

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  09/27/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47369</p> <p>Based on interview, and record review, the facility failed to ensure professional standards of care were met for three out three sampled residents (Resident 1, Resident 2, and Resident 3) who sustained falls, when post fall charting (documentation of assessments and observations) was not documented for Resident 1, Resident 2 or Resident 3.</p> <p>This failure had the potential for Resident 1, Resident 2, and Resident 3 to have unassessed injuries, untreated pain, and/or underlying illnesses.</p> <p>Findings:</p> <p>1a. A review of Resident 1's ADMISSION RECORD, indicated she was admitted to the facility in mid-2024 with diagnoses which included dementia (a progressive state of decline in mental abilities).</p> <p>A review of Resident 1's Progress Notes, indicated, .09/07/2024 03:35 .Outcomes of Physical Assessment . Nursing observations, evaluation, and recommendations are: CNA went to answer call light in [Resident 1's room number]. Resident was found on the floor between B and C bed .Resident has an injury to back of head and an old scab on her left wrist opened up, some redness on her right cheek noted. Resident c/o [complains of] pain .</p> <p>The next note in sequence in Resident 1's Progress Notes, indicated, .9/9/2024 10:15 .IDT [ interdisciplinary team, a group of healthcare professionals who assess and coordinate care] NOTE: On 9/7/24 around 0330 [3:30 AM] [Resident 1] had an unwitnessed fall in her room, old scab to L [left] wrist opened and injury back of head sustained. Root Cause: Resident is confused .</p> <p>During an interview on 9/27/24, at 2:47 PM, the Director of Nurses (DON) stated licensed staff should monitor residents on every shift for 72 hours after a fall for any late injuries or changes in neurological status (nerve and motor responses) and document their findings. The DON confirmed there was no 72-hour post fall documentation in Resident 1's chart and there should have been.</p> <p>1b. A review of Resident 2's ADMISSION RECORD, indicated he was admitted to the facility in mid-2024 with diagnoses which included muscle weakness and left below the knee amputation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's Progress Notes, indicated, .09/13/2024 09:07 .Outcomes of Physical Assessment . Nursing observations, evaluation, and recommendations are: Around 00:40am [12:40 AM] resident was found sitting on the floor in his bathroom near toilet seat .was trying to use the toilet and slipped .</p> <p>The next note in sequence, related to the fall, in Resident 2's Progress Notes, indicated, .09/16/2024 10:17 . IDT NOTE: On 9/13/24 around 0040 [Resident 2] had an unwitnessed fall in his bathroom stating he was trying to use the bathroom and slipped. Root Cause: Patient outbalanced while self toileting without assistance. Patient overestimated ability .</p> <p>A review of Resident 2's care plan initiated 9/14/24, indicated, .[Resident 2] had an unwitnessed fall .Monitor for signs and symptoms of delayed injuries including pain and notify MD if abnormalities noted .</p> <p>During an interview on 9/27/24, at 1:15 PM, Licensed Nurse (LN) 1 stated after a resident falls the licensed staff perform a head-to-toe assessment for any injuries and continue to assess the resident and perform post fall documentation for three days after the fall. LN 1 confirmed there was no post fall documentation in Resident 2's chart and there should have been.</p> <p>1c. A review of Resident 3's ADMISSION RECORD, indicated she was admitted to the facility in mid- 2023 with diagnoses which included history of falling and Alzheimer's disease (a progressive disease that affects the parts of the brain that control thought, memory, and language).</p> <p>A review of Resident 3's Progress Notes, indicated, .09/01/2024 17:10 [5:10 PM] Outcomes of Physical Assessment .Functional status evaluation: Fall .Skin Status Evaluation: Laceration .</p> <p>The next note in sequence, related to the fall, in Resident 3's Progress Notes, indicated, .09/03/2024 10:17 . IDT NOTE: On 9/21/24 around 1100 [11 AM] [Resident 3] had an unwitnessed fall in her room from w/c [wheelchair]. Bleeding noted from R [right] eyebrow .Risk Factors .wrist fx [fracture] .muscle weakness, seizures .hx of mx [history of multiple] falls .</p> <p>A review of Resident 3's care plan initiated 9/2/24, indicated, .Episode of fall with injury skin tear to left eyebrow .First aide applied to eyebrow. Monitor q [every] shift for healing or worsening .</p> <p>During an interview on 9/27/24, at 1:48 PM, LN 2 stated after a resident falls a full assessment is performed including neurological checks. LN 2 further stated the assessments are done for 72 hours after the fall to monitor for injuries. LN 2 confirmed there was no 72 -hour post fall documentation in Resident 3's chart after her fall and there should have been.</p> <p>During an interview on 9/27/24, at 2:47 PM, the Director of Nurses (DON) confirmed there was no post fall documentation in Resident 1, Resident 2, or Resident 3's charts. The DON further stated it was her expectation that all residents would have post fall documentation to monitor for late injuries.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility policy and procedure titled, Falls-Clinical Protocol, dated 2001, indicated, .Monitoring and Follow-Up .The staff, with the physician's guidance, will follow up on any fall with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma have been ruled out or resolved . Delayed complications such as late fractures and major bruising may occur hours or days after a fall, while signs of subdural hematomas or other intracranial bleeding could occur up to sev-eral [sic] weeks after a fall .The staff and physician will monitor and document the individual's response to interventions in-tended [sic] to reduce falling or the consequences of falling .Frail elderly individuals are often at greater risk for serious adverse consequences of falls .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47369</p> <p>Based on observation, interview, and record review the facility failed to maintain standards of infection prevention and control for a census of 99 when the freestanding air conditioning (AC) units on each hallway contained air filters that were caked with dust and debris.</p> <p>This failure had the potential to spread infection to the 99 residents residing in the facility.</p> <p>Findings:</p> <p>During an observation on 9/27/24, at 11:19 AM, in the North long hall, the air filter in the freestanding air conditioning unit at the end of the hall was observed to be caked with dust and debris.</p> <p>During an observation on 9/27/24, at 11:21 AM, in the North short hall, the air filter in the freestanding air conditioning unit at the end of the hall was observed to be caked with dust and debris.</p> <p>During an observation on 9/27/24, at 11:27 AM, in the South long hall, the air filter in the freestanding air conditioning unit at the end of the hall was observed to be caked with dust and debris.</p> <p>During an observation on 9/27/24, at 11:30 AM, in the South short hall, the air filters in the freestanding air conditioning unit at the end of the hall were observed to be caked with dust and debris.</p> <p>During a concurrent interview and record review on 9/27/24, at 12:16 PM, in the South short hall, the Maintenance Director (MDir) stated the AC units were placed at the end of each hallway at the beginning of summer. The MDir further stated the air filters on the units should be changed monthly and as needed. The MDir confirmed there was no documentation in the maintenance logs to indicate the filters had been changed in July, August, or September of 2024. The MDir stated the filters should have been changed to prevent the residents from breathing dirty air.</p> <p>During an interview on 9/27/24, at 3:45 PM, the Administrator confirmed the filters did not appear to have been changed and looked ready to be changed.</p> <p>A review of a facility policy and procedure titled, Departmental (Maintenance)- Plumbing, HVAC and Related Systems, dated June 2011, indicated, .the purpose of this procedure is to guide the sanitary handling of the plumbing, heating, ventilation, air conditioning, and related systems within the facility .General guidelines . Inspect air conditioning unit drains and filters weekly. Change filters at least monthly during use. Discard soiled filters .</p> <p>A review of an online document, CDC [Center for Disease Control] December 21, 2023, Infection Control Guidelines for Environmental Infection Control in Health-Care Facilities (2003) retrieved September 30, 2024, from <a href="https://www.cdc.gov/infection-control/hcp/environmental-control/air.html">https://www.cdc.gov/infection-control/hcp/environmental-control/air.html</a>, indicated, .Decreased performance of healthcare facility HVAC systems, filter inefficiencies, improper installation, and poor maintenance can contribute to the spread of health-care associated airborne infections .</p> <p>(continued on next page)</p>		

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