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	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Garden City Healthcare Center	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to use safe lifting technique to move one of two sampled residents (Resident 1) from the wheelchair to the bed on 7/5/25, after Resident 1 had an assisted fall (a situation where a resident begins to fall but is supported or guided by another person to minimize the impact of the fall) to the ground.This failure resulted in Resident 1 sustaining a left distal femoral fracture (broken bone in the lower part of the left thigh bone near the knee).Findings:Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with diagnosis of dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and repeated falls. Review of Resident 1's Brief Interview for Mental Status (BIMS, an assessment tool), dated 5/9/25, indicated Resident 1 scored three out of fifteen points total. A score of three indicated that Resident 1 had severe cognitive impairment (when a person is likely to experience significant difficulties with mental tasks and may require substantial assistance with daily activities).Review of Resident 1's Progress Notes, dated 7/5/25, indicated, .Resident was not like himself this shift, wasn't talking and looking weak. When CNA [certified nursing assistant] went to get him ready she alerted writer that his left leg was at an weird angle and his knees were stuck together and it was hard hold them apart without resident screaming in pain. Sent out to [name of emergency department] around 1645 [4:45 p.m.].Review of Resident 1's Progress Notes, dated 7/6/25, the document indicated, Licensed Nurse (LN) 2 received a call from the emergency room staff who informed her that Resident 1 .has been admitted [to the hospital] and that he has a shattered knee.A review of Resident 1's hospital record titled, History and Physical/admission Notes, dated 7/6/25, indicated the following: Resident 1 was admitted to the hospital on [DATE], a Computed Tomography (CT) scan (a special x-ray that takes detailed pictures inside your body) of Resident 1's left knee was conducted on 7/6/25, with the following reported findings, .Displaced fracture centered at the distal femoral metaphysis, with intra-articular extension at the level of the anterior medial femoral condyle [a broken bone near the bottom of the thighbone (femur), close to the knee joint. The pieces of bone are out of place (displaced), and the break goes into the knee joint itself].During a concurrent observation and interview on 7/15/25, at 2:04 PM, the Restorative Nursing Aide (RNA) stated that on 7/5/25 between 1 PM to 1:30 PM, she offered Resident 1 to attend the RNA Program and Resident 1 agreed. RNA 1 explained, at that time, she assisted Resident 1 to sit on the edge of the bed, however, Resident 1 was unable to stand like he used to and began sliding off the bed. The RNA stated she then sought assistance from CNA 1, who happened to be inside Resident 1's room. The RNA stated, both herself and CNA 1 were unable to help Resident 1 to stand. The RNA stated they then assisted Resident 1 slowly to the floor. The RNA stated, once Resident 1 was on the floor, CNA 1 and herself transferred Resident 1 to the wheelchair using a gait belt (a safety device used by caregivers to assist patients with mobility and transfers, such as walking or rising from a chair) while supporting Resident 1 under both armpits. The RNA explained, from the wheelchair, they transferred Resident 1 back to the bed using a towel transfer technique. The RNA explained and demonstrated that she placed a towel behind Resident 1's leg, just above the backs of his knees. The RNA stated CNA 1 and herself then positioned themselves on each side of the resident. The RNA further explained, with one arm, each of them supported Resident 1 under his armpits while holding the gait belt; with the other arm, each held one end of the towel. The RNA stated they then lifted and swung Resident 1 back onto the bed. The RNA stated that she taught CNA 1 how to execute the towel transfer on 7/5/25 - at the time of said towel transfer. The RNA stated that she did not document the incident because she had told the nurse in-charge of Resident 1 on that day about what happened. The RNA stated FM 1 went to the facility on 7/6/25 and was able to speak with her regarding what happened.During an interview on 7/15/25 at 4:06 PM, the RNA stated that on 7/5/25, she did not think of using a mechanical lift (a device used to safely transfer individuals who cannot bear weight or have limited mobility, from one place to another) or requesting assistance from a physical therapist (a person qualified to treat disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise) to assist Resident 1 off the ground. RNA 1 stated she used the towel transfer technique and manually transferred Resident 1 from the wheelchair to the bed. The RNA stated that she believed a therapy order was required to use the mechanical lift.During an interview with the Director of Nursing (DON) and Administrator (ADM) on 7/15/25 at 4:50 PM, the DON stated when a resident was heavy or considered dead weight or unable to assist during transfers, the expected practice