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	05/12/2026

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for 2 of 12 sampled residents (Resident 1 and Resident 2) when insulin (a medicine that helps control blood sugar) orders lacked parameters for licensed nurses regarding when to notify the physician and when to hold insulin administration for abnormal blood glucose levels.This failure had the potential to result in inconsistent clinical decision-making, inappropriate insulin administration, and adverse outcomes, including hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Findings:1. Review of Resident 1's admission RECORD, indicated Resident 1 was admitted to the facility with a diagnosis of, but not limited to type 2 diabetes mellitus with hyperglycemia (the person has diabetes with very high blood sugar).Review of Resident 1's clinical record titled, Order Details, ordered 8/20/24, indicated, Order Summary: NovoLOG Solution 100 UNIT/ML (Insulin Aspart) [a fast-acting insulin medicine used to lower high blood sugar - unit of measurement] Inject 6 unit subcutaneously [given under the skin] before meals for diabetes.Review of Resident 1's clinical record titled, Care Plan Report, dated 12/14/22 and revised 2/25/26, indicated under the section titled, Focus, indicated, .[Resident 1] has Diabetes Mellitus: WITH HYPERGLYCEMIA. Further review under the section titled, Goal, indicated, . Will have no complications.During an interview and concurrent record review on 5/12/26 at 7:45 AM, Resident 1's order for NovoLOG (insulin), dated 8/20/24, was reviewed with Licensed Nurse (LN) 7. LN 7 stated that Resident 1 was diabetic. LN 7 confirmed Resident 1's order for insulin indicated to administer 6 units of insulin and that the 6 units of insulin were administered as ordered. LN 7 confirmed that Resident 1's NovoLOG insulin order did not contain parameters for when to notify the physician and when the insulin should be held. LN 7 stated even though there were no parameters listed on Resident 1's NovoLOG insulin order, that blood sugar levels still needed to be checked because insulin administration could place the resident at risk for adverse outcomes, explaining that low blood sugar could result in a coma and elevated blood sugar could result in adverse effects related to hyperglycemia. LN 7 further reviewed Resident 1's electronic health record (EHR) and stated there were no progress notes or documentation indicating the physician had been notified regarding the need for insulin administration parameters. LN 7 stated it was important to have parameters to guide nurses on when to notify the physician or when to hold insulin administration. LN 7 further stated that without parameters, there was a risk for inconsistent nursing interpretation and management of insulin administration.2. Review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with a diagnosis of type 2 diabetes mellitus (DM) with hyperglycemia (the person has diabetes with very high blood sugar) and diabetic neuropathy (nerve damage caused by diabetes).During an interview with concurrent record review on 5/12/26 at 9:23 AM, Resident 2's insulin orders for Glargine and Lispro, dated 5/7/26 and 5/8/26, and Resident 2' Medication Administration Record (MAR), dated 5/26, were reviewed with LN 3. LN 3 confirmed Resident 2's insulin order indicated the following: Insulin Glargine 36 units at bedtime (HS) and Insulin Lispro 10 units before breakfast, lunch, and dinner. LN 3 further stated that Insulin Glargine was a long-acting insulin and Insulin Lispro was a short-acting insulin. During further record review, LN 3 stated that there were no physician-ordered parameters for either insulin medication indicating when to notify the (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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician or when to hold insulin administration based on blood sugar levels. LN 3 stated, since there are no parameters, she would use her own critical thinking to hold or administer the insulin. Further review of the EHR revealed that on 5/11/26 before breakfast, Resident 2's blood sugar was 110, and documentation indicated that a licensed nurse administered 10 units of Insulin Lispro. Further review revealed that on 5/11/26 before lunch, the resident's blood sugar was 93, and documentation indicated the insulin was held. Additional review revealed that on 5/11/26 before dinner, the resident's blood sugar was 112, and documentation reflected code 5, indicating that Resident 2 refused the insulin administration. LN 3 stated that it was important to have physician-ordered parameters to guide nursing staff and ensure resident safety during insulin administration. LN 3 further stated that the absence of parameters could place the resident at risk for inconsistent nursing judgment and potential complications related to hypoglycemia or hyperglycemia, including loss of consciousness, change in condition, and possible hospitalization.During an interview on 5/12/26 at 10 AM, with Resident 2 in the resident's room, Resident 2 stated that he had been diabetic for approximately 10 years. Resident 2 stated that licensed nurses routinely checked his blood sugar levels and informed him of the results. Resident 2 confirmed that he refused the insulin administration before dinner on 5/11/26 and stated that he was familiar with how his body reacted when his blood sugar level was becoming too low. Resident 2 stated, I can usually feel when something is not right. When asked whether nursing staff followed specific blood sugar parameters or guidelines indicating when insulin should not be administered, Resident 2 stated that he was unsure whether licensed nurses used a specific lower or upper blood sugar limit for insulin administration. Resident 2 further stated that he could not recall nursing staff explaining any physician-ordered parameters or guidelines regarding when insulin should be held or when the physician should be notified. Resident 2 stated that having such guidelines was important to help prevent possible complications related to blood sugar fluctuations and insulin administration.During an interview on 5/12/26 at 1:29 PM, with the Director of Staff Development (DSD), the DSD stated that all insulin orders should include physician-ordered parameters to provide licensed nurses with clear guidance regarding when insulin should be administered, when insulin administration should be held, and when the physician should be notified based on blood sugar results or changes in the resident's condition. The DSD stated that clearly defined physician parameters were important to promote consistent nursing practice and resident safety, and to help prevent complications associated with hypoglycemia and hyperglycemia. The DSD further stated that it was not considered acceptable or safe nursing practice for licensed nurses to rely solely on personal judgment or individual critical thinking when determining whether insulin should be administered or withheld in the absence of physician-ordered parameters. The DSD stated that without clear physician guidance, residents could be placed at risk for adverse outcomes, including low blood sugar, changes in condition, loss of consciousness, and possible hospitalization. The DSD reiterated that all insulin orders should contain specific physician-ordered parameters and instructions to guide nursing staff in the safe administration and monitoring of insulin therapy.During an interview on 5/12/26 at 3:54 PM, with the Director of Nursing (DON), the DON stated that it was her expectation for licensed nurses to follow insulin orders as written and according to physician instructions. The DON further stated that all insulin orders should include clear physician-ordered parameters indicating when insulin administration should be held and when the physician should be notified based on blood sugar results, changes in condition, or signs and symptoms of hypoglycemia or hyperglycemia. The DON stated that without physician-ordered parameters, licensed nurses would not have clear guidance regarding appropriate interventions, monitoring, or physician notification requirements related to insulin administration and blood sugar management. The DON further stated that the absence of specific parameters could result in inconsistent nursing practices and place residents at risk for complications associated with improper insulin administration, including hypoglycemia, hyperglycemia, changes in condition, and possible hospitalization.Review of facility policy and procedure (P&P) titled, Diabetes - Clinical Protocol, revised date 3/25, the P&P indicated, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The provider will order desired glucose targets and monitoring regimens, as well as parameters for reporting information related to blood sugar management.The staff will incorporate orders and reporting parameters into the Medication Administration Record and care plan.