

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>47369</p> <p>Based on interview, and record review, the facility failed to ensure accurate and complete documentation for one of three residents sampled (Resident 2) when Resident 2 was transferred to an acute care hospital and the facility did not document the date and time of her transfer, where she transferred to, how she was transported, or the disposition of her personal effects and her medications.</p> <p>This failure had the potential to negatively impact resident 2's continuity of care and had the potential risk of her receiving inadequate care or services.</p> <p>Findings:</p> <p>A review of Resident 2's ADMISSION RECORD, indicated she was readmitted to the facility in February of 2024 with diagnoses which included chronic obstructive pulmonary disease (COPD-long term lung disease that causes shortness of breath and cough) and urinary tract infection.</p> <p>A review of Resident 2's Progress Notes, indicated, 2/11/2024 19:09 [7:09 PM] .resident receiving acute care outside of facility . on 2/12/24, at 12:51 AM the notes indicated, .Sent out to hospital.</p> <p>A review of Resident 2's SBAR [Situation, Background, Appearance, Review and Notify] Communication Form, dated 2/11/24, at 6:15 PM, indicated, .resident was shaking uncontrollably when asked to grab fingers tightly; resident receiving acute care outside of facility .Recommendations of Primary Clinicians .did not receive response, sent SBAR at 1930 [7:30 PM] did not receive a fax receipt; sent again around 2130 [9:30 PM] .</p> <p>During a concurrent interview and record review on 3/21/24, at 3:16 PM, the Director of Nurses (DON) confirmed Resident 2's health record did not contain a physician's order for transfer to the hospital. The DON further confirmed a transfer form, or other documentation was not completed to indicate when resident 2 was transferred to the hospital, how she was transferred or which hospital she was transferred to. The DON stated the documentation should have been completed.</p> <p>A review of a facility policy and procedure titled, Transfer or Discharge, Emergency, revised August 2018, indicated, .should it become necessary to make an emergency transfer or discharge to a hospital .our facility will implement the following procedures .Notify the resident's Attending Physician .Notify the receiving facility that a transfer is being made .Prepare a transfer form to send with the resident .</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47369</p> <p>Based on interview, and record review, the facility failed to ensure professional standards of practice were followed for one of three sampled Residents (Resident 1) when Resident 1 did not receive her medication as prescribed, and the physician was not informed the medication was unavailable for administration.</p> <p>This failure had the potential to negatively impact the health and well-being of Resident 1.</p> <p>Findings:</p> <p>Resident 1 was admitted to the facility in March of 2024 with diagnoses which included chronic obstructive respiratory disease (COPD, long term lung disease that causes shortness of breath and cough).</p> <p>A review of Resident 1's Order Summary Report, indicated, .Trelegy Ellipta inhalation [medication used to make breathing easier and improve lung function] .1 puff inhale orally [by mouth] one time a day for dyspnea [shortness of breath] .start date 3/14/24 .</p> <p>A review of Resident 1's progress notes indicated the medication was unavailable on 3/16/24, 3/17/24, 3/18/24, 3/19/24, and 3/20/24.</p> <p>During an interview on 3/20/24, at 10:33 AM, Resident 1 stated the facility did not have her Trelegy inhaler yet. Resident 1 further stated sometimes her breathing was worse because she did not receive the medication.</p> <p>During a concurrent interview and record review on 3/20/24, at 1:21 PM, licensed nurse (LN) 1 stated today was his first day working with Resident 1 and he noticed the inhaler was missing during his medication pass. LN 1 further stated when a medication was not available, he called the pharmacy. LN 1 stated if the medication was unavailable on the second day, the issue was elevated to a pharmacist to have the medication delivered as soon as possible. LN 1 stated if the medication continued to be unavailable, he would contact the Director of Nurses (DON).</p> <p>A review of Resident 1's progress notes dated 3/16/24, at 2:10 PM, indicated, .Trelegy Ellipta .pharm [pharmacy] was notified about med not in cart, spoke to [name] .who stated meds are delivered on 3/14/24. staff unable to find med in all med cart. Spoke to [pharmacy] and requested a refill to [sic] soon form to be send to facility .</p> <p>During a concurrent interview and record review of Resident 1's progress notes on 3/20/24, at 2:04 PM, the DON confirmed the Trelegy inhaler for Resident 1 had been documented as not available on 3/16, 3/17, 3/18, 3/19, and 3/20/24. The DON stated Resident 1 was at risk of experiencing increased respiratory symptoms when she did not receive her inhaler as ordered. The DON further stated when a medication was unavailable for administration the physician should be informed. The DON stated the physician could readjust the orders to meet the resident needs. The DON confirmed there was no documentation to indicate the physician was informed that several doses of the inhaler were missed.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/21/24, at 12:01 PM, the DON stated the Trelegy inhaler had been delivered to the facility by the pharmacy on 3/14/24 at midnight. The DON further stated the inhaler may have accidentally been placed in the medication destruction pile in the medication room.</p> <p>During a concurrent interview and record review on 3/21/24, at 3:02 PM, the DON confirmed the inhaler was documented as destroyed on the medication destruction form dated 3/17/24.</p> <p>A review of a facility provided pharmacy policy titled Medication Administration-General Guidelines, revised 10/2017, indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices .If a vital medication is withheld, refused, or not available the physician is notified. Nursing documents the notification and the physician response .</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47369</p> <p>Based on interview, and record review, the facility failed to provide a safe environment for one of three sampled residents (Resident 2) when Resident 2 fell from bed while her fitted sheet was being replaced.</p> <p>This failure resulted in Resident 2 receiving lacerations (deep cut or tear of skin) to her left great toe, right knee, a nosebleed, and a hematoma (pooling of blood from ruptured vessels, causing a bump under the skin) to her forehead.</p> <p>Findings:</p> <p>A review of Resident 2's ADMISSION RECORD, indicated she was admitted to the facility in the fall of 2007 with diagnoses which included chronic obstructive pulmonary disease (COPD-long term lung disease that causes shortness of breath and cough) and morbid obesity (being 80 - 100 pounds above an individuals recommended weight).</p> <p>A review of Resident 2's Progress Notes, dated 2/10/24, at 10:21 PM, indicated, .pt [patient] fell out of bed, the CNA [certified nurse assistant] stated that CNA was giving a bed bath and turned pt over to put a fitted sheet on bed, pt was holding on to side rail and let go, pt fell face first with injuries to the nose and hematoma to the forehead, big left toe has laceration, right knee has laceration, and nose was bleeding .</p> <p>During an interview on 3/21/24, at 11:09 AM, CNA 1 stated on the day of the fall he had completed Resident 2's bed bath and was changing the fitted sheet underneath her. CNA 1 further stated Resident 2 was turned on her side facing away from him, she was holding on to the short rail, similar to a handlebar, with two hands. CNA 1 stated the sheet was under Resident 2 on her side and he was pulling it toward him. CNA 1 stated he was not sure if Resident 2 had lost focus, but she suddenly let go of the rail and he was unable to hold on to her and prevent the fall. CNA 1 further stated Resident 2 was on an air mattress and it may have been too soft.</p> <p>A review of Resident 2's Minimum Data Set (MDS, a resident assessment and screening tool) Section GG, dated 12/7/2023, indicated, .Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on bed . the section was coded 02 which indicated, .Substantial/maximal assistance-Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort .</p> <p>A review of Resident 2's care plan initiated 1/5/2023, indicated, .[Resident 2] has a self care ADL [Activities of Daily Living, activities related to personal care] deficit r/t [related to] weakness, SOB [shortness of breath], .Obesity .Interventions/Tasks .needs 2 person limited to extensive assist with bed mobility .</p> <p>A review of Resident 2's care plan initiated 1/5/2023, indicated, .[Resident 2] is at risk for falls . Interventions/Tasks .Follow facility fall protocols .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/21/24, at 2:34 PM, the Director of Nurses (DON) stated the CNA's could view the residents care plans on their electronic charting system. The DON further stated the system indicated information detailing how many staff were needed to provide care for the residents. The DON further stated the CNA's should review their residents care information.</p> <p>A review of a facility policy and procedure (P&P) titled, Repositioning, revised May 2013, indicated, . Repositioning the Resident in Bed .Check the care plan .to determine resident's specific positioning needs including .resident level of participation and the number of staff required to complete the procedure .</p> <p>A review of a facility P&P titled, Fall Risk Assessment, revised March 2018, indicated, .The nursing staff .and others, will seek to identify and document resident risk factors for falls and establish a resident- centered falls prevention plan based on relevant assessment and findings .The staff .will evaluate .factors that may increase fall risk, including ambulation, mobility .</p>		