STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055185	A. Building B. Wing	01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden City Healthcare Center	1310 West Granger Modesto, CA 95350

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42432 Based on interview and record review, the facility failed to provide care and services after an unwitnessed fall for one of three sampled residents (Resident 1) when: 1. Resident 1 was found on the floor next to his bed on 12/5/24 at 1:25 a.m., with signs of delirium (a sudden, severe change in mental state which can include confusion, disorientation, and an inability to think clearly) and Licensed Nurse (LN) 1 delayed notifying the physician until 7:00 a.m. on 12/5/24; and, 2. LN 1 documented Resident 1 was experiencing signs of delirium after an unwitnessed fall but did not document a neurological (to evaluate level of alertness, orientation, mood), pain, or skin evaluation (to evaluate for trauma, scratches, bruising) was completed. These failures had the potential for Resident 1 to experience pain, suffering, and an increased length of recovery and rehabilitation. Findings: Review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses including but not limited to dehiscence of an amputation stump (surgical site of an amputated limb reopens), muscle weakness, cirrhosis of the liver (chronic liver disease which can cause a buildup of toxins in the brain), Disseminated Coccidioidomycosis Infection (also known as Valley Fever, a fungal infection that infects the lungs and can affect breathing), and metabolic encephalopathy (disorder of the brain and can cause confusion). A review of Resident 1's NURSING-ADMISSION/READMISSION EVALUATION/ASSESSMENT, dated 12/3/24, indicated, .Level of Consciousness .Alert [marked] .Mood and behavior patterns .Calm/Cooperative [marked] .Admission Summary Note .Resident was admitted from [Hospital A] .Resident is alert and orientated x3 [oriented to person, place, time]. Is here for therapy . A review of Resident 1's Nurse's Note, written by LN 1 and dated 12/5/24 at 2:08 a.m., indicated, at 1325 [1:25 a.m.] found resident sitting up on floor next to bed . assessed for injury .slight confusion . (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 1's SBAR Communication Form [SBAR, Situation-Background-Assessment-Recommendation, technique which provides a framework for communication between members of the health care team about a patient's condition], dated 12/5/24 and unsigned by a nurse, indicated, .SITUATION .The change in condition, symptoms, or signs observed and evaluated is/are: falls .This started on: 12/05/24 .Mental Status Evaluation . delirium (inability to pay attention disorganized thinking) [marked] .Skin Evaluation .Not clinically applicable to the change in condition being reported [marked] .Pain Evaluation . Not clinically applicable to the change in condition being reported [marked] .Neurological Evaluation . Not clinically applicable to the change in condition being reported [marked] .REVIEW AND NOTIFY .Primary Care Clinician Notified .Yes [marked] Date .12/5/2024 .Time .7:00 AM . A review of Resident 1's Liver Cirrhosis Care Plan, initiated on 12/4/24, indicated, .[Resident 1] has Liver Cirrhosis .Monitor/document/report to MD [medical doctor] s/sx [signs/symptoms] of delirium: Changes in behavior, Altered mental status . A review of Resident 1's Disseminated Coccidioidomycosis Infection (also known as Valley Fever, is a fungal infection that infects the lungs and can affect breathing) Care Plan, initiated on 12/4/24, indicated, .[Resident 1] has DESSEMINATED COCCIDIOIDOMYCOSIS infection .[Resident 1] will be free from complications related to infection through the review date .Monitor/document/report to MD s/sx of delirium: Changes in behavior, Altered mental status . A review of Resident 1's Fall Care Plan, initiated on 12/4/24 and revised on 12/6/24, indicated, .Falls: Resident is at risk for falls with or without injury related to altered balance while standing and/or walking . During a concurrent interview and record review on 1/2/25, at 4:15 p.m., the Assistant Director of Nursing (ADON) stated the Resident 1's SBAR Communication Form was not signed and submitted by LN 1 and was in a draft form. During a review of the document titled SBAR Communication Form , the ADON confirmed the document was dated 12/5/24 and initiated at 1:48 a.m. by LN 1. The ADON confirmed Resident 1's physician was notified of the change in condition on 12/5/24 at 7:00 a.m. The ADON confirmed the document included a Mental Status Evaluation which indicated other symptoms or signs of delirium and Functional Status Evaluation of Falls was marked by LN 1. The ADON confirmed there was no evaluation or assessment performed for Resident 1 indicated on the document for neurological checks, pain, and skin. The ADON stated her expectation was for a resident who has a fall should be immediately assessed for any injuries and for an unwitnessed fall, such as was the case for Resident 1, neurological checks were to be performed. The ADON stated this was especially important for Resident 1 who had a BIMS score of 9 (Brief Interview for Mental Status, a test that measures cognition, a BIMS score of 0-7 indicates severe cognitive impairment, 8-12 indicates moderate cognitive impairment, 13-15 indicates intact cognition) and was sometimes confused. The ADON stated the risk to Resident 1 if the LN did not perform the assessments would be delayed treatment and not catching a potential problem. The ADON stated once a resident was in a safe place the physician should be notified, followed by family and management. The ADON stated it was the facility's protocol to notify the physician within thirty minutes of the event. The ADON stated the importance of notifying the physician was so the physician can decide if there were new orders needed including x-rays and additional monitoring. The ADON stated the risk to the resident if the physician was not notified would be delay of treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 12/31/24, at 10:09 a.m., Family Member 1 stated Resident 1 was currently in the hospital after being transferred to the hospital from the facility on 12/11/24. FM 1 stated this was due to increased confusion and his doctor was concerned his ammonia levels (the amount of ammonia in your blood. High ammonia levels can cause serious brain damage) were too high and/or he had a possible infection. FM 1 stated (Resident 1) had his leg amputated in July of 2024. FM 1 stated after he goes to dialysis (a procedure to remove toxins/waste from the blood when the kidneys do not function well), he gets confused and disoriented and forgets he does not have a leg and will try to get out of bed. FM 1 stated on the evening of 12/4/24 she visited Resident 1 after he returned from dialysis. FM 1 stated she left the facility around 9:20 p.m. and prior to leaving had spoken to the LN regarding (Resident 1's) confused state and told the LN he was more confused than normal. FM 1 stated Resident 1 called her with his cell at 11:27 p.m. on 12/4/24 and told her he was in pain. FM 1 stated the nurse told her (Resident 1) had fallen out of his bed and was found on the floor. FM 1 stated when she went to visit (Resident 1) on 12/5/24 he had a lot of bruises and his side and on his back from the fall. During an interview on 12/31/24 3:18 p.m., Certified Nurse Assistant (CNA) 1 stated on the night of 12/4/24, she was the CNA assigned to Resident 1. CNA 1 stated there was another CNA translating for Resident 1 (CNA 2) and stated they were letting the nurses know he was in super pain and stated the pain was in his stomach, he was upset, and his stomach was bloated. CNA 1 stated Resident 1 was moaning and groaning in pain, and explained he never sounded like this before. CNA 1 stated a staff member went into Resident 1's room at 1:45 a.m. and found him on the ground in his room. CNA 1 stated Resident 1 had a scratch on his back from his bed frame and the bar on his bed. During a phone interview on 1/2/25, at 3:40 p.m., LN 1 stated after a resident falls, the expectation was to follow up with the doctor within thirty minutes to one hour of the fall and inform them of the resident's condition. LN 1 stated it was important to inform the doctor of the residents' condition in case follow-up orders were needed. During a phone interview on 1/2/24, at 1:56 p.m., LN 2 stated she recalled Resident 1 and remembered his fall on 1/5/25. LN 2 explained he was on the floor and she and other staff assisted in getting him back into his bed. LN 2 stated one of the CNA's found him on the floor could not remember if he hit his head. LN 2 stated the protocol for a resident who has a fall was resident safety first, and then to get them back to their bed safely, perform neurological checks, inform the doctor, assess for pain, and to complete a head-to-toe assessment. LN 2 stated the expectation was to contact the doctor immediately and stated if the resident was experiencing confusion or delirium, it would be important to know if this was a new onset and unusual for the resident. LN 2 explained informing the doctor, allows them to decide on treatment and perform interventions for the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 1/7/24, at 12:21 p.m., the Medical Doctor (MD) 1 stated he was familiar with Resident 1 and stated he examined Resident 1 on 12/5/24. MD 1 stated Resident 1 was a complicated patient with a lot of health problems including liver, kidney, and stomach problems, and was admitted with a lot of pain. MD 1 stated for a fall and/or change of condition including a mental status change his expectation was for the nurse to call the doctor. MD 1 stated for a resident who has a fall accompanied with delirium as Resident 1 experienced, his expectation was the LN would have called to inform him after the incident. MD 1 stated this was important due to the possibility of the resident having an infection and he would have wanted to send him to the hospital immediately. MD 1 stated the LN should have conducted a pain, neurological, and skin evaluation for Resident 1 after his fall. MD 1 stated the risk to the resident experiencing a fall with changes such as delirium would be the resident could be experiencing bleeding to the brain. MD 1 stated for something important such as a fall the nurses can call him at any time. Review of a facility policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised 2/21, indicated, .Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .The nurse will notify the resident's attending physician or physician on call when there has been a(an): accident or incident involving the resident .significant change in the resident's . physical/emotional/mental condition .need to alter the resident's medical treatment significantly .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 or by implementing standard disease- related clinical interventions (is not self-limiting); impacts more than one area of the resident's health status; requires interdisciplinary review and/or revision to the care plan .Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form .Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status . During a review of a facility P&P titled, Falls-Clinical Protocol, revised 3/18, indicated, .Assessment and Recognition .The nurse shall assess and document/report the following: Vital signs .Recent injury .or head injury . Change in cognition or level of consciousness .Neurological status . Pain .Precipitating factors, details on how fall occurred .All current medications, especially those associated with dizziness or lethargy [feeling tired] .All active diagnoses .Falls should also be identified as witnessed or unwitnessed events .Monitoring and Assessment .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 [brain bleed] have been ruled out or resolved . The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 42432 Based on interview and record review, the facility failed to provide comprehensive and effective pain management, for one out of three sampled residents (Resident 1) when Resident 1's pain assessment scale (a tool used to assess the level of pain) indicated moderate pain, and Resident 1 was administered a pain medication intended for mild pain. This failure had the potential for Resident 1's pain not being effectively managed. Findings: Review of Resident 1's ADMISSION RECORD, indicated Resident 1 was admitted to the facility with diagnoses including but not limited to dehiscence of an amputation stump (surgical site of an amputated limb reopens), cirrhosis of the liver (chronic liver disease which can cause a buildup of toxins in the brain), end-stage renal disease(kidney disease which leads to an ability to remove waste from the blood), and ascites (excess fluid accumulates in the belly). A review of Resident 1's NURSING-ADMISSION/READMISSION EVALUATION/ASSESSMENT, dated 12/3/24, indicated, .Level of Consciousness .Alert [marked] .Mood and behavior patterns .Calm/Cooperative [marked] .Admission Summary Note .Resident was admitted from [Hospital A] .Resident is alert and orientated x3 [oriented to person, place, time]. Is here for therapy . A review of Resident 1's Nurse's Note, written by Licensed Nurse (LN) 1 and dated 12/5/24 at 2:08 a.m., indicated, .at 1325 [1:25 a.m.] found resident sitting up on floor next to bed .he states, he slid down in bed and pressed the call light wanting to go to bathroom .Assist patient back to bed with the help of staff .resident provided prn [as needed] pain medication prior . A review of Resident 1's Medication Administration Record (MAR), dated 12/2024, indicated Resident 1 had the following orders: .Pain- Monitor For Presence Of Pain Every Shift Using Scale 0-10. 0= No Pain 1-2= Least Pain 3-4= Mild Pain 5-6= Moderate Pain 7-8= Severe Pain 9-10 Very Severe/Horrible/Worst Pain every shift for Monitoring Level of Comfort . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1's MAR, dated 12/2024, indicated Resident 1 had the following medications ordered for pain: 1. Acetaminophen [pain medication] Give 2 tablets by mouth every 4 hours as needed for mild pain. 2. Hydrocodone-Acetaminophen [a strong pain medication used to treat moderate to severe pain] Give 1 tablet by mouth every 4 hours as needed for Pain management. Resident 1's 12/2024 MAR indicated the following pain medications were administered to Resident 1 as follows: 1. Acetaminophen on 12/4/24 at 1:39 a.m. for a pain rating of 6 2. Hydrocodone-Acetaminophen on 12/4/25 at 6:48 a.m. for a pain rating of 8 3. Hydrocodone-Acetaminophen on 12/4/24 at 8:45 p.m. for a pain rating of 8 (severe pain) 4. Acetaminophen on 12/5/24 at 12:34 a.m. for a pain rating of 5 (moderate pain) The MAR indicated LN 1 administered acetaminophen prior to Resident 1's fall, on 12/5/24 at 12:34 a.m. for a pain level of 5 which was in the moderate pain category. During a review of Resident 1's IDT Fall (Interdisciplinary Team, group of health care professionals with various areas of expertise who work together toward the goals for resident), dated 12/6/24, indicated, .On 12/5/24 around 0140 [1:40 a.m.] [Resident 1] had an unwitnessed fall in his room stating he slid to the floor when he tried to get up to use the restroom .Root Cause: Poor safety awareness .Risk Factors .per hospital records easily agitated secondary to pain .New interventions implemented . Request Pain medication routine BID [given twice a day on a physician ordered schedule] . A review of Resident 1's Case Management Note, dated 12/7/24, indicated .Per hospitalization the patient presented with Suicidal Ideations [when you think about or consider death or suicide] .It appears the primary reasoning was pain . During a phone interview on 12/31/24, at 10:09 a.m., Family Member (FM) 1 stated Resident 1 had his leg amputated in July of 2024. FM 1 stated on the evening of 12/4/24 she visited Resident 1 after he returned from an appointment and left the facility around 9:20 p.m. FM 1 stated Resident 1 called her with his cell phone at 11:27 p.m. on 12/4/24 and told her he was in pain. FM 1 stated at 11:49 p.m. (12/4/24), while still on the phone with Resident 1, staff came into his room, and she was able to speak with them. FM 1 stated the staff member (certified nursing assistant (CNA) 1) told her she would ask his nurse to get him some medication for his pain. FM 1 stated while still on the phone with Resident 1 via his cell phone, a nurse came into his room. FM 1 stated she explained to the nurse (acetaminophen) does not do anything for (Resident 1's) pain, and he received (hydromorphone) at the hospital (hydromorphone-a very strong pain medication). FM 1 stated at 6:27 a.m., (12/5/24), she called the facility, and the nurse told her (Resident 1) had fallen out of his bed and was found on the floor. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/31/25 at 3:18 p.m., CNA 1 stated on the night of 12/4/24, she was the CNA assigned to Resident 1's care. CNA 1 stated there was another CNA translating for Resident 1 (CNA 2) and stated they were letting the nurses know he was in super pain and stated the pain was in his stomach, he was upset, and his stomach was bloated. CNA 1 stated on 1/4/25, around 11:00 p.m., she informed the LN (LN 1) of Resident 1's pain. CNA 1 stated Resident 1 was moaning and groaning in pain and explained Resident 1 never sounded like that before. CNA 1 stated a staff member went into Resident 1's room at 1:45 a.m. and found him on the ground in his room. CNA 1 stated she was in Resident 1's room six or seven times before his fall and stated she told the nurse (LN 1) nine times that he was in pain before the fall. During a phone interview on 1/2/25, at 3:40 p.m., LN 1 stated she could not recall taking care of Resident 1. LN 1 stated if a resident had signs or symptoms of pain, or complained of pain, she would assess where the pain was and review the MAR to see if the resident had pain medication ordered. LN 1 stated the medication she would administer would depend on the resident's pain level and medication order. LN 1 stated a pain level of five or six would be considered moderate pain, and she would give the pain medication which was ordered for moderate pain. LN 1 stated she would follow the medication orders. During a concurrent interview and record review on 12/2/24 at 1:45 p.m., Resident 1's record was reviewed. Through record review of Resident 1's MAR , LN 3 confirmed Resident 1 was experiencing moderate pain for both doses of administered acetaminophen on 12/4/24 at 1:39 p.m., and at 12/5/24 at 12:34 a.m., with a pain rating of 6 and 5 respectfully. LN 3 stated the acetaminophen was only indicated for mild pain and stated Resident 1 was complaining of moderate pain. LN 3 stated Resident 1 should have been given the stronger pain pill Hydrocodone-Acetaminophen and stated she wants her patients to be relieved of pain. During a concurrent interview and record review on 1/2/25, at 4:15 p.m., the Assistant Director of Nursing (ADON) stated her expectation for a resident in pain was the CNA or other staff member should notify the resident's LN so the LN can provide something according to the current orders. The ADON stated the expectation was for Resident 1 to be assessed for his pain timely within 15 minutes of a staff member becoming aware. The ADON confirmed Resident 1 was medicated on 1/4/25 at 8:45 p.m., with Hydrocodone-Acetaminophen for a pain level of 8. The ADON confirmed Resident 1 was medicated on 1/5/25 at 12:34 a.m., with acetaminophen for a pain level of 5. The ADON stated the acetaminophen was indicated for mild pain per the physician's order. The ADON stated the expectation was the nurse should always follow the medical doctor's orders. The ADON confirmed Resident 1 could have been given the Hydrocodone-Acetaminophen and was within the timing guidelines of four hours as stated in the physician's order. The ADON confirmed a pain level of 5 was categorized as moderate pain and confirmed Acetaminophen was indicated for mild pain per the medication order. The ADON stated her expectation was for the nurse to use her judgment and to follow doctor's orders. The ADON stated the risk for the resident if they were not medicated with the proper pain medication would be the resident would be in pain for longer than necessary. During a phone interview on 1/7/24, at 12:21 p.m., the Medical Doctor (MD) 1 stated he was familiar with Resident 1 and was the medical director of the facility and stated he first examined Resident 1 on 12/5/24. MD 1 stated Resident 1 was a complicated patient with a lot of health problems including liver issues, kidney issues, stomach problems, and explained he was admitted with a lot of pain. MD 1 stated if Resident 1 had orders for Hydrocodone-Acetaminophen he should have been given the medication to relieve his pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy and procedure (P&P) titled, Administering Medications, revised 4/19, indicated, . Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame .Medication administration times are determined by resident need and benefit, not staff convenience .Factors that are considered include . enhancing optimal therapeutic effect of the medication . During a review of a facility document titled Pain-Clinical Protocol, revised 10/22, indicated, .Assessment and Recognition .The physician and staff will identify individuals who have pain or who are at risk for having pain . The staff and physician will evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, as well as how pain may be contributing to complications such as .falls .The physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain .