical waste container. LN 11 further stated medication (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	destruction logs should be signed by the nurse destructing it and by a second nurse as a witness.During an interview, on 8/27/25, at 11:19 AM, with the DON, the DON stated that the facility was routinely inspecting all medication storage carts every week, and night shift nurses and/or desk nurse were responsible for destructing the expired and outdated medications. The DON further stated that expired and outdated medications should be removed from the active medication storage carts as soon as possible per the facility's policy.Review of the facility's policy titled, Storage of Medications, revised on 8/2014, indicated, .Expiration Dating (Beyond-use dating.C. Certain medications or package types, such as. ophthalmic [eye drug] .require an expiration date.to insure medication purity and potency.F. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.		

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 08/29/2025
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.			
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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident make transportation arrangements to and from radiology services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have 1 of 32 sampled residents (Resident 48) ready in time for a neurologist (medical specialist in the treatment of disorders of the nervous system) appointment. This failure resulted in Resident 48 feeling upset and frustrated due to the missed appointment and had the potential to delay his treatment. Findings: Review of Resident 48's admission RECORD, indicated Resident 48 was admitted to the facility in late 2024 with diagnoses including hemiplegia and hemiparesis (weakness or paralysis one side of the body) following a nontraumatic intracerebral hemorrhage (bleeding within the brain tissue) affecting the left non-dominant side, and polyneuropathy (a condition where multiple peripheral nerves [nerves that extend outside the brain and spinal cord] in the body become damaged). During a concurrent observation and interview on 8/28/25, at 4:44 PM, in Resident 48's room, Resident 48 and his family member (FM) 1, were visibly upset. Resident 48 stated that he had missed an important first appointment with a neurologist at 2:30 PM. Resident 48 stated he had been waiting for over 4 months to see the specialist and was particularly concerned about treatment for a condition involving a missing piece of skull bone and sciatic nerve (largest nerve that runs from the lower back down to the feet) pain. Resident 48 explained they were over 20 minutes late because his Certified Nurse Assistant (CNA) 6 did not get him ready on time. Resident 48 stated he felt frustrated due to the lack of communication between the staff and about the mechanical lift (a device that uses mechanical assistance to safely move and transfer individuals with limited mobility) not being nearby when needed. Resident 48 stated the transportation driver (TR) 1 was there at 1:30 PM, but CNA 6 did not come in until after 1:20 PM to get Resident 48 ready. During an interview on 8/29/25, at 8:43 AM, CNA 6 confirmed they were assigned to Resident 48 on 8/28/25. CNA 6 stated the process of getting a resident ready for transport included getting the resident dressed, transferred from bed to a wheelchair, and securing them in the vehicle. CNA 6, assisted by Restorative Nurse Assistant (RNA) 2, said it was known that it usually took about 45 minutes to transfer Resident 48 due to his preferred leg positioning with the mechanical lift. CNA 6 stated Resident 48 initially refused to get ready when she asked just after noon, but CNA 6 did not document the refusal, inform a charge nurse (CN), or ask for assistance. CNA 6 confirmed she had to ask CNA 9 to find a mechanical lift. During an interview on 8/29/25, at 10:16 AM, CNA 9 confirmed that CNA 6 asked her to search the facility to find a mechanical lift and bring it to Resident 48's room. During an interview on 8/29/25, at 9:17 AM, Resident 48 and FM 1 both confirmed FM 1 arrived at the facility on 8/28/25 at 11:30 AM. FM 1 stated she was early because she wanted to make sure Resident 48 received his pain medication at noon prior to them transferring him with the mechanical lift. Resident 48 and FM 1 both confirmed the nurse medicated Resident 48 for pain around noon, but no one came to get Resident 48 ready until it was almost time to leave. Resident 48 and FM 1 both stated Resident 48 never refused to get ready for the appointment as he had been anticipating it for months. During an interview on 8/29/25, at 11:07 AM, TR 1 stated he was outside Resident 48's room at the scheduled pick-up time of 1:30 PM, but Resident 48 was not ready. During an interview on 8/29/25, at 9:41 AM, the Social Services Director (SSD) confirmed Resident 48 had an appointment scheduled since April 2025 with the neurologist in [NAME], a 30-minute drive from the facility, with a pick-up time of 1:30 PM. The SSD stated the missed appointment could delay Resident 48's care. During an interview on 8/29/25, at 11:26 AM, the Assistant Director of Nursing (ADON) stated the process for getting a resident ready for an appointment started with the social services department scheduling the appointment. The ADON explained the day of the appointment the CNAs were alerted by the charge nurse (CN) at the beginning of their shift of the appointments and pick up times. The ADON stated the CNAs were responsible for getting the residents up, dressed, and ready to go before their scheduled pick-up time by transportation. The ADON explained the expectation was if a resident refused to get ready, the CNAs (continued on next page)		

Department of Health & Human Services
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F 0778 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were to attempt to ask the residents again and then document in the medical record, and alert the CN for assistance. The ADON stated it was important for residents to make their scheduled appointments and the risk of missing them was a delay in the residents' care, treatment, and a possible delay in discharge from the facility.A review of the facility's Transportation Sign In/Out Log, dated 8/28/25, indicated, .Resident Name [Resident 48].Date 8-28-25.Arrival Time [of driver TR1] 1:30 PM.Time Left Facility.2:20 PM.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure safe infection prevention and control practices for 5 of 12 residents (Resident 45, Resident 67, Resident 39, Resident 102, and Resident 49) observed for medication administration when shared glucometers (a device used to measure how much glucose (sugar) is present in the bloodstream at a given moment in time) were not cleaned and sanitized in between resident use. These failures had the potential to spread infection and cause health problems for residents in the facility. Findings: 1. During a medication administration observation with Licensed Nurse (LN) 3, on 8/26/25, at 11:15 AM, LN 3 used a glucometer (glucometer 1) to measure Resident 45's blood sugar. LN 3 placed supplies in a tray and went into the room with the supplies. With gloved hands, LN 3 poked the left middle finger with a lancet (small, sharp objects that are used to prick the skin to get drops of blood); then soaked the test strip (a strip that is attached to glucometer to measure the sugar level) with Resident 45's blood to measure the sugar level. Afterward, LN 3 exited the room and placed the glucometer on the top of the mobile medication cart just outside of Resident 45's room. LN 3 removed one sanitizing wipe called Super Sani-Cloth (brand name sanitizer wipe used by facility) and cleaned the outer surface of the glucometer for less than 5 seconds then left it on the top of the cart to dry. 2. During the next medication administration observation with LN 3, on 8/26/25, at 11:24 AM, LN 3 used the second glucometer (glucometer 2) to measure Resident 67's blood sugar. LN 3 placed supplies in a tray and went into the room with the supplies. With gloved hands, LN 3 poked the left ring finger with a lancet then soaked the test strip with Resident 67's blood to measure the sugar level. Afterward, LN 3 exited the room and placed the glucometer on the top of the mobile medication cart just outside of Resident 67's room. LN 3 used one sanitizing wipe called Super Sani-Cloth and cleaned the outer surface of the glucometer for less than 5 seconds then left it on the top of the cart to dry. 3. During the third medication administration observation with LN 3, on 8/26/25, at 11:29 AM, LN 3 used glucometer 1 to measure Resident 39's blood sugar. LN 3 placed supplies in a tray and went into the room with the supplies. LN 3 with gloved hands, poked Resident 39's finger with a lancet to get drops of blood, then put the drop of blood on the test strip attached to glucometer 1 to measure the blood sugar. Afterward, LN 3 exited the room and placed the glucometer on top of the mobile medication cart just outside Resident 39's room. LN 3 used one sanitizing wipe called Super Sani-Cloth and cleaned the outer surface of the glucometer for less than 5 seconds then left it on the top of the cart to dry. 4. During the fourth medication administration observation with LN 3, on 8/26/25, at 11:32 AM, LN 3 used glucometer 2 to measure Resident 102's blood sugar. LN 3 placed supplies in a tray and went into the room. LN 3 with gloved hands, poked Resident 102's left middle finger with a lancet to get drops of blood, put the drop of blood on the test strip attached to glucometer 2 to measure the blood sugar. Afterward, LN 3 exited the room and placed the glucometer on top of the mobile medication cart just outside Resident 102's room. LN 3 used one sanitizing wipe called Super Sani-Cloth and cleaned the outer surface of the glucometer for less than 5 seconds then left it on the top of the cart to dry. 5. During the fifth medication administration observation with LN 3, on 8/26/25, at 11:55 AM, LN 3 used glucometer 1 to measure Resident 49's blood sugar. LN 3 placed supplies in a tray and went into the room. LN 3 with gloved hands, poked Resident 49's left thumb finger with a lancet to get drops of blood, then soaked the test strip attached to glucometer with Resident 49's blood to measure the sugar level. Afterward, LN 3 exited the room and placed the glucometer on top of the mobile medication cart just outside Resident 49's room. LN 3 used one sanitizing wipe called Super Sani-Cloth and cleaned the outer surface of the glucometer for less than 5 seconds then left it on the top of the cart to dry. During an interview with LN 3, on 8/27/25, at 11:06 AM, LN 3 confirmed that she performed blood sugar checks for Resident 39, Resident 45, Resident 49, Resident 67, and Resident 102 on 8/26/25 prior to lunch time. LN 3 stated she used two glucometers alternatively while each was drying. LN 3 acknowledged that she cleaned both glucometers with one wipe quickly and did not (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use a second wipe to sanitize the devices or to keep the outer surfaces wet for 2 minutes as recommended per Super Sani-Cloth instruction. LN 3 further stated, it skipped my mind to do the second step of sanitizing. During an interview with the Infection Preventionist (IP), on 8/27/25, at 11:54 AM, the IP stated there was a two-step process for cleaning and sanitizing a glucometer, and nursing staff should use two wipes, one to clean the glucometer thoroughly and the other to sanitize the glucometer, and keep it wet as per instruction on the sanitizing wipe bottle. The IP further stated if glucometers were not cleaned and sanitized properly there would have been the risk of spreading infection to other residents in the facility. During an interview with the Director of Nursing (DON), in her office, on 8/29/25, at 11:51 AM, the DON stated she expected the nursing staff to follow best practices and manufacturer specification on cleaning and sanitizing the shared glucometers. Review of the undated glucometer manufacturer instruction sheet, provided by the facility, for the [Brand Name] Blood Glucose Monitoring System, the information sheet under .Cleaning and Disinfecting Procedures indicated .Two disposable wipes will be needed for each cleaning and disinfecting procedure; one wipe for cleaning and a second wipe for disinfecting. Wipe the entire surface of the meter 3 times horizontally and 3 times vertically using one towelette to clean blood and other body fluids. Dispose of the used towelette in a trash bin. The meter should be cleaned prior to each disinfection step. Pull out 1 new towelette and wipe the entire surface of the meter 3 times horizontally and 3 times vertically using a new towelette to remove blood-borne pathogens (germs). Review of the undated label on the container on the Super Sani-Cloth germicidal wipe (wipe that kills germs) used by the facility indicated, .use a wipe to remove visible soil prior to disinfecting. Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Use second germicidal wipe to thoroughly wet surface. Allow surface to remain wet two (2) minutes, let air dry. Precleaning is to vigorous wiping and/or scrubbing and all visible soil is removed. from right to left or left to right. top to bottom. to minimize the organism [germs]. Review of the facility's undated document, titled, Blood Sampling - Capillary (Finger Stick), provided by the facility, the document indicated, .The purpose of this procedure is to guide the safe handling of a capillary-blood sampling [blood from finger] devices to prevent transmission of bloodborne diseases to residents and employees. General Guidelines 1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. Steps in the Procedure. 8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use. The facility did not follow the procedures put in place for shared glucometer cleaning and sanitizing.		