

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: 055185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement appropriate safety interventions including supervision to ensure a safe environment free of accidents and hazards for one of two sampled residents (Resident 1) when: 1. Resident 1 was not initially assessed (around the time of admission to the facility) accurately for an elopement risk (the potential for a vulnerable individual to leave a facility without staff awareness, leading to serious dangers like injury or even death) and Resident 1 was not reassessed for an elopement risk after Resident 1 became more confused, began to wander (aimless movement), and attempted to and expressed a desire to leave the facility on several occasions; 2. An elopement risk care plan (a comprehensive resident centered plan which includes interventions such as environmental modifications, supervision, and/or technology integration to prevent a resident from leaving a facility) was not created for Resident 1; and 3. A doctor's order to send Resident 1 to the hospital for a change in condition (any significant physical, cognitive, or mental deviation from a resident's baseline that requires an adjustment to their care plan) was not carried out by facility staff over multiple shifts. These failures resulted in Resident 1 eloping from the facility on the morning of 10/4/25 between 7:30 a.m. and 7:40 a.m. (during rush hour traffic near a busy road) and being found one mile away near a shopping center at 8:30 a.m. by a family friend (FF), looking pale, clammy, sweaty, and shaking. These failures had the potential to result in physical and emotional danger: including injury, exposure to the elements (extreme heat or cold), and/or death and the emotional toll could be severe, leading to feelings of loneliness, depression, and increased anxiety. Findings: Review of Resident 1's admission RECORD, indicated, Resident 1 was admitted to the facility on [DATE] (Monday) with diagnoses which included hepatic encephalopathy (HE, when the liver is unable to properly filter toxins from the blood, leading to their accumulation in the brain which can cause confusion, disorientation, and personality changes among other symptoms) and hyponatremia (low levels of sodium (salt) in the blood which can cause restlessness, irritability, and dizziness when standing up among other symptoms). Review of Resident 1's BRIEF INTERVIEW FOR MENTAL STATUS (BIMS, an assessment tool that healthcare providers use to assess a person's cognitive function), dated 9/29/25, indicated, Resident 1 had a BIMS score of 5, which indicated severe cognitive impairment (Score of 0 to 7: Severe problems with thinking and memory). During a phone interview on 10/6/25, at 4:02 p.m., Emergency Contact (EC) 1 stated Resident 1 was recently admitted to the facility after his family took him to the emergency room (ER) for increased confusion. EC 1 stated Resident 1 experienced a fall on 5/20/25 and broke his neck and required surgery. EC 1 stated Resident 1 had been in and out of the hospital seven times since then due to complications from surgery. EC 1 stated a nurse from the facility called her on 9/29/25 (Monday) because Resident 1 seemed more confused and the family requested blood work be done because he would get confused when he had a low blood sodium level (a mineral needed by the body to keep body fluids in balance). EC 1 stated on 9/30/25 (Tuesday) family were visiting Resident 1 and noticed he was more confused, did not know where he was, and was making up stories. EC 1 stated Resident 1 did not make sense, and she told staff he might be getting an infection, or his blood labs were off. EC 1 (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: 055185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	stated while at the facility Resident 1 could not get off his bed independently or walk because it was not safe and when she visited him on 10/2/25 (Thursday) she pushed him around in a wheelchair. EC 1 stated someone from the facility called on Thursday night and told them Resident 1 was resisting care and very confused. EC 1 stated Resident 1's responsible party (RP) went to the facility that night and when the RP arrived at the facility Resident 1 was at the entrance door and was trying to leave. EC 1 stated on 10/3/25 (Friday) she met Resident 1 at a medical appointment and when Resident 1 returned to facility after his doctor's appointment he refused to get out of the transport van and would not go inside the facility. EC 1 stated staff called the RP, and the RP was able to get Resident 1 to go back into the facility. EC 1 stated at 5 p.m. on 10/3/25 (Friday), staff called and asked when someone was coming to get him because he was resisting the wander guard (wearable device attached to a bracelet that is integrated with a security system to alert caregivers when residents are near or exit a door leading outside) staff was trying to place on him. EC 1 stated the staff member told her staff would have to send him to the hospital because he was not listening and wanted to leave the facility. EC 1 stated she told the staff member she gave permission to send Resident 1 to the hospital if that was the safest place for him. EC 1 stated she did not hear back from the facility after that, so she thought everything was okay with Resident 1. EC 1 stated the next day, 10/4/25 (Saturday) the neighbor, who lived across the street from Resident 1's previous residence, found him disheveled and dirty, on a bench alone near a shopping center. EC 1 stated, just before 9 a.m., she called the facility to check if they knew Resident 1 was missing because she had not heard from them. EC 1 stated she was placed on hold for 25 minutes, so she used another phone line to call the facility back. EC 1 stated the person who answered the phone told her staff were trying to locate Resident 1. EC 1 stated she told the staff member Resident 1 was already found by the shopping center. EC 1 stated Resident 1 had walked very little since his surgery in May and now he just walked about 2 miles outside of the facility, alone. EC 1 stated Resident 1 could have fallen and reinjured himself, or could have gotten hit by a car, or not been found at all. EC 1 stated they did not take Resident 1 to the doctor after finding him because they were tired of doctors not being able to help him. EC 1 stated nobody from the facility has called her since Resident 1's elopement nor have they spoken to the RP regarding medical updates or the elopement. Review of Resident 1's [Hospital Name] HOSPITALIST DISCHARGE SUMMARY, dated 9/29/25, indicated, .admit date .9/26/25.discharge date .9/29/25.FINAL DISCHARGE DIAGNOSES.Encephalopathy acute [sudden].Hyponatremia.HOSPITAL COURSE.brought in from home for generalized weakness worsening confusion unable to take care of self at home.Patient is currently orientated to his name [and] place could tell me the year but unable to give me history of what happened at home is complaining of back pain. sodium of 131 [normal blood sodium levels are 135-145].ammonia 43 [normal blood ammonia levels are 11-32; high ammonia symptoms include confusion and disorientation].initial labs showed elevated ammonia, which had trended down.mentation improving [less confusion].9/28/25.NA [sodium] 126 (L) [low].HPI [history of present illness].recurrent admissions for hyponatremia.A review of Resident 1's Social Services/Case Management Initial Assessment Note, dated 9/30/25, indicated .Patient had a fall at home prior to admission. Family also emphasized the Importance of monitoring the patient's.hyponatremia and requested close observation of lab values [blood tests]. They asked to be notified of any changes in the patient's condition.Review of Resident 1's Care Plan Report, initiated 9/30/25, indicated, .Skilled PT [Physical Therapy] needed for impaired gait [walking], impaired balance.decreased endurance [strength], and decreased functional level [the loss of ability to perform usual activities due to a decline in physical or cognitive function].Review of Resident 1's Care Plan Report, initiated 9/30/25, indicated, .Falls: Resident is at risk for falls with or without injury related to altered mental status.Goal.Will be compliant with fall interventions.Interventions.Anticipate and meet needs.Education/remind resident to call for assistance with all transfers.Review of Resident 1's Care Plan Report, initiated 10/1/25, indicated, . Not alert to surroundings at eval [evaluation], thinks he is at [name of high school] in the gym.Pt (continued on next page)		

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 11/24/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	[patient] will be orientated to place/time/circumstances/new deficits and safety precautions.Skilled ST [speech therapy] 5x wk [times per week] x 4 wks to address Cognitive Communication Deficit.Review of Resident 1's Care Plan Report, initiated 10/3/25, indicated, . Cognitive Impairment.exhibits cognitive loss related to altered cognitive performance with BIMS score of 5.indicating severe impairment.Goal.Will avoid complications.Interventions.Anticipate needs and meet promptly.Monitor for changes in cognitive status. Notify physician if observed.Observe for indicators of clinical changes.behavior changes.Notify physician if occurs.Review of Resident 1's Care Plan Report, initiated 10/3/25, indicated, .[Resident 1] has an alteration in neurological status [mental status] r/t [related to].Encephalopathy. Intervention.Cueing, reorientation as needed.Obtain and monitor lab/diagnostic work as ordered. Report result to MD [Medical Doctor] and follow up as indicated.Review of Resident 1's Physical Therapy Medicare PT Evaluation & Plan of Treatment, dated 9/30/25, indicated, .Patient exhibits new onset of decrease in strength, decrease in functional mobility, decrease in transfers, reduced ability to safely ambulate and reduced functional activity tolerance. Pt is confused.Fall risk, confusion, poor endurance.Safety Awareness.Poor.the patient is at risk for: falls and further decline in function. Pt unable to take a step on first attempt of gait training [walking]. Pt instructed on side stepping on second attempt but only able to take 2 side steps. On third attempt, pt able to take 3 steps but drags R [right] foot d/t [due to] c/o [complaints of] pain on B [both] ankles and feet.Review of Resident 1's Physical Therapy Medicare PT Evaluation & Plan of Treatment, dated 10/3/25, indicated .Pt educated and instructed on gait training.utilizing FWW [front wheeled walker].Pt completed 200ft.Pt demonstrates increase in confusion requiring frequent redirecting back to therapy tasks. Nursing staff aware.A review of Resident 1's physician order, dated 9/29/25, indicated .CMP [Comprehensive Metabolic Panel - a blood test that includes a sodium level].A review of Resident 1's CMP results, dated 9/30/25, indicated .sodium.127.A review of Resident 1's physician order, dated 10/2/25, indicated .CMP in one week one time only for sodium.Review of Resident 1's PERSONAL HISTORY AND PHYSICAL EXAMINATION, dated 10/2/25, hand-written by Resident 1's Medical Doctor, indicated, .INITIAL EXAM watch mental [observe for mood/behavior changes], Repeat Lab.Na.NH3 [ammonia].A review of Resident 1's physician order, dated 10/3/25, indicated .NH3 one time only for confusion for 1 Day.Review of Resident 1's SBAR [Situation, Background, Assessment, and Recommendation] change in condition form, written by Licensed Nurse (LN) 1, dated 10/3/25 at 12:40 p.m., indicated, .Resident seems very confused.Increased confusion.This started on.10/03/2025.MD notified.if family wants, and condition not better.go back to ER [emergency room].Review of Resident 1's Nurse's Note, written by the director of nursing (DON), dated 10/3/25 at 2:01 p.m., indicated, .Resident noted with aggressive, restlessness behavior concerned about safety/high fall risk.Review of Resident 1's Order Details, created by the DON on 10/3/25 at 2:01 p.m., indicated, .Order Summary.OK to transfer the resident to ER for safety concerns.every shift for 2 days.Review of Resident 1's Nurse's Note, written by the assistant director of nursing (ADON) dated 10/3/25 at 4:30 p.m., indicated .Pt was wandering in building and verbalizing that he wanted to leave and go to various locations. I attempted to place wander?guard but pt continued to refuse. DON tried and sat and spoke to him for at least 15 min and pt continued to refuse wander-guard. RN [registered nurse] on shift also attempted to place wander guard without success. I spoke to [RP] and requested that he come and see pt and also try to place wander-guard. He stated that he is busy at this time but will try and come later.Review of Resident 1's Nurse's Note, written by LN 5, dated 10/3/25 at 9 p.m., indicated, .Patient attempted to elope multiple times, not compliant called and notified [EC 1].Review of Resident 1's Nurse's Note, written by LN 5, dated 10/3/25 at 9:58 p.m., indicated, PT REFUSED.LAB DRAWS [blood tests].Review of Resident 1's Behavior Note, written by LN 2, dated 10/4/25 at 7:23 a.m., indicated, .Writer attempted to place wanderguard on pt's ankle. Pt knocked writer's hand away and tried to hit writer. Non-compliant with care, risk for elopement.Review of Resident 1's Nurse's Note, written by LN 3, dated 10/4/25 at 12:57 p.m., indicated, .around 730 [7:30 a.m.], writer redirected resident back to (continued on next page)		

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 11/24/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	room because breakfast was coming, resident went back to room and around 8:30-8:45 [a.m.] CNA and nurse went looking for resident in all the bathrooms beds and all around the facility. DON notified. Writer called family and family told writer that resident was found at [shopping center] by a [FF]. [FF] took resident to her home and notified family. Family stated to writer that resident will not be returning to facility. DON and MD notified. During an interview on 10/6/25, at 4:52 p.m., LN 5 stated she was Resident 1's evening shift nurse for the two evenings prior to his elopement (10/2/25 Thursday and 10/3/25 Friday). LN 5 stated during her shifts Resident 1 had made multiple attempts to try to elope and was non-compliant of nursing care. LN 5 stated Resident 1 verbalized that he wanted to get out of the facility. LN 5 stated Resident 1 became more confused throughout her two shifts with him, was walking around the facility, and would not listen to instructions to go back to his room. LN 5 stated she and a CNA were watching Resident 1 to prevent him from leaving the facility, but he was not on one-on-one supervision (a single caregiver is continuously and closely monitoring a person who requires constant attention). LN 5 explained she felt Resident 1 needed one-on-one supervision and he was at risk for eloping. LN 5 confirmed she did not send Resident 1 out to the hospital during her shift. LN 5 stated she told the night nurse (LN 2) Resident 1 was wandering and was on visual monitoring. LN 5 stated Resident 1 did not have a wander guard, and she believed he should have one due to him being an elopement risk. LN 5 stated when she returned to the facility for her next shift (10/4/25 Saturday), she learned Resident 1 had eloped. LN 5 indicated that Resident 1's risk of eloping included potential harm, injury, or falls. LN 5 emphasized the importance of providing care to prevent such injuries. During a concurrent interview and record review on 10/6/25, at 3 p.m., LN 1 stated she was Resident 1's day shift nurse (7:30 a.m. to 3:30 p.m.) for the three days prior to his elopement. LN 1 stated Resident 1 seemed more confused on the morning of 10/3/25 and she completed a change of condition and informed Resident 1's doctor. LN 1 stated Resident 1 had a doctor's appointment on 10/3/25 (Friday) and when he returned, he would not listen and began to walk around the facility by himself, would not use his walker, and/or accept staff assistance. LN 1 stated Resident 1 was pacing for a couple of hours in the afternoon after returning from his appointment and the DON was walking with Resident 1 because he would not sit down and was a fall risk. LN 1 stated the DON told her the doctor said it was okay to send Resident 1 out to the ER (emergency room) and the DON had placed the order in Resident 1's clinical record. LN 1 confirmed she did not send Resident 1 out to the ER. LN 1 stated the risk to Resident 1 for not being sent to the ER was risk of symptoms getting worse and elopement. LN 1 stated this morning (10/6/25) she found out from another nurse Resident 1 had eloped over the weekend. LN 1 stated the process when a resident goes missing was to check inside and outside the facility and if the resident was not found then they would call the responsible party, complete a police report, and inform the DON and the Administrator (ADM). During an interview on 10/7/25, at 9:55 a.m. LN 2 stated she worked the night shift from 11 p.m. to 7 a.m. and was Resident 1's nurse on Thursday night (10/2/25) and Friday night (10/3/25) prior to his elopement. LN 2 stated Resident 1 was up and about a lot more, was walking and pacing, was not listening and was non-compliant (not doing what someone asks you to do) with care. LN 2 stated Resident 1 told her he wanted to go home and needed to borrow a phone. LN 2 stated Resident 1 did not know where he was. LN 2 stated he finally settled around 4 a.m. Saturday morning (10/4/25). LN 2 explained Resident 1 was back at it pacing at 6 a.m. LN 2 stated doctor orders were to send Resident 1 out to the hospital if he gets aggressive. LN 2 explained Resident 1 went to the front door around 2:30 a.m. on Saturday morning. LN 2 stated she instructed CNA 1 to keep eyes on him, and she did. LN 2 stated Resident 1 kept his shoes on the whole night and was wearing his clothes from the day before. LN 2 stated she gave shift report to the oncoming nurse (LN 3) at 7:30 a.m., and she saw Resident 1 down the hall, and he was pacing. LN 2 stated she told the incoming nurse who had not worked with Resident 1 that it was her discretion to send Resident 1 out to the hospital. When asked why Resident 1 was not sent out to the hospital, LN 2 stated for her, Resident 1 did not meet the threshold and would have needed to be more aggressive. LN 2 stated (continued on next page)		

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: 055185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/24/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident 1 should have had a one-on-one staff member supervising him from the beginning. During a concurrent interview and record review on 10/7/25, at 1:18 p.m., Resident 1's Wandering/Elopement Risk Evaluation, dated 9/29/25, and Resident 1's PERSONAL HISTORY AND PHYSICAL EXAMINATION, written by the MD on 10/2/25, was reviewed with the DON. The DON confirmed Resident 1's elopement risk evaluation indicated the following, .If the total score is 10 or greater, the resident would be considered At risk for Wandering or Elopement. Interventions implemented as determined by the facility IDT [Interdisciplinary Team, a collaborative group of healthcare professionals, including nurses, social services, who work together to provide a plan of care for residents] .MOBILITY STATUS.Is the resident able to move or propel themselves in a wheelchair with some assistance from others? [checked].COGNITIVE STATUS.Is the resident disoriented or has periods of confusion and/impaired attention span but does not wander? [checked].DISEASE DIAGNOSIS.Does the resident have a diagnosis that may impact cognition? (i.e., .Dementia [memory loss].or other not listed) .None present. [checked] RESIDENT EVALUATION FACTORS: Does the resident have the ability to walk or self-propel off the premises without assistance .No. The DON stated the questions on the elopement risk evaluation that was completed on 9/29/25 were not correct and staff marked that Resident 1 did not have any cognitive diagnosis, and encephalopathy was a cognitive diagnosis. The DON stated had the section of cognitive diagnosis had been marked correctly, the elopement evaluation tool would have given Resident 1 a positive elopement risk score (10 or greater) and elopement care plan measures would have been put in place at that time. The DON confirmed a new elopement risk assessment should have been completed due to Resident 1's increased confusion and wandering behavior but was not. The DON stated an elopement risk care plan should have been initiated for Resident 1 on 10/3/25 but it was not. The DON confirmed Resident 1's elopement care plan was not initiated until 10/6/25, after he eloped. The DON explained the care plan was important as it offered a guide for staff on how to care for residents and provided interventions for staff to incorporate in their care to keep the residents safe. The DON stated during the afternoon hours of 10/3/25 she called the MD to inform him Resident 1 was more confused and she received new orders to send Resident 1 to the hospital for his safety due to physical therapy stating that Resident 1 was a high fall risk and was walking around unassisted and could not be redirected. The DON stated Resident 1 was trying to go outside and wanted to leave the facility to go to his classroom. The DON explained Resident 1 was pacing, not redirectable, and was an elopement risk. The DON stated she spoke to EC 1 on the afternoon of 10/3/25 regarding sending Resident 1 out to the hospital for safety reasons and EC 1 agreed. The DON stated they were concerned about Resident 1's previous neck surgeries and his risk of falling and injuring himself. The DON stated they tried to place a wander guard on Resident 1, but he refused. The DON stated she sat with him for 40 minutes. The DON stated she did not send Resident 1 to the hospital because he had calmed down while she was sitting with him in the dining room. The DON stated there were no issues with Resident 1 during his first couple of days at the facility and suddenly, he was talking about going to class and teaching. The DON stated she noticed a change in Resident 1's behavior starting on 10/2/25 (Thursday). The DON explained on the evening of 10/2/25 Resident 1's RP was contacted and came in to help Resident 1 since he was more confused. The DON stated the nurses did not follow the protocol and her expectation was the nurse should have sent Resident 1 to the hospital when he became more confused on the evening of 10/3/25 and was walking and pacing in the facility without his walker or assistance. The DON explained that the nurse should have recognized the importance of the need for Resident 1 to be assessed by a medical doctor in emergency room since Resident 1's change of condition and the new symptoms could not be managed safely by facility staff. The DON stated that each nurse interpreted the order to send Resident 1 to the hospital differently. Through review of Resident 1's clinical record, Resident 1's PERSONAL HISTORY AND PHYSICAL EXAMINATION, written by the MD on 10/2/25, the DON stated the MD wanted to repeat labs including ammonia and sodium levels but acknowledged there was no order created for Resident 1 based off the written (continued on next page)		

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 11/24/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	notes made by the MD. Through review of Resident 1's clinical record, the order for .NH3.one time only for confusion. inputted by LN 5 on 10/3/25 at 12:29 a.m., was reviewed. The DON stated the labs were never drawn for Resident 1. The DON stated she expected the labs to be done immediately (STAT) due to their impact on Resident 1's cognition and medical condition, including his ammonia level. She stated that LN 5 did not understand the urgency of ordering the labs STAT given Resident 1's encephalopathy and increased confusion. During a phone interview on 10/9/25, at 2:49 p.m., the ADM stated he recalled Resident 1, and stated he exhibited off and on wandering behavior. The ADM stated he had reviewed the facility's video cameras located outside the main entrance of the building and Resident 1 was alone when he left through the front doors of the building at 7:45 a.m. on 10/4/25. The ADM stated the night shift staff were responsible for unlocking the front doors each morning at 7 a.m. The ADM explained there was nobody at the front desk at the entrance of the facility at the time Resident 1 eloped and the receptionist, who sits at the main entrance desk, does not start her day until 8 a.m. The ADM stated Resident 1 had refused his wander guard and so there was a preemptive order from the MD to send Resident 1 out to the hospital. The ADM stated staff were watching and trying to redirect Resident 1 and him receiving one-on-one supervision from staff would not be a first-level intervention as it could be restrictive. The ADM recognized the seriousness of Resident 1 leaving the facility and being found about one and half to two miles away, with staff unaware of his absence for roughly an hour and a half. During a concurrent phone interview and record review on 10/7/25, at 4:31 p.m., the MD stated Resident 1 was admitted to the facility for confusion and had a diagnosis of encephalopathy. The MD stated Resident 1's low sodium and/or high ammonia levels could have been related and/or a contributing factor to his increased confusion which was why he was monitoring them by ordering labs. The MD stated he gave staff an order to send Resident 1 to the hospital for confusion and for his own safety, if he was not better and remained confused. The MD explained this was due to the hospital's ability and access to perform faster evaluations including labs and other tests for Resident 1. The MD stated the nurse contacted him regarding Resident 1's confusion and he ordered labs earlier in the week and his expectation was they should be done. The MD stated the next thing he knew he received a phone call from staff stating Resident 1 had eloped from the facility. The MD stated if Resident 1 was confused and combative the staff should have anticipated his risk for elopement; care planned the behavior and notified him. The MD explained had he been aware of Resident 1's increased confusion and refusal of care he might have changed his mind and ordered different interventions. The MD stated his expectation was for the facility to inform the RP and/or family of pending labs, including labs ordered but not followed up on, and inform the family to follow up with Resident 1's primary medical doctor for care. The MD stated the elopement could have put Resident 1 at risk for a negative psychosocial effect and possible injury due to his elopement but that everybody was at risk for this generally. During a phone interview on 10/8/25, at 8:43 p.m., with the RP and EC 1, the RP stated Resident 1 had been more confused and was saying get me out of here and let's make a go and was paranoid. The RP stated at that time Resident 1 was using a wheelchair with assistance and he witnessed Resident 1 get up and walk to his room which was about 100 to 200 feet away. The RP stated on Friday afternoon around 4:30 p.m. (10/3/25), the facility called him to report Resident 1 was not listening and was refusing to get out of the transport van and would not go inside the facility to his room. The RP stated the facility requested he speak to Resident 1 over the phone, and he told Resident 1 he could not leave the facility and needed to go inside. EC 1 stated later in the evening around 5:15 p.m., a nurse called EC 1 and told her she needed to come get Resident 1 because the facility did not have twenty-four-hour care. EC 1 stated staff told her if she did not come to the facility then the nurse would have to call the doctor and get an order to take him to the hospital. The RP stated he told the nurse to do whatever they needed to do to keep Resident 1 safe. The RP explained that was the last phone call they received from the facility regarding Resident 1. The RP stated up until today, the facility never reached out to them regarding Resident 1's elopement or any updates of tests that were pending or ordered from the MD. The RP (continued on next page)		

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 11/24/2025
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	stated he received a phone call from Resident 1's neighbor (FF) on 10/4/25 around 8:40 a.m., and she told him Resident 1 was in a shopping center sitting on a bench. The RP stated he hung up the phone and drove there. The RP stated by the time he arrived the FF had walked home and returned to Resident 1 with her vehicle, and Resident 1 was in the FF's house when he arrived. The RP stated Resident 1 was wearing shorts and a T-shirt and did not look right. The RP explained Resident 1 appeared scruffy, confused, disoriented, and did not know where he was or how he got there. The RP stated Resident 1 was happy to see her [referring to the FF]. The RP explained Resident 1 was freezing and shaking and was very thirsty. The RP stated he felt Resident 1 was scared and he had not walked that far since he broke his neck in May of 2025. The RP stated Resident 1 looked exhausted and after the elopement slept for three days, barely waking up. The RP stated Resident 1 expressed his body hurt. The RP stated he was not sure how Resident 1 was able to walk almost two miles without falling. The RP explained he was frustrated with the lack of communication from the facility regarding Resident 1's care. The RP stated anything could have happened to him once he left the facility alone. During a phone interview on 10/9/25, at 2:01 p.m., the Family Friend (FF) stated, on 9/4/25, she went on a walk with her son and dog, whom she had adopted from Resident 1 a few months prior. The FF explained they went into the grocery store and when they came out and started the return walk home, she saw Resident 1 sitting on a bench located on the walking trail behind the grocery store. The FF stated Resident 1 looked very fragile and appeared to be dead. The FF further explained Resident 1 looked grey and had lost his color in his face and was shivering. The FF stated she immediately went to him, and Resident 1 appeared super pale, clammy, with sweat on his face, and was shaking and she asked him if he escaped the facility. The FF stated Resident 1 seemed relieved when he saw her. The FF stated Resident 1 was a stubborn guy who does not want help with things but when she found him, he told her he needed help. The FF stated she left Resident 1 with her son and dog while she walked back home to get her car. The FF further explained she returned and loaded Resident 1 into her vehicle. The FF stated Resident 1 was confused and disorientated and was in and out in terms of his ability to recognize her or understand the situation. The FF stated Resident 1 appeared dehydrated and was unbalanced. The FF stated it would have been a long walk and a lot of strenuous physical activity for him to get to the location she found him at. The FF stated she estimated she found Resident 1 around 8:30 a.m. as she had called his son (RP 1) at 8:39 a.m. and he was coming to meet her. The FF stated she didn't know what would have happened to him if she hadn't found him and she was walking a different path home that went behind the building and was very grateful she did because she found Resident 1. The FF stated she felt Resident 1 would have continued to deteriorate while sitting on the bench. The FF explained it could have been much worse as the area was sketchy, and the roads were busy, and Resident 1 could have been hit by a car. A review of a facility policy and procedure (P&P) titled Wandering and Elopements, revised 3/19, the P&P indicated, .The facility will identify residents who are risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.If a resident is missing, initiate the elopement/missing resident emergency procedure.determine if the resident is out on a authorized leave or pass.if the resident was not authorized to leave, initiate a search of the building (s) and premises; and.If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and as necessary v		