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	10/24/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49823 Based on interview and record review, the facility failed to ensure a resident's right to a dignified existence when one resident (Resident 49) in a sample of 21 was exposed to hearing her roommate and another resident engage in sexual activity in their shared room at the facility. The facility was aware of the situation, yet failed to address the issue. This failure led to Resident 49 feeling humiliated and embarrassed and had the potential to negatively impact her psychosocial well-being. Findings: A review of Resident 49's Admission Record indicated that Resident 49 was admitted to the facility in 2023. The Admission Record further indicated that Resident 49 had diagnoses which included but were not limited to arthritis (painful inflammation and stiffness of the joints), and depression (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living). A review of Resident 49's Minimum Data Set (MDS, a comprehensive care assessment tool), indicated that Resident 49 required maximum assistance with transfers from her bed to a wheelchair, bathing, dressing, and personal hygiene. During an interview with Resident 49 on 10/21/24 at 3:44 p.m. in her room, Resident 49 stated that her roommate had sex with her boyfriend in their room, sometimes at night, and that she had to listen to it because she couldn't leave the room without help. Resident 49 stated that listening to her roommate and her roommates boyfriend engage in sexual activity was embarrassing and humiliating. Resident 49 stated that she complained to staff, but staff did not listen to her. During an interview on 10/21/24 at 3:55 p.m. with the facility Activity Assistant (AA), the AA stated that facility staff were well-aware that Resident 49's roommate and her boyfriend engaged in sexual activity together in Resident 49's room. AA stated that Resident 49's roommate and her boyfriend needed their own spot, as they were loud. AA stated that she had worked at the facility for [AGE] years but did not know if there was a policy regarding residents engaging in sexual activity in the facility. AA stated that it had been going on since January (2024). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 10/24/24 at 4:20 p.m., the DON stated that the facility was aware that Resident 49's roommate and her boyfriend were engaging in sexual activity in the facility. The DON confirmed that Resident 49 was not able to leave the room without assistance. The DON acknowledged that residents who could not leave the room without assistance while the roommate and her boyfriend engaged in sexual activity could have suffered a negative psychological effect. A review of a facility policy and procedure (P&P) titled, Dignity, revised February 2021, indicated, .Policy Statement .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs . A review of a facility P&P titled, Resident Rights, Revised December 2016, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .b. be treated with respect, kindness, and dignity .g. exercise his or her rights as a resident of the facility .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 43943 Based on observation, interview, and record review, the facility failed to ensure one of 21 sampled residents (Resident 37) had her call light (a handheld device that allowed Resident 37 to communicate with nurses and caregivers in the facility setting) within reach. This failure resulted in Resident 37 not being able to reach staff when she needed assistance on 10/21/24 and could have resulted in injury due to her needs not being met in a timely manner. Findings: During a review of Resident 37's clinical record titled, Admission Record (a document that contained Resident 37's demographic information), indicated Resident 37's diagnosis included epilepsy (a brain disorder that can cause seizures/uncontrolled body movements), osteoporosis (a bone disease that caused bones to become weak and more likely to break), and dementia (a chronic condition that caused a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life). During an observation on 10/21/24, at 9:20 a.m., Resident 37 was in her bed and her right hand was contracted (a permanent or temporary tightening of muscles, tendons, skin, and nearby tissues that limits the normal movement of a joint or body part of all extremities). The call light was hanging off the right side of the upper bed side rail and out of Resident 37's reach. Resident 37 attempted to grab the call light string but was not able to do so because her hand was contracted. Resident 37 requested that the State Agency notify facility staff that she needed assistance. During a concurrent observation an interview on 10/21/24, at 9:51 a.m., Licensed Nurse (LN) 1 verified Resident 37 was not able to reach the call light. LN 1 stated Resident 37 was dependent on staff to meet all her physical needs and she was a high fall risk. LN 1 stated the call light should have been placed near her left hand or an adaptive (different/specialized) call light should have been implemented. During an interview on 10/21/24, at 9:55 a.m., with Certified Nursing Assistant (CNA 1), CNA 1 stated it was all the staff's responsibility to ensure Resident 37's call light was in reach and that she had the ability to use the call light that was in place. CNA 1 stated Resident 37 was unable to walk, and take care of her physical needs. A review of Resident 37's clinical record titled, Care Plan (a document that indicated Resident 37's problems, goals, and interventions), dated 10/20/23, indicated Resident 37 had an alteration in musculoskeletal (bones and muscles) status related to contracture. Additionally, Resident 37 had severe cognitive (mental health) impairment. An intervention included to anticipate Resident 37's needs and meet them promptly. A review of Resident 37's clinical record titled, Care Plan, dated 7/20/23, indicated Resident 37 was at risk for falls and an intervention included to keep the call bell in reach and answer promptly. (continued on next page)

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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 10/24/2024

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 37's clinical record titled, Fall Risk Observation/Assessment (an assessment that indicated Resident 37's contributing factors to a fall and risk for falls), indicated Resident 37 was a high risk for falls (score 20) related to Resident 37's inability to walk, change in metal status in the past 90 days, being incontinent (unable to control bowel and bladder), and was on medications that contributed to falls. A review of Resident 37's clinical record titled, Section GG - Functional Abilities and Goals (an assessment that indicated Resident 37's admission and discharge self-care and mobility performance data), dated 9/26/24, indicated Resident 37 was dependent on staff for eating, oral hygiene, toileting hygiene, shower/bathe, dressing, and transferring from bed to chair. During a concurrent interview and record reviews on 10/23/24, at 9:087 a.m., with the Director of Nursing (DON), the facility's Policies and Procedure (P&Ps) titled, Accommodation of Needs, dated 3/21, and Answering the Call Light, dated 4/16, were reviewed. The P&P titled, Accommodation of Needs, indicated, . Our facility's environment and staff behaviors are directed toward assisting and resident in maintaining and/or achieving safe independent functioning, dignity and well-being . 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis . The P&P titled, Answering the Call Light, indicated, . 4. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident . The DON acknowledged Resident 37 may have been a candidate for an adaptive call light and that the P&Ps were not followed.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161 Based on observation, interview, and record review, the facility failed to protect resident rights to be free from abuse (verbal, mental, sexual, or physical abuse) and neglect (failure to provide goods and services necessary to avoid physical harm or mental anguish) for two of twenty-one sampled residents (Resident 32 and Resident 38) when the facility was aware that Resident 32 and Resident 38 were continuing to engage in sexual activity which began on or around [DATE] and: 1. The facility did not determine if Resident 32 and Resident 38 had the capacity for sexual consent (physical and psychological actions that involve sexual arousal, desire, and satisfaction); 2. The facility failed to notify the medical doctor and/or psychiatrist regarding the sexual relationship between Resident 32 and Resident 38 to assist in determining if both residents were able to consent to the sexual relationship; and, 3. The facility did not put protective measures in place to prevent potential sexual abuse for Resident 32 and Resident 38 until it was determined if both residents had the ability to give sexual consent. This failure had the potential to result in psychosocial, sexual and/or physical harm to Resident 32 and Resident 38 when it was undetermined if either resident was able to consent to a sexual relationship. This failure also caused Resident 32 and Resident 38 to feel upset and confused due to some staff allowing them to engage in sexual activity and other staff preventing the sexual activity. The failure also placed other vulnerable residents in the facility at risk of sexual abuse due to the facility's lack of a process to evaluate residents' capacity to consent to sexual activity. This created a likelihood of serious physical and/or psychosocial harm (negative impact on physical, emotional, and/or mental wellness) to occur, if not corrected immediately. The Immediate Jeopardy (IJ-a threat to resident health or safety which requires immediate corrective action due to the likelihood of serious injury or harm) began on or around [DATE] when the facility failed to assess Resident 32's and Resident 38's ability to consent to sexual activity and did not identify the sexual contact as potential abuse. The Administrator (ADM) was notified of the IJ on [DATE], at 4:30 PM. On [DATE], at 6:08 PM, a removal plan was provided by the facility. The State Agency verified the facility's implementation of the removal plan while onsite at the facility. On [DATE], at 6:30 PM, the ADM was notified the IJ immediacy was removed. There was no non-compliance identified at a lower level upon removal. Findings: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of Resident 32's ADMISSION RECORD, indicated Resident 32 was admitted to the facility with a diagnosis including but not limited to cerebral infarction (blood supply to brain is blocked or reduced and can cause brain cell damage), hypertension (heart has to work harder to pump blood), and non-ST elevation myocardial infarction (a type of heart attack when your heart's need for oxygen cannot be met). Resident 32's admission record had a Resident Representative (RP) identified as RP 2. Review of Resident 32's Order Summary Report (document which includes all medication, tests, and non-medication orders), dated [DATE], indicated, .Resident is not capable Of Understanding Right, Responsibilities, And Informed Consent [process of communication between you and your health care provider that often leads to agreement or permission for care, treatment, or services]. Review of Resident 32's BRIEF INTERVIEW FOR MENTAL STATUS (BIMS) (a tool that healthcare providers use to assess a person's cognitive function), dated [DATE], indicated, Resident 32 had a BIMS score of 10, which indicated moderately impaired cognition (when a person has some trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). Review of Resident 32's BIMS, dated [DATE], indicated, Resident 32 had a BIMS score of 8, which indicated moderately impaired cognition. Review of Resident's 32's Cognitive Impairment Care Plan (a document that outlines a patient's care needs, diagnosis, treatment goals, and nursing orders), dated [DATE], indicated, . [Resident 32] exhibits cognitive loss related to altered cognitive performance with BIMS Score of ,d+[DATE] indicating moderately impaired and hx [history] of TIA [transient ischemic attack, or TIA, is a temporary blockage of blood flow to the brain] . [Resident 32] will continue to recognize family [Resident 32] will communicate basic needs to the extent possible . Communicate with resident and [RP 2], regarding residents capabilities and needs . Identify yourself at each interaction. Face [Resident 32] when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc .[Resident 32] understands consistent, simple, directive sentences. Provide [Resident 32] with approaches that maximize involvement in daily decision making and activity (limit choices, ask yes or no questions, use cueing, instructions)- stop and return if agitated . Monitor for changes in cognitive status. Observe for indicators of clinical changes . behavior changes. Notify physician if occurs . Review of Resident 32's Activities Note, dated [DATE], indicated, .(Late Entry) on [DATE] at approximately 3pm, [Resident 32] was found in [Resident 38's] bed, when asked what he was doing he explained that she invited him to lie down with her and watch a movie, writer explained to him and her that, that isn't allowed, then writer escorted him out of the room. Writer returned a few minutes later and he was back in her bed . writer again escorted him back to his room and again explained to him the facility rules, he seemed to understand . Review of Resident 32's Nurse's Note, dated [DATE], indicated, .Resident has became [sic; used after a copied or quoted word that appears odd or erroneous to show that the word is quoted exactly as it stands in the original] very affectionate with [Resident 38]. Reported to [staff name redacted] in S.S. [Social Services] . Review of Resident 32's Nurse's Note, dated [DATE], indicated, .resident is being monitored with being affectionate towards [Resident 38] in room [Resident 38's room], but was easily redirected, endorsed behavior to noc [night shift] nurse. will continue to monitor . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 32's Social Service Note, dated [DATE], written by the Social Services Director (SSD), indicated, .I had a lengthy meeting with the patient and their peer [Resident 38], during which they referred to each other as boyfriend and girlfriend. They expressed their desire to be discharged from the skilled nursing facility (SNF) and to live in the female resident's apartment .The male party [Resident 32] needed reminders about the purpose of our meeting .overall it was determined and expressed by both, they wish to have private intimateness together. This appears to be the primary motive for wishing to discharge from the SNF . Review of Resident 32's Case Management Note dated [DATE], written by the SSD, indicated, .A female resident [Resident 38] and this patient [Resident 32] have openly expressed their relationship and love for each other .Both residents express their decide to engage in sexual relations and intimate experiences such as holding hands, snuggling, kissing, and fondling .The male resident's responsible party has been informed of this relationship, while the female resident is her own responsible party .The Ombudsman [OMB, representatives who assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preferences] has been notified and has met with both parties. A care plan will be developed to respect the resident's dignity and autonomy while ensuring safety and minimizing the risk of harm . Review of Resident 32's Behavior Note, dated [DATE], indicated, .resident is being monitored with being affectionate towards a female resident in room [Resident 38's room number], but was easily redirected. endorsed behavior to noc [night] nurse. will continue to monitor . Review of Resident 32's Intimate Behavior Care Plan, dated [DATE], indicated, .Resident displays intimate behavior towards another resident. Both residents consent to these mutual feelings .Goal . Resident will safely act on his feeling with both residents consenting .Interventions/Tasks . Educate/in-service staff regarding mutual feelings as being consented . Encourage residents to act on their intimate desires in privacy and respecting other residents . Encourage safe intimacy practices Invite Psychologist . Provide private space/time . Review of the document did not indicate any communication the facility had with Resident 32's psychologist. Review of Resident 32's Summary for Providers dated [DATE], written by the Director of Nurses (DON), indicated, .the Change in Condition/s reported .Nursing observations, evaluation, and recommendation are: Patient was last seen walking toward the front lobby when this writer asked where he was going he sounded upset prior to that and he wanted to be with his partner .Cna [CNA, Certified Nurse Assistant] stated he was sitting in front of lobby. Then this cna [CNA] went back to front he wasn't to be found immediately made staff aware to look for patient. Housekeeping found him outside by the water shut off .Primary Care Provider responded with the following feedback .apply wander guard frequent visual checks . Review of Resident 32's IDT Note (Interdisciplinary Team, a group of healthcare professionals who work together to assess, coordinate, and manage a resident's care), dated [DATE], written by the SSD, indicated, LATE ENTRY .Elopement Risk On [DATE] around 2030 [8:30 p.m.] [Resident 32] was found outside, within facility grounds and assisted back into the facility. Resident got upset of not spending enough time with another resident. Resident displays intimate behavior towards another resident . New Interventions Implemented .Invite the Psychologist . Note text . [names redacted: SSD, ADM (Administrator), DON, CM (Case Manager) 1] . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 32's Nurse's Note, dated [DATE], indicated, .Resident was told to go to his room multiple times he is in room [Resident 38's room number] unable to redirect making roommates uncomfortable . Review of Resident 32's Nurse's Note, dated [DATE], indicated, .resident found with female resident having sex in female resident room. after separating the two residents, both residents refused medication and assessments for am shift; no adverse s/s [signs and symptoms] of missed dose of medications; plan of care ongoing . Review of Resident 32's Physician Progress Note, dated [DATE], written by the Nurse Practitioner (NP), indicated, .Assessment .Dementia [loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life] .Plan .Monitor neuro and mental status . Review of Resident 32's physician progress notes through [DATE] did not indicate or mention Resident 32 engaging in sexual activity with another resident or Resident 32's ability to consent to sexual activity. During a phone interview on [DATE], at 12:14 p.m., RP 2 stated Resident 32 had a girlfriend (Resident 38), and she was dragging him around all over the facility. RP 2 stated Resident 32 will lay down in her [Resident 38's] bed and she was not sure if it was still going on as this was a few months ago. RP 2 stated when visiting, she saw Resident 32 with his pants off, wearing no undergarments, and he was laying in Resident 38's bed. The RP 2 stated she told him to go to his room. RP 2 stated the night Licensed Nurse (LN) told her he was always in Resident 38's room. RP 2 stated the night LN would call her on her phone at 9:00p.m. or 10:00 p.m. and inform her he would not leave Resident 38's room and would ask RP 2 for help in getting him to leave her room. RP 2 stated she was not aware of Resident 32 and Resident 38 engaging in any type of sexual behavior and the SSD had never informed her of this. RP 2 stated Resident 38 was not able to consent to sexual touching due to his dementia. RP 2 stated she would have wanted to be informed by the facility and she stated she would not want him to engage in sexual activity with Resident 38 or other residents. 2. Review of Resident 38's ADMISSION RECORD, indicated, Resident 38 was admitted to the facility with diagnoses including but not limited to dementia, bipolar disorder (mental health condition which causes extreme mood swings), obsessive compulsive disorder (lasting and unwanted thoughts that keeping coming back or urges or images that are intrusive and cause distress or anxiety), anxiety disorder (excessive fear or worry about a specific situation), major depressive disorder (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), attention-deficit hyperactivity disorder (combination of persistent problems, such as difficulty sustaining attention, hyperactivity and impulsive behavior), and herpes viral vesicular dermatitis (a skin infection caused by a virus and spread by skin-to-skin contact). Resident 38's admission record indicated she was her own RP (she made her own medical decisions). Review of Resident 38's Order Summary Report, indicated, physician orders written on [DATE], for the medication Valacyclovir 500 mg [an antiviral medication] to be taken two times a day orally, as follows, .Give 1 tablet by mouth two times a day for HSV [herpes simplex virus] prophylaxis [prevention] If you get an outbreak increase to 4 tablets (BID) [twice a day] ONLY FOR 24 HOURS AFTER THAT RETURN TO 1 TABLET BID . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 38's Mood Care Plan, dated [DATE], indicated, .[Resident 38] is a risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social .Being fidgety or restless, moving around a lot more than usual, feeling down, depressed, or hopeless .observe for signs and symptoms of depression/emotional distress and notify physician as needed .Review medications as a possible cause or contributing factor to mood .Social services to visit and evaluate as needed . Review of Resident 38's Antidepressant Medication (prescription medicines to treat depression. Depression is more than feeling a little sad or blue for a few days) Care Plan, dated [DATE], indicated, . [Resident 38] uses antidepressant medication r/t [related to] Depression .Monitor/document/report to MD [medical doctor] prn [as needed] .fear of being alone or with others, attention seeking, concern with body functions, anxiety, constant reassurance . Review of Resident 38's Order Summary Report, indicated physician orders written on [DATE], as follows, . Resident does not have the capacity to make her own decisions related to: DEMENTIA, MAJOR NEUROCOGNITIVE DISORDER DUE TO MULTIPLE ETIOLOGIES [decreased mental function and loss of ability to do daily tasks] . Review of Resident 38's Nurse's Note, dated [DATE], indicated, .Resident noted with unappropriated [sic] sexual behavior. Found performing sexual act with male patient in his room. Staffing intervened and separated both patients. SBAR [Situation, Background, Assessment, and Recommendation-a method used to communicate important information] sent to MD. Social service, administrator, and Ombudsman aware . Review of the clinical record did not indicate communication with Resident's 38's medical physician or psychiatrist. Review of Resident 38's Nurse's Note, dated [DATE], written by the Case Manager (CM) 1, indicated, .This writer met today with the local county ombudsman to address a recent incident involving a resident [Resident 38] and another custodial member [Resident 32]. The resident had contacted the ombudsman expressing concerns about needing her cell phone, purse, clothing from her apartment, and the desire to engage in sexual activity with a companion. During this meeting, the writer and the ombudsman extensively discussed the resident's current major neurocognitive disorders as documented by the doctor. The resident's previous living and functional levels, her ongoing treatment plan, RNA [Restorative Nurse Aide; provides assistance with walking, mobility, dressing, and grooming to prevent decline in activities of daily living] services, and discharge plan was also discussed in length. The most recent recommendation for the resident's transition to custodial care was to provide ,d+[DATE] [24 hours a day, 7 days a week] caregiver support upon discharge due to her functional and progressive cognition conditions. The ombudsman agreed to allow sexual activities within the facility's protocol, ensuring privacy and dignity for others. All parties involved were in agreement with the plan, and the IDT (Interdisciplinary Team) was notified . Review of Resident 38's Behavior Note, dated [DATE], indicated, .Resident was found laying in [Resident 32's] bed next to [Resident 32]. Resident stated that she was sleeping. Resident was convinced by registered dietitian to leave the bed as it was unsafe. Resident agreed and was assisted into wheelchair by LN and CNA and escorted out of room . Review of Resident 38's Social Service Note, dated [DATE], indicated, .RESIDENT REQUESTED TO SPEAK WITH SOCIAL SERVICES ABOUT THE POSSIBILITY OF HER AND ANOTHER RESIDENT MOVING INTO HER APARTMENT; ENDORSED TO SOCIAL SERVICES . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 38's Case Management progress note, written by the SSD, dated [DATE], indicated .I had a lengthy meeting with the patient and their peer, during which they referred to each other as boyfriend and girlfriend. They expressed their desire to be discharged from the skilled nursing facility (SNF) and live together in the female resident's apartment. We extensively discussed the necessary coordination that would need to take place for this to realistically happen. This included securing a 24-hour caregiver, addressing financial matters, involving both families, planning for a safe discharge .We also contacted the apartment complex where the female resident resides. However, we were informed that she has been evicted and her whereabouts are unknown. Additionally, her rent has not been paid since [DATE], and her . assistance has expired. The female resident was unaware of these circumstances and believed her rent was being paid automatically. It seems that returning to this apartment, even with a safe discharge plan, is no longer an option .Both parties expressed their love for each other and their desire to leave the SNF together. However, the male party needed reminders about the purpose of our meeting. I emphasized the importance of involving the male resident's responsible party (RP) in this discussion, and both parties agreed to speak with her. I subsequently spoke with the male resident's RP [RP 2] and informed her about everything discussed, including the ongoing relationship between the two. [RP 2] expressed strong disagreement with the male resident's desires to discharge from Garden City. She said she would be speaking with both parties to discuss. Overall it was determined and expressed by both, they wish to have private intimateness together. This appears to be the primary motive for wishing to discharge from SNF. Writer explained to both remaining in the SNF would allow them to be together, as they wish and continue to do safely as they have the care they currently require . Review of Resident 38's Behavior Note, dated [DATE], indicated .resident is being monitored with being affectionate towards a male resident in room [Resident 32's room number], but was easily redirected. endorsed behavior to noc nurse. will continue to monitor . Review of Resident 38's IDT NOTE, dated [DATE], written by the SSD, indicated, .It has been brought to our attention of IDT that this female patient and a male patient are in a romantic relationship and have expressed their desire to engage in sexual intimacy and pursue a relationship Review of the document indicated in attendance at the meeting was the ADM, and the DON amongst others. Review of Resident 38's Nurse's Note, dated [DATE], indicated, Resident kept going in [Resident 32's] room . Tried to redirect but patient won't listen. Finally patient in room [Resident 32's room number] came out she woke him up. She wanted him in her room. Then later she came to nurse station trying to get all her medication she wanted to check out. Will continue to monitor . Review of Resident 38's BRIEF INTERVIEW FOR MENTAL STATUS (BIMS), dated [DATE], indicated, Resident 32 had a BIMS score of 12, which indicated she had moderately impaired cognition. Review of Resident 38's Nurse's Note, dated [DATE], indicated, . Patient's boyfriend came to nurse station saying someone was on floor. When this writer went to evaluate patient she was sitting on floor next to partner's bed. She was able to move upper and lower extremities. No injuries . (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident 38's IDT NOTE, dated [DATE], written by the SSD, indicated, .On [DATE] around 2331 [11:31 p.m.] . [Resident 38] had an unwitnessed fall in her partners room, refused to answer what led to fall. Resident status prior to event: The patient was attempting to visit peer in his room Risk Factors .dementia, muscle weakness .bipolar disorder, OCD, anxiety, depression, ADHD, herpes viral vesicular dermatitis, hx [history] of falls .Cognitive impairment . Review of the document indicated the SSD, Assistant Director of Nursing (ADON), and the Administrator (ADM) were in attendance. Review of Resident 38's Nurse's Note, dated [DATE], indicated, . Resident found with male resident having sex in female resident's room. after separating the two residents, both residents refused medication and assessments for am [morning] shift; no adverse s/s of missed dose of medications; plan of care ongoing . During an interview on [DATE], 3:55 p.m., the Activities Assistant (AA) stated staff had reported to her that Resident 32 and Resident 38 were known to have sex together. The AA stated staff were aware and Resident 38's roommate (Resident 49) had complained about their loud sex and stated she must turn up her television loud. The AA stated Resident 32 and Resident 38 needed their own spot to have sexual activities but stated she did not know what to do about it. the AA stated she had been working at the facility for twelve years and was unsure if there was a policy regarding two residents having a sexual relationship. The AA stated they could not stop their behavior and staff tell the residents to be respectful because they share rooms. The AA stated both families were aware. The AA stated Resident 32 had a responsible party, RP 2 who stated Resident 32 could not consent to the sexual relationship. The AA stated Resident 38 can be persistent and stated she was in charge of the relationship. The AA stated RP 2 was not happy about Resident 32 and Resident 38's relationship. The AA stated their relationship had been going on since January of 2024. During a concurrent observation and interview on [DATE], at 4:02 p.m., Resident 32 and Resident 38 entered Resident 38's room. Resident 32 then sat at the edge of Resident 38's bed. Resident 38 stated she and Resident 32 would like to be together and have privacy. Resident 38 stated it was impossible for them to be alone. Resident 38 stated her roommates did not want them to have sexual partners. Resident 38 stated she spoke to the Administrator (ADM) and asked for their own room to share and was told the facility was not set up to have couples in a room together or cohabitating. Resident 38 stated Resident 32's family was not for it. Resident 38 stated they were going to contact the senior advocacy to get Resident 32's house back and Resident 32 did not remember signing his house away. During a concurrent interview and observation on [DATE], at 8:23 a.m., Resident 32 stated he did not know what day or year it was and stated since his stroke he had become forgetful. Resident 32 stated he cannot remember anything, and RP 2 made all his decisions for him. Resident 32 stated he had a girlfriend but could not remember her name and stated her room was close to his room, but he cannot recall what room she was in. Resident 32 stated he visits with her in the hallway, and he does not visit with her in her room nor was she allowed to visit him in his room. Resident 32 stated he likes to kiss her, but staff do not like them being together. Resident 32 stated he wanted privacy with her, but staff did not give them privacy. Resident 32 stated they just wanted to be together by themselves and stated he was never allowed to be alone with her. It was observed that Resident 32's room was next door to Resident 38's room. As Resident 32 was walking to the dining room, Resident 38 was heard calling Resident 32's name and asking him to come into her room. After leaving the dining room Resident 32 stated he did not remember where his room was. Staff then assisted Resident 32 back to his room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 8:51 a.m., Resident 38 stated she wanted to move out of the facility, and she had a boyfriend who lived here, and he owned a home and she wanted to move out of here into his home and get married to him (Resident 32). Resident 38 stated it was hard for them to get together and she could not consistently see him. Resident 38 stated some of the Certified Nursing Assistants (CNA) did not allow her to be with Resident 32 and stated it depended on what staff member was working. Resident 38 stated sometimes her boyfriend (Resident 32) came to her room and sat on or would lay on her bed. Resident 38 stated they talked and hugged and had intimate touching. Resident 38 stated Resident 32 touched her breasts and her vagina. Resident 38 stated she touched Resident 32's private parts. Resident 38 stated the CNAs were aware of what they were doing. Resident 38 stated Resident 32 had a stroke three to four year ago and he was now very forgetful. Resident 38 stated it was very difficult to visit each other, they love each other, and they wanted to be with each other. Resident 38 stated she started seeing a memory doctor recently and she had been seeing a psychiatrist for over [AGE] years, but since being in the facility she could not make an appointment with her psychiatrist. During an interview on [DATE], at 9:05 a.m., CNA 1 stated Resident 38 and Resident 32 were boyfriend and girlfriend and were always together. CNA 1 stated the nurses told her they cannot be together in their rooms alone due to privacy for the other roommates. During an interview on [DATE], at 9:11 a.m., CNA 2 stated Resident 38 had days where she was more confused, and stated she will try to go in Resident 32's room and hold his hand and they kissed each other. CNA 2 stated Resident 38 was not allowed to go in Resident 32's room because they will want to touch each other. CNA 2 stated she had not been instructed by the LN's that Resident 32 and Resident 38 could not be together but had been told by nurses to watch them, so they are not sexually intimate. During an interview on [DATE], at 9:17 a.m., the Rehabilitation Technician (RT) 1 stated she worked with Resident 38 and helped her get dressed in the morning. RT 1 stated last week she observed Resident 32 sitting on Resident 38's bed. RT 1 stated about a month ago she opened Resident 38's bedroom curtain and both Resident 38 and Resident 32 were laying naked in her bed together. RT 1 stated she closed the curtain, spoke to the Director of Rehabilitation (DOR), and was told the residents had a right to privacy and just to close their curtain. RT 1 stated the licensed nurses were aware of the situation and instructed her to respect Resident 32 and Resident 38's privacy and allow them to be intimate together. RT 1 stated she thought staff had an in-service more than a month ago regarding sexual intimacy among residents. During an interview on [DATE], at 9:26 a.m., LN 4 stated Resident 38 and Resident 32 were very close and try to be intimate together. LN 4 stated they were entitled to have intimate relations and they like to be naked. LN 4 stated she had asked questions to administration, and it was up in the air whether it was okay for them to be intimate together. LN 4 stated Resident 32 was confused and had a RP. LN 4 stated Resident 38 was her own RP but did seem confused at times. LN 4 stated she had not heard from management on whether the resident's sexual activity was allowed or not allowed, and she had spoken with social services, and it was up in the air. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on [DATE], at 1:52 p.m., the Administrator (ADM) stated Resident 38 and Resident 32 were both here for long term care, and they had taken a liking to each other and had established an intimate relationship. The ADM stated his understanding was the relationship included holding hands, kissing, and potentially a sexual relationship. The ADM stated he became aware of their sexual relationships over the last couple of months. The ADM stated he wanted to make sure it was safe and consensual but was not sure if they had met for an IDT regarding their sexual relationship. The ADM stated Resident 32 had a BIMS score of 10 on [DATE], which falls into the category of moderately impaired cognition. The ADM stated Resident 32's RP was not okay with the sexual relationship. The ADM stated if the resident's BIM's score indicates moderately impaired, we should be notifying the RP. The ADM stated so far Resident 32 had not shown distress as far as their relationship. The ADM stated as a facility the IDT approaches residents engaging in sexual activity by asking the family member or RP, and reviewing with their physician was an important step to determine if the moderate impairment was in that area as well, or if they were able to give sexual consent with a BIM's score indicating moderately impaired and lack of medical capacity. The ADM stated he would want to get Resident 38's psychiatrist or psychologist involved in the IDT as well. The ADM stated he was not aware of Resident 38's not having medical capacity. In a record review of Resident 38's clinical record, the ADM confirmed the order dated [DATE] and stated the resident did not have medical capacity to make decisions. The ADM stated the physician order limiting capacity is from a cognition standpoint and stated the RP and the Ombudsman would participate in the IDT meeting to determine what next steps to take and what safeguards should be placed to prevent the residents engaging in sexual activity. In a record review of the Resident 32 and Resident 38's clinical record, the ADM confirmed there were currently no safeguards put in place to prevent Resident 32 and Resident 38 from engaging in sexual contact. The ADM stated the IDT team had not determined if Resident 32 or Resident 38 had capacity to give sexual consent. The ADM stated the risk to residents if safeguards were not in place to prevent sexual activity was for unwanted sexual contact and other behaviors and stated their sexual contact could be considered sexual abuse. The ADM stated he was aware Resident 32 and Resident 38 had sexual intercourse and stated staff have not been instructed to keep the residents apart. The ADM stated he first became aware of Resident 32's and Resident 38's sexual relationship about a month ago and stated since becoming aware he has not put any measures in place to prevent the sexual activity. The ADM stated we were trying to give them privacy, close the curtain, and remove other roommates in their room. During a record review of Resident 32's sexual relations care plan, the ADM stated they ultimately could not keep them separated so they tried to give them a space for pr [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50161 Based on interview and record review, the facility failed to ensure allegations of abuse were reported to the state survey agency after the allegations of abuse were witnessed by staff and reported to facility administration involving four of twenty-one sampled residents (Resident 32, Resident 38, Resident 25, and Resident 311) when; 1. Resident 32 and Resident 38 engaged in sexual activity, but neither Resident 32 or Resident 38 had the decision-making capacity (the ability of a patient to understand the benefits and risks of, and the alternatives to, a proposed treatment or intervention) to consent to the sexual activity; and, 2. Resident 311 was involved in a verbal altercation, which included threats of physical violence and racial derogatory remarks, with her roommate, Resident 25, in their room, on 10/6/24. These failures resulted in a delay of the state survey agency investigating the allegations of abuse, which had the potential to put residents' psychosocial and physical health and safety at risk. Findings: 1. Review of Resident 32's ADMISSION RECORD, indicated Resident 32 was admitted to the facility with diagnoses which included cerebral infarction (blood supply to brain is blocked or reduced and can cause brain cell damage), hypertension (heart has to work harder to pump blood), and myocardial infarction (a type of heart attack when your heart's need for oxygen cannot be met). Resident 32's admission record had a Resident Representative (RP, a person who makes decisions for another) identified as RP 2. Review of Resident 32's Order Summary Report (a document which includes all medication, tests, and non-medication orders), dated 9/26/24, indicated, .Resident is not capable of Understanding Rights, Responsibilities, And Informed Consent [process of communication between you and your health care provider that often leads to agreement or permission for care, treatment, or services]. Review of Resident's 32's Cognitive Impairment Care Plan (a plan of care that outlines a patient's care needs related to understanding and thought), dated 5/15/23, indicated, . [Resident 32] exhibits cognitive loss . [Resident 32] will continue to recognize family .[Resident 32] will communicate basic needs .Communicate with resident and [RP 2], regarding residents capabilities and needs .Identify yourself at each interaction. Face [Resident 32] when speaking and make eye contact. Reduce any distractions- turn off TV, radio, close door etc .[Resident 32] understands consistent, simple, directive sentences. Provide [Resident 32] with approaches that maximize involvement in daily decision making and activity (limit choices, ask yes or no questions, use cueing, instructions)- stop and return if agitated . Monitor for changes in cognitive status. Observe for indicators of clinical changes . behavior changes. Notify physician if occurs . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32's Activities Note, dated 5/27/24, indicated, .(Late Entry) on 5/26/2024 at approximately 3pm, [Resident 32] was found in [Resident 38's] bed, when asked what he was doing he explained that she invited him to lie down with her and watch a movie, writer explained to him and her that, that isn't allowed, then writer escorted him out of the room. Writer returned a few minutes later and he was back in her bed . writer again escorted him back to his room and again explained to him the facility rules, he seemed to understand . Review of Resident 32's Nurse's Note, dated 6/21/24, indicated, .Resident has became [sic] very affectionate with [Resident 38]. Reported to [staff name] in S.S. [Social Services] . Review of Resident 32's Social Service Note, dated 6/24/24, written by the Social Services Director (SSD), indicated, .I had a lengthy meeting with the patient and their peer [Resident 38], during which they referred to each other as boyfriend and girlfriend. They expressed their desire to be discharged from the skilled nursing facility (SNF) and to live in the female resident's apartment .The male party [Resident 32] needed reminders about the purpose of our meeting .overall it was determined and expressed by both, they wish to have private intimateness together. This appears to be the primary motive for wishing to discharge from the SNF . Review of Resident 32's Case Management progress note, dated 6/28/24, written by the SSD, indicated, .A female resident [Resident 38] and this patient [Resident 32] have openly expressed their relationship and love for each other .Both residents express their decision to engage in sexual relations and intimate experiences such as holding hands, snuggling, kissing, and fondling .The male resident's responsible party has been informed of this relationship, while the female resident is her own responsible party .The Ombudsman [OMB, patient advocate] has been notified and has met with both parties. A care plan will be developed to respect the resident's dignity and autonomy while ensuring safety and minimizing the risk of harm . Review of Resident 32's Behavior Note, dated 7/5/24, indicated, .resident is being monitored with being affectionate towards a female resident in room [Resident 38's room number], but was easily redirected. endorsed behavior to noc [night] nurse. will continue to monitor . Review of Resident 32's Intimate Behavior Care Plan, dated 7/17/24, indicated, .Resident displays intimate behavior towards another resident. Both residents consent to these mutual feelings .Goal . Resident will safely act on his feeling with both residents consenting .Interventions/Tasks . Educate .staff regarding mutual feelings as being consented . Encourage residents to act on their intimate desires in privacy and respecting other residents . Encourage safe intimacy practices Invite Psychologist . Provide private space/time . Review of the document did not indicate any communication the facility had with Resident 32's psychologist. Review of Resident 32's Nurse's Note, dated 8/8/24, indicated, .Resident was told to go to his room multiple times he is in room [Resident 38's room number] unable to redirect making roommates uncomfortable . Review of Resident 32's Nurse's Note, dated 9/7/24, indicated, .[Resident 32] found with [Resident 38] having sex in female resident room. after separating the two residents, both residents refused medication and assessments . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 10/22/24, at 12:14 p.m., RP 2 stated (Resident 32) had a girlfriend (Resident 38), and she was dragging him around all over the facility. RP 2 stated (Resident 32) will lay down in her [Resident 38's] bed but she was unsure if it was still going on as this was a few months ago. RP 2 stated when visiting, she saw (Resident 32) with his pants off, wearing no undergarments, and he was laying in (Resident 38's) bed. RP 2 stated she told him to go to his room. RP 2 stated the night Licensed Nurse (LN) told her he was always in (Resident 38's) room. RP 2 stated at night an LN would call her on the phone at 9:00 p.m. or 10:00 p.m. and inform her he would not leave (Resident 38's) room and would ask RP 2 for help in getting him to leave her room. RP 2 stated she was not aware of (Resident 32) and (Resident 38) engaging in any type of sexual behavior and the SSD had never informed her of this. RP 2 stated (Resident 38) was not able to consent to sexual touching due to his dementia. RP 2 stated she would have wanted to be informed by the facility and she stated she would not want him to engage in sexual activity with (Resident 38) or any other residents. Review of Resident 38's ADMISSION RECORD, indicated, Resident 38 was admitted to the facility with diagnoses including dementia, bipolar disorder (mental health condition which causes extreme mood swings), obsessive compulsive disorder (lasting and unwanted thoughts that keep coming back or urges or images that are intrusive and cause distress or anxiety), anxiety disorder (excessive fear or worry about a specific situation), depression (affects how you feel, think and behave and can lead to a variety of emotional and physical problems), attention-deficit hyperactivity disorder (combination of persistent problems, such as difficulty sustaining attention, hyperactivity and impulsive behavior), and herpes viral vesicular dermatitis (a skin infection caused by a virus and spread by skin-to-skin contact). Review of Resident 38's Order Summary Report, indicated physician orders written on 4/26/24, as follows, . Resident does not have the capacity to make her own decisions related to: DEMENTIA, MAJOR NEUROCOGNITIVE DISORDER [the ability to think and reason] DUE TO MULTIPLE ETIOLOGIES [decreased mental function and loss of ability to do daily tasks] . Review of Resident 38's Nurse's Note, dated 5/30/24, indicated, .Resident noted with unappropriated [sic] sexual behavior. Found performing sexual act with male patient in his room. Staffing intervened and separated both patients. SBAR [Situation, Background, Assessment, and Recommendation-a method used to communicate important information] sent to MD [medical doctor]. Social service .and Ombudsman aware . Review of the clinical record did not indicate further communication with Resident's 38's medical doctor. Review of Resident 38's Nurse's Note, dated 5/30/24, written by CM 1, indicated, .This writer met today with the local county ombudsman to address a recent incident involving a resident [Resident 38] and another custodial member [Resident 32]. The resident had contacted the ombudsman expressing concerns about needing her cell phone, purse, clothing from her apartment, and the desire to engage in sexual activity with a companion. During this meeting, the writer and the ombudsman extensively discussed the resident's current major neurocognitive disorders as documented by the doctor .The ombudsman agreed to allow sexual activities within the facility's protocol, ensuring privacy and dignity for others. All parties involved were in agreement with the plan, and the IDT (Interdisciplinary Team) was notified . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 38's Behavior Note, dated 6/19/24, indicated, .Resident was found laying in [Resident 32's] bed next to [Resident 38]. Resident stated that she was sleeping. Resident was convinced by registered dietitian to leave the bed as it was unsafe. Resident agreed and was assisted into wheelchair by LN and CNA and escorted out of room . Review of Resident 38's Case Management progress note, written by the SSD, dated 6/24/24, indicated .I had a lengthy meeting with the patient and their peer, during which they referred to each other as boyfriend and girlfriend. They expressed their desire to be discharged from the skilled nursing facility [SNF] and live together in the female resident's apartment .Both parties expressed their love for each other and their desire to leave the SNF together. However, the male party needed reminders about the purpose of our meeting. I emphasized the importance of involving the male resident's responsible party (RP) in this discussion, and both parties agreed to speak with her. I subsequently spoke with the male resident's RP [RP 2] and informed her about everything discussed, including the ongoing relationship between the two .Overall it was determined and expressed by both, they wish to have private intimateness together. This appears to be the primary motive for wishing to discharge from SNF. Writer explained to both remaining in the SNF would allow them to be together, as they wish and continue to do safely as they have the care they currently require . Review of Resident 38's IDT NOTE, dated 7/19/24, written by the SSD, indicated, .It has been brought to our attention of IDT that this female patient and a male patient are in a romantic relationship and have expressed their desire to engage in sexual intimacy and pursue a relationship Review of the document indicated in attendance at the meeting was the ADM, and the DON amongst others. During an interview on 10/21/24, 3:55 p.m., the Activities Assistant (AA) stated staff had reported to her that Resident 32 and Resident 38 were known to have sex together. The AA stated staff were aware and Resident 38's roommate (Resident 49) had complained about their loud sex and stated she must turn up her television to drown out the noise. The AA stated Resident 32 and Resident 38 needed their own spot to have sexual activities but stated she did not know what to do about it. The AA stated she was unsure if there was a policy regarding two residents having a sexual relationship. The AA stated they could not stop their behavior and staff tell Resident 32 and Resident 38 to be respectful because they share rooms. The AA stated both families were aware. The AA stated Resident 32 had a responsible party (RP 2) who stated Resident 32 could not consent to the sexual relationship. The AA stated Resident 38 can be persistent and stated she was in charge of the relationship. The AA stated RP 2 was not happy about Resident 32 and Resident 38's relationship. The AA stated their relationship had been going on since January of 2024. During a concurrent observation and interview on 10/21/24, at 4:02 p.m., Resident 32 and Resident 38 entered Resident 38's room and Resident 32 sat at the edge of Resident 38's bed. Resident 38 stated she and Resident 32 would like to be together and have privacy. Resident 38 stated it was impossible for them to be alone. Resident 38 stated her roommates did not want them to have sexual partners. Resident 38 stated she spoke to the Administrator (ADM) and asked for their own room to share and was told the facility was not set up to have couples in a room together. Resident 38 stated Resident 32's family was not for the relationship. Resident 38 stated they were going to contact the senior advocacy to get Resident 32's house back because Resident 32 did not remember signing his house away. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and observation on 10/22/24, at 8:23 a.m., Resident 32 stated he did not know what day or year it was and stated since his stroke he had become forgetful. Resident 32 stated he cannot remember anything, and RP 2 made all his decisions for him. Resident 32 stated he had a girlfriend but could not remember her name and stated her room was close to his room, but he cannot recall what room she was in. Resident 32 stated he visits with her in the hallway, and he does not visit with her in her room nor was she allowed to visit him in his room. Resident 32 stated he likes to kiss her, but staff do not like them being together. Resident 32 stated he wanted privacy with her, but staff did not give them privacy. Resident 32 stated they just wanted to be together by themselves and stated he was never allowed to be alone with her. It was observed that Resident 32's room was next door to Resident 38's room. As Resident 32 was walking to the dining room, Resident 38 was heard calling Resident 32's name and asking him to come into her room. During an interview on 10/22/24, at 8:51 a.m., Resident 38 stated she wanted to move out of the facility with her boyfriend who currently lived at the facility with her. Resident 38 stated some of the CNA's did not allow her to be with Resident 32 and stated it depended on what staff member was working. Resident 38 stated sometimes her boyfriend (Resident 32) came to her room and sat on or would lay on her bed. Resident 38 stated they talked and hugged and had intimate touching. Resident 38 stated Resident 32 touched her (private parts). Resident 38 stated she touched Resident 32's (private parts). Resident 38 stated she started seeing a memory doctor recently and she had been seeing a psychiatrist for over [AGE] years, but since being in the facility she could not make an appointment with her psychiatrist. During an interview on 10/22/24, at 9:05 a.m., CNA 1 stated Resident 38 and Resident 32 were boyfriend and girlfriend and were always together. CNA 1 stated the nurses told her they cannot be together in their rooms alone due to privacy for the other roommates. During an interview on 10/22/24, at 9:11 a.m., CNA 2 stated Resident 38 had days where she was more confused, and stated she will try to go in Resident 32's room and hold his hand and they kissed each other. CNA 2 stated Resident 38 was not allowed to go in Resident 32's room because they will want to touch each other. CNA 2 stated she had not been instructed by the LN's that Resident 32 and Resident 38 could not be together but had been told by nurses to watch them, so they are not sexually intimate. During an interview on 10/22/24, at 9:26 a.m., LN 4 stated Resident 38 and Resident 32 were very close and try to be intimate together. LN 4 stated they were entitled to have intimate relations and they liked to be naked. LN 4 stated she had asked questions to administration, and it was up in the air whether it was okay for them to be intimate together. LN 4 stated Resident 32 was confused and had a RP. LN 4 stated Resident 38 was her own RP but did seem confused at times. LN 4 stated she had not heard from management on whether the resident's sexual activity was allowed or not. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/22/24, at 1:52 p.m., the Administrator (ADM) stated Resident 38 and Resident 32 had taken a liking to each other and had established an intimate relationship. The ADM stated his understanding was the relationship included holding hands, kissing, and potentially a sexual relationship. The ADM stated Resident 32's RP was not okay with the sexual relationship. In a record review of Resident 38's clinical record, the ADM confirmed Resident 38 did not have capacity to make medical decisions. In a record review of Resident 32 and Resident 38's clinical record, the ADM confirmed there were currently no safeguards in place to prevent Resident 32 and Resident 38 from engaging in sexual contact. The ADM stated the risk to residents if safeguards were not in place to prevent sexual activity was for unwanted sexual contact and other behaviors and stated their sexual contact could be considered sexual abuse. During a concurrent interview and record review on 10/24/24 at 2:44 p.m., Resident 38 and Resident 32's medical record was reviewed with the Director of Nurses (DON). Through record review of Resident 32's clinical record, the DON confirmed there was no note from the SSD or any other form of documentation the RP or medical provider was notified regarding Resident 32's ability to give consent for sexual activity or to understand the risks for him contracting a contagious skin disease. During a phone interview on 10/25/24, at 9:41 a.m., MD 1 stated he was familiar with Resident 32, and stated the resident had dementia and was forgetful. MD 1 stated he examined Resident 32 yesterday (10/24/24) to determine if he could give sexual consent. MD 1 stated Resident 32 did not have the ability to give medical consent and stated sexual consent would need to be determined separately. MD 1 stated the facility should have called him once they became aware of the residents engaging in physical sexual activity. MD 1 stated he would have wanted to determine sexual capacity prior to Resident 32 engaging in sexual activity especially since there was a risk of him being exposed to a contagious skin disease from Resident 38. MD 1 stated it complicated matters, in terms of Resident 32's ability to understand the risks of his exposure and possibility of contracting a disease through contact. MD 1 stated he would have to explain the risks to Resident 32 and was not sure if he would understand those risks. During a phone interview on 10/25/24, at 2:28 p.m., MD 2 stated he was Resident 38's psychiatrist and stated the resident had not seen by him since 8/2023. The MD 2 stated Resident 38 did have an appointment scheduled with him in 1/2025 and was not aware of the sexual activity or relationship between Resident 38 and another facility resident. MD 2 stated regarding capacity, there were different kinds of capacity for residents including the ability to give medical consent, sexual consent, or financial consent. MD 2 stated he assesses the specific type of capacity separately by asking patients specific related questions. MD 2 stated Resident 38 does not have medical capacity to give consent and would have needed to be assessed for sexual consent separately. MD 2 stated if Resident 38 was engaging in sexual relations with another resident at the facility, he would have expected the facility to inform him of the situation. MD 2 stated it would of have been important for him to be aware, as her psychiatrist, especially with Resident 38's history of dementia. 2. Review of Resident 25's ADMISSION RECORD, indicated, Resident 25, was admitted to the facility in the summer of 2024, with diagnoses including but not limited to anxiety disorder (excessive fear or worry about a specific situation), and depression (affects how you feel, think and behave and can lead to a variety of emotional and physical problems). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 311's ADMISSION RECORD, indicated, Resident 311 was admitted to the facility on [DATE], with diagnoses including but not limited to, bipolar disorder (mental health condition which causes extreme mood swings), anxiety disorder, and major depressive disorder. Review of Resident 311's Case Management [note], written by CM 1, dated 10/7/24, indicated, .The writer met with a resident today [Resident 311], as she had concerns about her roommate and wanted her roommate to move to a different room. The writer explained the policy on room changes and assured the resident her request could be honored. However, the writer clarified she couldn't request for the roommate to move. The resident was hesitant to move rooms as she preferred to have her roommate move, instead of herself. To address this, the writer offered to show the resident a room which was available for her to move into. The resident liked her new room and agreed to the move . Review of Resident 311's Case Management [note], written by CM 1, dated 10/8/24, indicated, .The writer met with [FM 2] this day, as she was upset about the recent conflicts between a resident [Resident 311] and her roommate [Resident 25] over the weekend. She was concerned about the facility's response to the situation and wanted to know what steps were being taken to address the resident's concerns. The resident felt the staff was favoring her roommate over her, making it seem like she was being forced to move. The writer offered to have a conversation between the resident and [FM 2] to help resolve the issues together . Review of Resident 311's Case Management [note], written by CM 1, dated 10/10/24, indicated, .This writer met with [Case Worker (CW) 1] .as she came to writers' office to inquire about why the resident [Resident 311] had to move to a new room instead of another resident. The writer offered to help resolve the issue by meeting with the resident and [CW 1] the writer was concerned about the previous meeting, where the resident had thanked the writer for resolving the issue, in which the writer seemed to think the matter was fully resolved .The writer took the opportunity to explain the policy behind room changes when there are conflicts . In a concurrent observation and interview on 10/21/24, at 11:56 a.m., Resident 311 stated she had an altercation recently with a roommate and was upset because of the way staff handled the situation and felt like they were discriminating against her. Resident 311 stated during the altercation, Resident 25 had called her a dirty [racial slur, an insulting remark] and she had told staff this, including the Case Manager (CM 1). Resident 311 stated the (CM 1) told her if she did not move out of her room she would call the police on her. Resident 311 stated (CM 1) told her if she was not happy with her care she could leave the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a concurrent interview and record review on 10/24/24, at 11:06 a.m., Case Manager (CM) 1 stated she was a LN and had worked with Resident 311 since her admission. The CM 1 stated, Resident 311 had placed a call to the Ombudsman (OMB) regarding her recent room change and the verbal altercation that had occurred on 10/6/24 with her former roommate, Resident 25. The CM 1 stated Resident 311 had come to her office on the morning of 10/7/24, regarding a room change and wanted to know why no one was moving Resident 25 out of her room. The CM 1 stated Resident 311 asked her what would happen if they were to get in a fight. The CM 1 stated Resident 311 told her they could possibly get in a fight. The CM 1 stated she offered Resident 311 to move rooms for her safety. The CM 1 stated she told Resident 311 she would have to call the authority's or law enforcement when it became a danger for Resident 311 and Resident 25 to be in the same room. The CM 1 stated she thought the previous fight occurred over a bathroom issue. The CM 1 stated Resident 311 told her she felt she should not have to move rooms, and the roommate should have to move rooms. The CM 1 stated Resident 311's sister came to the facility to meet with the CM 1 the next day because Resident 311 was upset about the room change and altercation. The CM 1 stated the following day she met with Resident 311 and Resident 311's Case Worker (CW 1) regarding the altercation and the subsequent room change of Resident 311. When asked if there was an IDT meeting held for Resident 311 regarding the altercation, the CM 1 stated they usually do IDTs for cases like this such as when a resident felt threatened by another resident. Through a record review of Resident 311's clinical record, CM 1 confirmed there was not an IDT meeting held for Resident 311. The CM 1 stated it was important to create an action plan and interventions regarding Resident 311's concerns, and the IDT meeting allows various disciplines to meet so they are all aware of the issue. The CM 1 stated there was a group message sent out after the altercation on 10/6/24, and the ADM received the message as well as other managers. In a concurrent interview and record review on 10/24/24, 12:19 p.m., LN 7 stated she was Resident 311's and Resident 25's LN on 10/6/24, when CNA 4 alerted her there was a verbal altercation occurring between the two residents in their room. LN 7 stated Resident 25 was threatening to go outside and fight Resident 311. LN 7 stated Resident 311 asked Resident 25 to just leave her alone and stated Resident 311 had felt threatened by Resident 25. LN 7 stated Resident 311 stated she did not feel safe. LN 7 stated the manager on duty for the facility that day was the Registered Dietician (RD) and she called her to speak with Resident 311. LN 7 stated Resident 311 told the RD she felt like staff was being discriminatory towards her because she was expected to change rooms and Resident 25 was not. Through review of Resident 311's clinical record, LN 7 confirmed she did not write a nursing note in her chart and stated she was not sure why she did not do it and stated she must have gotten busy. LN 7 stated it was important to document the incident in Resident 311's clinical record for patient care and to help advise other staff, including LNs of the event. LN 7 stated the RD placed a message out to alert administration of the altercation between the residents and stated this was important because she did not want Resident 311 and Resident 25 to hurt each other or lead to a physical altercation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/24/24, at 1:51 p.m., CNA 4 stated on 10/6/24, which was a Sunday, she walked in Resident 311's room and witnessed her and roommate, Resident 25, engaged in an altercation. CNA 4 stated Resident 25 was upset there was a smell of Resident 311's commode (a portable toilet) and gave Resident 311 a pack of briefs (disposable underwear for lack of control of the bowel and bladder). CNA 4 stated Resident 311 called Resident 25 a (derogatory name) and stated she did not want the briefs and tried to give them back to Resident 25. CNA 4 stated they were using violent words towards each other and threatening each other. CNA 4 stated they were telling each other they were going to meet outside with boys to take care of the situation, so she called LN 7 for assistance. CNA 7 stated LN 7 entered the room and Resident 311 and Resident 25 continued to threaten each other. CNA 7 stated Resident 311 stated it was not fair they were asking her to change rooms and felt staff were siding with Resident 25. In a concurrent interview and record review on 10/24/24, at 2:04 p.m., the ADM stated he was aware of Resident 311 and her roommate, Resident 25, were not getting along. The ADM stated he had spoken to the SSD regarding the altercation that occurred in their room on 10/6/24, since most issues regarding conflicts amongst residents go through the SSD. The ADM stated the expectation was if there was an altercation between two residents which included fighting and threatening of each other then they determine if the situation needs to be investigated or reported to the state agency. The ADM stated it was important to investigate resident to resident altercations for resident safety and to have resolution between the residents. The ADM stated he was notified using tiger texts phone messaging regarding both Resident 311 and Resident 25, since the altercation occurred on the weekend. The ADM stated his understanding of the altercation was the residents had an argument over the smell of the commode and Resident 311 agreed to move to another room. The ADM stated typically there would have been an IDT collaboration meeting to ensure there was a multidisciplinary approach. The ADM stated there should have been monitoring of the residents, including 72-hour charting by staff. The ADM stated this would have been effective to ensure whatever actions taken were effective for the residents involved in the altercation. Through record review of Resident 311's clinical record, the ADM confirmed, there was no follow-up or investigation into the altercation which occurred between Resident 311 and Resident 25 nor was the altercation reported to the state agency. During a review of a facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, the document indicated, .Residents have the right to be free abuse .This includes but is not limited to .verbal, mental, sexual or physical abuse .Identify and investigate all possible incidents of abuse .mistreatment .Investigate and report any allegations within timeframes required by federal requirements .Protect residents from further harm during investigations . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of a facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating, revised 9/2022, the document indicated, .All reports of resident abuse .neglect, exploitation .of resident are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings are documented and reported .If resident abuse, neglect, exploitation .the suspicion must be reported immediately to the administrator and to other officials according to state law .The administrator or the individual making the allegation immediate reports his or her suspicion to the following persons or agencies .The stated licensing/certification agency responsible for surveying/licensing the facility .The local/state ombudsmen .The resident's representative .Adult protective services .Law enforcement officials .The resident's attending physician .The facility medical director .Immediately is defined as . within two hours of an allegation involving abuse .within 24 hours of an allegation that does not involve abuse .Verbal/written notices to agencies are submitted via special carrier, fax, email, or by telephone .Upon receiving any allegation of abuse, neglect, exploitation .the administrator is responsible for determining what actions (if any) are needed for the protection of residents . [TRUNCATED]

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 49823 Based on interview and record review, the facility failed to ensure allegations of abuse were investigated and safeguards were implemented to prevent further abuse for two of 21 sampled residents (Resident 25, and Resident 311) after the facility was made aware of an allegation of verbal abuse and the threat of physical violence involving Resident 311 and Resident 25. These failures placed Resident 311 and Resident 25 at risk for unidentified and ongoing abuse. Findings: A review of Resident 311's Admission Record indicated Resident 311 was admitted to the facility with diagnoses which included, but were not limited to, cellulitis (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), anxiety, and depression (a persistent feeling of sadness and loss of interest that can interfere with activities of daily living). During an interview with the Ombudsman (Omb) on 10/22/24 at 11:40 a.m. at the facility, the Omb stated that Resident 311 reported to her that she was harassed and called a (racial slur) by her roommate. The Omb stated that Resident 311 stated that the roommate had been discharged from the facility. The Omb stated that the incident was a resident-to-resident verbal altercation and that Resident 311 stated she was asked to move to a different room. The Omb stated that Resident 311 stated she felt the resident who called her a (racial slur) should be the one to move to another room. The Omb stated it seemed the Case Manager (CM) 1 sided with the other resident, so she spoke with the Social Worker Director and requested that a different CM to investigate the incident. During an interview with Resident 311 on 10/23/24 at 10:39 a.m. in her room, Resident 311 stated that she reported to CM 1 that her roommate called her a (racial slur). Resident 311 stated that CM 1 told her she needed to move to another room. Resident 311 stated that she asked CM 1 why, since her roommate was the one that was verbally abusive to her. Resident 311 stated that CM 1 stated that if she did not move out of the room the police would be called. Resident 311 stated that CM 1 also stated to her that if she was not happy with her care, she could leave the facility. In an interview on 10/24/24, at 1:51 p.m., Certified Nursing Assistant (CNA) 4 stated on 10/6/24, which was a Sunday, she walked in Resident 311's room and witnessed her and her roommate, Resident 25, engaged in an altercation. CNA 4 stated Resident 25 was upset there was a smell of Resident 311's commode (a portable toilet) and gave Resident 311 a pack of briefs (disposable underwear for lack of control of the bowel and bladder). CNA 4 stated Resident 311 called Resident 25 a (derogatory name) and stated she did not want the briefs and tried to give them back to Resident 25. CNA 4 stated they were using violent words towards each other and threatening each other. CNA 4 stated they were telling each other they were going to meet outside with boys to take care of the situation, so she called LN 7 for assistance. CNA 7 stated Licensed Nurse (LN) 7 entered the room and Resident 311 and Resident 25 continued to threaten each other. CNA 7 stated Resident 311 stated it was not fair they were asking her to change rooms and felt staff were siding with Resident 25. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a concurrent interview and record review on 10/24/24, at 2:04 p.m., the Administrator (ADM) stated he was aware of Resident 311 and her roommate, Resident 25, were not getting along. The ADM stated he had spoken to the Social Service Director (SSD) regarding the altercation that occurred in their room on 10/6/24, since most issues regarding conflicts amongst residents go through the SSD. The ADM stated the expectation was if there was an altercation between two residents which included fighting and threatening of each other then they determine if the situation needs to be investigated or reported to the state agency. The ADM stated it was important to investigate resident to resident altercations for resident safety and to have resolution between the residents. The ADM stated he was notified using phone messaging regarding both Resident 311 and Resident 25, since the altercation occurred on the weekend. The ADM stated his understanding of the altercation was the residents had an argument over the smell of the commode and Resident 311 agreed to move to another room. The ADM stated typically there would have been an IDT collaboration meeting to ensure there was a multidisciplinary approach. The ADM stated there should have been monitoring of the residents, including 72-hour charting by staff. The ADM stated this would have been effective to ensure whatever actions taken were effective for the residents involved in the altercation. Through record review of Resident 311's clinical record, the ADM confirmed, there was no follow-up or investigation into the altercation which occurred between Resident 311 and Resident 25 nor was the altercation reported to the state agency. A review of a facility policy and procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised 4/2021, indicated, .Residents have the right to be free from abuse .This includes but is not limited to .verbal, mental, sexual or physical abuse .Protect residents from abuse .by anyone including .other residents .develop and implement policies and protocols to prevent and identify . abuse or mistreatment of residents .Implement measures to address factors that may lead to abusive situations .adequately prepare staff for caregiving responsibilities .Identify and investigate all possible incidents of abuse .Investigate and report any allegations within timeframes required by federal requirements .Protect residents from further harm during investigations . A review of a facility P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, indicated, .All reports of resident abuse .are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Finding of all investigations are documented and reported .1. If resident abuse .is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 6. Upon receiving any allegations of abuse .the administrator is responsible for determining what actions (if any) are needed for the protection of residents .All allegations are thoroughly investigated. The administrator initiates investigations .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 43943 Based on interview and record review, the facility failed to ensure one of 21 sampled resident's (Resident 20) Preadmission Screening and Resident Review (PASARR - an assessment tool that evaluated Resident 20 for serious mental illness (SMI) and/or intellectual disability (ID), prior to admission to the facility) was completed accurately. This failure could have resulted in Resident 20 not receiving additional psychological services that could have assisted her in living her highest quality of life. Findings: During a review of Resident 20's clinical record titled, Admission Record (a document that contained Resident 20's demographic information), indicated Resident 20's diagnoses included schizoaffective disorder (a mental health condition that is marked by hallucinations (seeing things that are not there) and mood disorders) and Bipolar Disorder (a mental illness that caused extreme shifts in mood, energy, and activity levels). A review of Resident 20's clinical record titled, Progress Note, dated 10/2/24, at 11:13 p.m., by the Licensed Nurse (LN) 9, indicated, Resident refused shower x 3 [three times]. Offered multiple times, continues to refuse .resident started becoming physically combative. A review of Resident 20's clinical record titled, Progress Note, dated 10/15/24, at 9:50 p.m., by LN 8, indicated, Physical Aggression. Resident threw her dinner tray on the floor and will try to hit staff. A review of Resident 20's clinical record titled Care Plan (a document that reviewed Resident 20's problems, goals, and interventions), dated 8/14/24, indicated Resident 20 had psychosocial behavior such as yelling, verbally abusive, and cursing. During a concurrent interview and record review on 10/22/24, at 3:53 p.m., with the Medical Records (MR) staff, Resident 20's clinical record titled, Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 11/18/22, was reviewed. The document indicated, . Section III - Serious Mental Illness - Definition 10. Does the Individual have a serious diagnosed mental disorder such as . Schizophrenia/Schizoaffective Disorder, or symptoms of . delusions, and/or Mood Disturbance . The document indicated Resident 20 did not meet the criteria of a severe mental illness and the results of the level I PASRR was negative. MR stated Resident 20's PASRR should have indicated Resident 20 had a positive level 1 screening because of her diagnoses of Schizoaffective Disorder and Bipolar Disorder. MR stated the level I PASRR needed to be redone. The MR stated the importance of a PASRR level I being completed accurately was to ensure Resident 20 received the mental health services required to treat her mental health care needs. During a phone interview on 10/22/24, at 4:40 p.m., with Responsible Party (RP, a person who make decisions for another) 3, RP 3 verified Resident 20's diagnoses included Schizoaffective Disorder and Bipolar Disorder. RP 3 stated Resident 20 had delusions (holding false beliefs) that staff were trying to poison her. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review 10/23/24, at 9:08 a.m., with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Admission Criteria - PASRR, dated 3/2019, was reviewed. The P&P indicated, Our facility admits only residents whose medical and nursing care needs can be met . 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) . a. the facility conducts a Level 1 PASARR screen for all potential admissions . b. If the level 1 screen indicated that individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. 1). The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID, or RD. 2) The social worker is responsible for making referrals to the appropriate state-designated authority . The DON stated the PASRR level I was not completed correctly for Resident 20 and the P&P was not followed.

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43943 Based on interview and record review, the facility failed to ensure one of 21 sampled residents (Resident 96), received neurological (brain) assessments (assessment of mental status, strength, and sensation) following a fall, per the implemented care plan (a list of Resident 96's problems, goals, and interventions), and the facility policy. This failure could have resulted in a delay in identification of neurological changes prior to Resident 96's death. Findings: During a review of Resident 96's clinical record titled, Admission Record (a document that contained Resident 96's demographic information), indicated Resident 96's diagnoses included muscle wasting and weakness, cognitive (mental) impairment, and Parkinson's disease (a degenerative brain condition that caused tremors (shaking), stiffness, slowed movement, and memory and thinking problems). A review of Resident 96's clinical record titled, EMERGENCY DEPARTMENT NOTE, dated [DATE], at 10:04 p.m., by the Medical Doctor (MD) 3, indicated Resident 96 had frequent falls at home since [DATE]. Resident 96 was discharged from [ACUTE CARE HOSPITAL NAME] and admitted to the facility. A review of Resident 96's clinical record titled, Change in Condition Evaluation, dated [DATE], at 4:16 p.m., by Licensed Nurse (LN) 8, indicated LN 8 heard a noise and went to Resident 96's room. Resident 96 was found on the ground by his bed and became incontinent of stool (poop). Resident 96 stated he had hit his head and there was discoloration to his buttocks and left knee. A review of Resident 96's clinical record titled, Situation, Background, Assessment, and Recommendation (SBAR-a structured communication framework that assisted in sharing information about the condition of a resident) Summary for Providers, dated [DATE], at 4:16 p.m., by LN 8, indicated the primary care provider ordered staff to monitor Resident 96 and placed him on scheduled neurological assessment checks. A review of Resident 96's clinical record titled, Neurological Assessment Flowsheet, dated [DATE] through [DATE], indicated neurological checks were supposed to be completed every 15 minutes (four times), then every 30 minutes (two times), then every hour (two times), then every two hours (two times), then every four hours (four times), and then every eight hours (six times). Assessments were not fully completed on [DATE] at 12:01 a.m., and [DATE] at 5:01 a.m. A review of Resident 96's clinical record titled, Progress Notes, dated [DATE], at 12:29 a.m., by LN 10, indicated, Notified by Certified Nursing Assistant [CNA] at approximately 11:05 p.m., that patient was found not breathing. Writer went to assess patient and found patient foaming at the mouth at approximately 11:15 p.m., we stopped Cardio Pulmonary Resuscitation [CPR -chest compressions to attempt to restart the heart] . (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 96's clinical record titled, Progress Notes, dated [DATE], at 8:12 a.m., by LN 10, indicated Resident 96 died on [DATE], at 11:15 p.m. A review of Resident 96's clinical record titled, Care Plan, dated [DATE], indicated Resident 96 was a high risk for falls, related to balance problems, poor communication, and dementia (a condition that caused confusion). Interventions included to anticipate the needs of Resident 96. A review of Resident 96's fall care plan, dated [DATE], indicated Resident 96 had an actual fall and the staff were supposed to assess for post fall injuries and conduct neurological checks per facility policy. A review of Resident 96's clinical record titled, Fall Risk Observation/Assessment (an evaluation that assessed Resident 96's risk for falls), indicated Resident 96 was a high risk for falls (score 18), related to past falls in the last 90 days, problems with walking, needed assistance to the bathroom, and took medication that contributed to falls. During an interview on [DATE], at 10:40 a.m., with LN 11, LN 11 stated neurological assessments were supposed to all be completed for Resident 96 post fall to assess for possible signs of bleeding inside the brain (as evidenced by deviations from there neurological baseline status). LN 11 stated all the ordered neurological checks should have been completed in order to avoid missing a possible change in condition. During a concurrent interview and record review, on [DATE], at 9:24 a.m., with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Neurological Assessment, dated ,d+[DATE], was reviewed. The P&P indicated, . The purpose of this procedure is to provide guidelines for a neurological assessment; . upon physician order; . when following an unwitnessed fall; . subsequent to a fall with a suspected head injury . information should be recorded in the resident's medical record . the date and time the procedure was performed All assessment data obtained during the procedure . The DON confirmed there were missing Neurological assessments. The DON stated the risks for not completing all of Resident 96's neurological checks was that the staff could have missed possible neurological changes and not acted on the changes in a timely manner. The DON stated the P&P was not followed.

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1310 West Granger Modesto, CA 95350	

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 43943 Based on observation, interview, and record review, the facility failed to ensure one of 21 sampled residents (Resident 45) received daily communication in Resident 45's preferred spoken language (Greek). This failure could have resulted in Resident 45's not being able to maintain or improve her ability to communicate with staff. Finding: During a concurrent observation and attempted interview on 10/21/24, at 10:00 a.m., with Resident 45, Resident 45 looked at State Agency and did not respond when asked if Resident 45 had any concerns regarding her care at the facility. Several attempts were made to communicate with Resident 45 in English, without success. During a concurrent observation and interview on 10/21/24, at 10:01 a.m., with the Licensed Nurse (LN) 1, LN 1 asked Resident 45 how she was doing and if she was in any pain. Resident 45 did not respond but looked at LN 1. LN 1 stated Resident 45 was unable to speak fluent English and her preferred spoken language was Greek. LN 1 stated Resident 45 pointed at objects that she wanted and said a few words in English to make her needs known. During an interview on 10/21/24, at 10:05 a.m., with the Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 45 did not speak a lot of English but communicated by pointing at objects and could say a couple words in English. CNA 1 stated Resident 45 was unable to walk and was dependent on staff for all her care. During a follow-up concurrent observation and attempted interview on 10/22/24, at 1:40 p.m., Resident 45 was unable to answer the question if she was in any pain. During a follow-up concurrent interview, and record review on 10/22/24, at 1:43 p.m., with LN 1, the document titled, Care Plan (a document that contained Resident 45's problems, goals, and interventions), dated 9/12/23, was reviewed. The care plan indicated, . impaired communication related to preference to speak primary language of Greek . Interventions . Use interpreter services as needed . LN 1 stated she was not aware that facility had access to interpreter services. During a follow-up interview on 10/22/24, at 1:50 p.m., with CNA 1, CNA 1 stated the facility did not have any staff members that spoke Greek that could translate for Resident 45, and CNA 1 was not aware the facility offered language interpreter services. CNA 1 stated there was a language barrier between the staff and Resident 45. (continued on next page)

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	10/24/2024

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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 10/22/24, at 1:59 p.m., with LN 2, LN 2 asked Resident 45 if she was in any pain and if she liked her lunch. Resident 45 was unable to verbalize an answer. LN 2 stated she had never used a language communication services to communicate with Resident 45 or any other residents. LN 2 stated there were not any staff members that spoke Greek at the facility that could interpret for Resident 45. LN 2 stated Resident 45 was only able to give one-word answers in English. During an interview on 10/22/24, at 2:10 p.m., with the Director of Nursing (DON), DON stated she was unsure if the facility had an interpreter service that could be utilized to communicate with Resident 45. DON stated if there were said services, it was her expectation that staff would utilize interpreter services to effectively communicate with Resident 45 During an interview on 10/22/24, at 2:15 p.m., with LN 3, LN 3 stated Resident 45 did not speak English fluently and Resident 45's preferred language was Greek. LN 3 stated she had never used an interpreter service at the facility to communicate with Resident 45. During an interview on 10/22/24, at 2:25 p.m., with Resident 45's Responsible Party (RP 1), RP 1 stated Resident 45 used to be able to speak English fluently but had lost the ability to do so. During a follow-up concurrent interview and record review on 10/23/24, at 8:51 a.m., with the DON, the Policies and Procedures (P&P) titled, Effective Communication, dated 2/2018 and Notice or Resident Rights and Responsibilities, dated 3/2017, were reviewed. Effective Communication indicated, . staff will assist residents . with language barriers to maintain effective communication . Notice of Resident Rights and Responsibilities, indicated, . Our facility will inform the resident of his or her rights . in a language that is understandable to the resident . The DON acknowledged the P&Ps were not followed and the staff could have been utilizing [LANGUAGE LINE COMPANY NAME - interpreter services].

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

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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. 49823 Based on observation, interview, and record review, the facility failed to ensure an environment free of accidents and hazards for one of 21 sampled residents (Resident 84) when Resident 84 left cigarettes and a cigarette lighter accessible to other residents outdoors on a patio. This failure had the potential for an accidental injury to occur to other residents in the facility. Findings: A review of Resident 84's Admission Record indicated that Resident 84 was admitted to the facility in 2024. Resident 84's Admission Record indicated Resident 84 was admitted with diagnoses which included but were not limited to wedge compression fracture of third lumbar vertebra (the broken bone in the lower back collapses causing the front part of the spine to form a wedge shape), neuropathy (damage to nerves causing pain, numbness, muscle twitching, weakness and swelling), and chronic obstructive pulmonary disease (COPD, a long-term lung disease that cause airflow blockage and breathing related problems, shortness of breath, and cough). A review of Resident 84's Smoking Acknowledgement and Agreement, signed 9/21/24 indicated that Resident 84 was assessed by facility staff to be safe to maintain and use smoking products. Resident 84's Smoking Acknowledgement and Agreement further stated that Resident 84 agreed to not provide smoking materials or lighters/matches to any other residents for any reason or at any time. A review of Resident 84's Care Plan initiated 9/21/24, indicated that Resident 84's cigarettes and cigarette lighter would be stored at the nurses' station. During an observation on 10/22/24 at 1:49 p.m., Resident 84 was observed smoking on the patio outside of her room. Resident 84 put out the cigarette on the ground on the patio and went inside her room. Resident 84 left her cigarettes, cigarette lighter, and cigarette butt on the patio outside her room. During an interview on 10/22/24 at 2:50 p.m. with Resident 84 in her room, Resident 84 confirmed that she smoked and left her cigarettes and her cigarette lighter on the patio outside of her room. Resident 84 confirmed that other residents had access to her cigarettes and her cigarette lighter. Resident 84 stated she thought other residents might take her cigarettes and her lighter. During an interview on 10/23/24 at 9:25 a.m. with Licensed Nurse (LN) 5 and the Assistant Director of Nursing (ADON), LN 5 stated that residents went to assigned areas to smoke. LN 5 stated that staff kept residents' cigarettes and cigarette lighters locked in the medication carts. The ADON stated that staff kept residents' cigarettes and cigarette lighters in the medication carts even if the resident signed a waiver (a signed statement voluntarily giving up a privilege or right). LN 5 stated that residents smoked on the designated smoking patio and were not allowed to smoke on the patio outside their room. The ADON stated that residents must wear a smoking vest (a loose-fitting garment designed to protect clothing from ashes that may cause burns) unless the resident signed a waiver. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/23/24 at 9:30 a.m. with the Director of Nursing (DON), the DON stated that her expectation was that nurses assessed residents to see if it was safe for them to smoke. The DON stated that residents followed the facility smoking schedule and smoked in designated smoking areas only. The DON stated that residents could not smoke on patio areas outside their rooms due to it being a safety risk as some residents were on oxygen. The DON stated that nurses or Activity staff kept residents' cigarettes and cigarette lighters until residents smoked, unless residents were assessed to be safe with those items. The DON confirmed it was unsafe for residents to keep cigarettes and cigarette lighters on the patio outside the resident rooms where other residents had access to those items. The DON confirmed that the facility policy was not followed. A review of a facility P&P titled, Smoking Policy-Residents, revised October 2023, the P&P indicated .1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas .13. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession .

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40903 Based on observation, interview, and record review, the facility failed to ensure safe use and storage of Emergency kits (or Ekit, a collection of emergency medications) for a census of 98 residents when: 1. Three Emergency kits (Ekit) for IV (Intravenous, Into the Vein) medications at facility's North Station were open and/or unsealed with no documentation on when it was opened, what was removed, or the medications used for specific residents. 2. Two Emergency kits (Ekit) for refrigerated medications containing a controlled drug called lorazepam (or Ativan, a restricted medication in injectable form used for anxiety or seizure- uncontrolled brain activity) were opened, used, and unsealed with no documentation on when or who it was used for. These failures could contribute to unsafe medication use, lack of accountability and risk of drug diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber). Findings: 1. During a concurrent observation and interview, at facility's North station, accompanied by Licensed Nurse (LN) 3, on 10/21/24, at 9:45 AM, LN 3 stated the Utility Room at the North station stored the IV supplies. The Utility Room IV section was observed to have two open, unsealed IV Ekits sitting on the floor with several plastic buckets of supplies for IV drug administration. A third opened and resealed IV Ekit was located outside of the Utility Room sitting on the floor next to the Automated Dispensing Machine (or ADM; an electronic medication storage and dispensing machine). LN 3 was not sure why the two Ekits were left open and unsealed and did not know why a third opened/resealed Ekit was not in a locked room or when they were used or opened as follows: i. The first Ekits had an outer green sticker marked as [Pharmacy Name] Kit #138 did not have a content list of items. The Ekit #138 contained IV medications, premixed antibiotics, IV solutions and supplies in a disorganized manner. Ekit #138 stored opened and unwrapped IV solution medication for antibiotic mixing in 50 mL and 100 mL (mL stands for milliliter, a unit of volume) sizes with no beyond use date (the date after which the IV bag should not be used after removal from outer protective cover based on manufacturer instruction.) ii. The second Ekit labeled as Ekit #101 was opened, unsealed and contained IV solution, supplies, and premixed antibiotics plus supplies in a disorganized manner. The Ekit content list indicated it was prepared by the pharmacy on 8/11/24. iii. The third Ekit labeled as Ekit #118 was opened, resealed by a yellow tag and the content list indicated it was last prepared by the pharmacy on 10/11/24. (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER: Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1310 West Granger Modesto, CA 95350	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further inspection of the Utility Room indicated several Ziplock bags of supplies for residents that were no longer in the facility. LN 3 acknowledged the findings and used a yellow color tag to re-seal the Ekits. LN 3 could not find any recent documentation on when these Ekits were opened and why the Ekits were not replaced. During a concurrent interview and record review with LN 3 of a binder, titled . Emergency Kit IV infusion Log, at North nursing station, on 10/21/24 at 10 AM, the record indicated pages of IV medication and supply use in July 2024, August 2024, one single resident entry for 9/19/24 and one single resident entry on 10/7/24. The written instruction on the binder indicated For new IV hydration or IV medication orders, continue with the process in taking the supplies and IVF [IV fluid] from Ekit, complete the charge form and fax to pharmacy to request Ekit change .Any medication, IV fluids or supplies taken from house stock Ekit should be documented and logged, complete the charge form and fax to pharmacy. LN 3 confirmed that any medication or supplies taken from Ekits should have been faxed to pharmacy for billing purposes and replacement. LN 3 was not sure how and when pharmacy exchanged the Ekits. 2. During a concurrent observation and interview, at facility's North station, accompanied by LN 2 and LN 3, on 10/21/24, at 10:15 AM, the medication refrigerator was located in a closet across from the North nursing station. The Locked room had a refrigerator which stored refrigerated drugs. The refrigerator stored two opened, unsealed Ekits, in a clear plastic box, with refrigerated drugs such as insulin (drug used to treat blood sugar disease) and lorazepam (Ativan) for emergency use as follow: i. The first opened and unsealed refrigerated Ekit was labeled by Pharmacy as Kit #3065 with Date Sealed of 7/23/24. The opened Ekit contained Compazine suppository (rectal medication used to treat nausea) and a special needle for Insulin pen injection. The Kit was missing Ativan and the three insulin products. There was no documentation of medication removal inside the Ekit. ii. The second opened and unsealed refrigerated Ekit was labeled by Pharmacy as Kit #2017 with Date Sealed of 8/27/24. The opened Ekit was missing insulin vials. There was no documentation of medication removal inside the Ekit. LN 2 acknowledged the findings and stated she will look into why the Ekits were unsealed and not replaced. LN 2 stated the staff should fax the usage slip to pharmacy for kit replacement. LN 3 stated any controlled medication should have had a pharmacy code/approval before removal. In an interview with the Director of Nursing (DON), in her office, on 10/22/24, at 2:11 PM, the DON stated the nursing staff should use the Ekit when there was a new physician order that required immediate use of the medication. The DON stated the staff should document any medication or supplies removed from the Ekit and fax it to pharmacy for replacement. The DON stated the staff should have re-sealed the Ekit with the yellow color sealer stored inside each Ekit. The DON stated the Ekit should have been replaced based on facility's policy within 72 hours. The DON stated the controlled drugs required calling the pharmacy for an authorization code before removing the controlled drug. The DON stated she will look into the Ekit medication removal process and the staff may have not followed the facility's policy. (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy, titled . Practice standards for Long term Care Pharmacy, dated 2019, the policy on section 8 indicated . Only authorized individuals who have been trained in the appropriate use of emergency kit may obtain medications from it in accordance with state and federal laws and regulation and subject to the following requirements: . Emergency kits shall be provided complete and sealed by a pharmacist . The emergency kit shall be stored in a secured area such as a locked cabinet, medication room or other enclosures to prevent unauthorized access, and to ensure a proper environment for preservation of medications contained within. A list of emergency kit contents must be readily accessible and include at least the following information: name (trade and/or generic), strength, and quantity of medication. A mechanism must be in place to ensure that emergency kit shall be properly labeled with name, strength, and expiration date. Removal of any drug from emergency kit, pursuant to a valid prescription drug order, must be documented to indicate patients name, name of the drug, strength, amount, date, time, and identification of the authorized individual removing the drug. The policy did not address how the Ekit replacement and medication removal including controlled drugs should be handled by nursing staff.

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 40903 Based on interview and record review the facility failed to monitor the use of high-risk medications (medications that pose a health risk if not monitored closely) for two out of 21 sampled residents (Resident 70 and Resident 306) when: 1. Resident 70's hold parameters (a set of numbers that guide the nursing staff to hold and not give medication for safety reasons) for use of blood pressure medication (medication use to lower pressure in arteries) were not followed. 2. Resident 306's blood sugar was not monitored while on two insulin products (insulin an injectable drug used to treat blood sugar disease or diabetes). These failed practices could put Resident 70 and Resident 306 at risk of adverse drug effects. Findings: 1. During a review of Resident 70's medical record, titled Medication Administration Record (or MAR, a document that list medications administered with nursing monitoring parameters), dated 10/2024, the record indicated Resident 70 was receiving a medication to counter low blood pressure as follow: Fludrocortisone Acetate Oral Tablet 0.1 MG (or Florinef; drug used to raise blood pressure, mg is milligram a unit of measure); Give 1 tablet by mouth one time a day for Hypotension (low blood pressure) Hold if SBP>130 (hold if Systolic Blood Pressure is more than 130; Systolic is the pressure in arteries when heart contracts and pumps blood) -Start Date- 5/24/24 Further review of the MAR record indicated Florinef was administrated 7 times during the first 3 weeks of October 2024 despite a physician order to hold the medications on 10/1/24, 10/7/24, 10/9/24, 10/15/24, 10/16/24, 10/17/24 and 10/19/24. During a concurrent interview and record review with Licensed Nurse (LN) 7 of Resident 70's MAR record, at North station, on 10/24/24, at 2:20 PM, the order for Florinef was reviewed and LN 7 confirmed that Florinef was not withheld when Resident 70's documented blood pressure numbers indicated to hold (Hold if SBP>130) the medication (Florinef). In an interview with the Director of Nursing (DON), in her office, on 10/24/24, at 3:59 PM, the DON stated the nursing staff should follow the doctor's order and the listed parameters for safe medication use. Review of the facility's policy, titled Medication Administration, dated 4/2019, the policy indicated Medications are administered in accordance with prescriber orders, including any required timeframe. 2. During a record review of Resident 306's medical record, titled Medication Administration Record (or MAR), dated 10/2024, the MAR record indicated Resident 306 had two Insulin orders to treat diabetes (a blood sugar disease) as follows: (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	i. Insulin Glargine Solution 100 Units/mL (A long-acting insulin used to treat diabetes (Units/mL is amount of insulin unit in a milliliter- a measure of quantity); Inject 25 units subcutaneously (inject under the skin) in the morning for diabetes. Start date: 10/16/24. ii. Humalog KwikPen Subcutaneous Solution Pen-Injector 100 Units/mL (or Insulin Lispro, a quick acting insulin given as a shot; in a pen form for easy use); Inject 5 units subcutaneously before meals for DM (Diabetes Mellitus- Blood sugar disease); Start Date: 10/16/24. Further review of the MAR record indicated the nursing staff were measuring FSBG (or FSBG; when finger is poked to get blood and measure the sugar in the blood by a device called a glucometer) with each insulin dose without a physicians order, or guide on how to manage blood sugar numbers if they were too high or too low. During a concurrent interview and record review with LN 7 of Resident 306's MAR record, at North station, on 10/24/24, at 2:25 PM, the insulin orders for Resident 306 were reviewed and LN 7 confirmed that there was no order to measure the blood sugar when Resident 70 was readmitted from the hospital on 10/16/24. LN 7 stated nursing staff were measuring the blood sugar without an order and there were no parameters or guide on how to address the low or high blood sugar levels. LN 7 stated not having parameters and an order for blood sugar testing could have created confusion and lack of consistency on how to treat the resident's blood sugar irregularities. In an interview with DON, in her office, on 10/24/24, at 4 PM, the DON stated the FSBG monitoring and having parameters on how to handle blood sugar irregularities should have been addressed upon readmission. Review of the facility's policy, titled Administering Medications, dated 4/2019, the policy indicated Medications are administered in a safe and timely manner, and as prescribed. The policy further indicated The director of nursing services supervises and direct all personnel who administer medications and/or have related functions.

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40903

Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in medications carts for a census of 98 when:

1. Hazardous medications (drugs that can cause harm to the body when handled unsafely) were stored in the medication cart at North station with no warning label on how to be handled by nursing staff and without being in a protective bag.

2. A cart designed as an extra IV medication cart (IV is Intravenous, Into the Vein) stored a large supply of prescription IV medications bags with no patient specific label in the facility's North station and without a way to track each IV medication bag and what it was used for.

3. The IV medication cart at North station stored resident specific IV medications that were outdated, undated, or for residents no longer in the facility or no longer receiving IV medications, with medication and supplies co-mingled in a cluttered way.

4. The medication Cart and refrigerator at South station stored undated, unlabeled, and outdated medications and included a missing emergency drug kit (Ekit, medications used with a physician order if needed quickly).

5. The medication cart in North station stored undated medications and stored a medication that should have been refrigerated.

These failed practices may contribute to unsafe medication use and risk of residents receiving spoiled or unusable medications.

Findings:

1. During a concurrent interview and inspection of medication cart #2, at North station hallway, accompanied by Licensed Nurse (LN) 7, on [DATE], at 1:49 PM, the cart stored three bottles of a medication in liquid form called Megestrol (or Megace, a drug used for cancer treatment and/or increase the appetite). The label on the Megace liquid bottle did not have any auxiliary information for it being a hazardous drug and how it should have been handled by nursing staff. The Megace bottles additionally were not stored in a Ziplock bag to prevent hand contamination during storage. LN 7 was not aware of safe handling and did not know this medication should have been labeled for safe handling.

In an interview with Director of Nursing (DON), in her office, on [DATE], at 3:59 PM, the DON stated if a medication is hazardous, it should have been marked by pharmacy so the nurses would safely handle it. The DON stated the MAR record should also alert the nurse to use gloves when handling during administration or storage.

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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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy, titled Material Safety Data Sheets (or MSDS, a document that provides information on how to safely handle and work with a chemical or substance), dated 2019, the policy indicated .The pharmacy will provide a set of material safety data sheets for all hazardous medications dispensed by the dispensing pharmacy as defined by the Occupational Safety and Health Administration (or OSHA, a U.S. federal agency that ensures safe and healthy working conditions for employees) . The policy further indicated the common medications that are considered hazardous included Megestrol (or Megace). The policy did not provide any information or guide on how the nursing staff should handle the hazardous drugs, drug use, storage, or drug administration. Review of the drug information for Megace (Megestrol), last accessed via Lexicomp (an online drug information resource) on ,d+[DATE], the drug information indicated the following: .Hazardous Drugs Handling Considerations: Hazardous agent (NIOSH .) .Use appropriate precautions for receiving handling, storage, preparation, dispensing, transporting, administration, and disposal . Review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, a federal agency sets standard of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated ,d+[DATE], the document indicated .Many . drugs intended for individual use can be hazardous to healthcare workers with potential occupational exposure to those who handle, prepare, dispense, administer, or dispose of these drugs. Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes .PPE (or Personal Protective Equipment, items like glove or mask) provides worker protection to reduce exposure to hazardous drugs .Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. NIOSH suggests careful precautions and safeguards to protect workers, fetuses, and breastfed infants . Further review of the document indicated to use a single glove for handling an intact tablets and double glove for handling oral liquid of the hazardous medications as directed. 2. During a concurrent interview and inspection of a mobile cart that stored extra IV medication and supplies, in the North station hallway, accompanied by LN 3, on [DATE], at 2:20 PM, LN 3 stated the content of the cart was used as a backup when the IV Ekit (Emergency Kit- a box with emergency medications and IV fluids) did not provide the needed IV medication. The Cart stored multiple bags of IV fluids as follows: Dextrose 5% Solution 1 liter and 0.45% Sodium Chloride 1 Liter (% is percent, a measure of concentration, dextrose is same as Sugar; Both IV solution bags) with no resident specific label. LN 3 stated the IV bags and supplies were supplied by the provider pharmacy and were not resident specific. LN 3 could not find a list that listed the quantity of items and medications stored in the cart. In an interview with the DON, in her office, on [DATE], at 2:11 PM, the DON stated the Smaller IV Cart contained supplies and IV solution bags provided by the pharmacy and it was a back up to the Ekit with different types of IV fluids. The DON acknowledged that the bags were considered prescription items and needed accountability for use per a physician order. (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 10/24/2024

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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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent interview and inspection of a mobile IV cart, in the North station hallway, accompanied by LN 3 and the ADON, on [DATE], at 2:30 PM, the cart stored resident specific IV medications including antibiotics and IV solutions and supplies to administer the IV medications. The cart content and drawers were cluttered and included discontinued and active medications in the same drawer. LN 3 confirmed three sets of labeled IV medications belonged to residents that were discharged or no longer on IV medications. Further inspection of the IV cart content indicated opened and unwrapped IV solution medication in 50 mL, 100 mL and one- liter bags (mL stands for milliliter, a unit of volume, Liter a unit of volume) with no beyond use date (the date after which the IV bag should not be used after removal from outer protective cover based on manufacturer instruction) or markings. The ADON stated she needed to check with the pharmacy provider for a beyond use date and she removed the discontinued IV medication from the active storage areas. 4a. During a concurrent interview and inspection of facility medication cart #4, located at South station hallway, on [DATE], at 10:54 AM, accompanied by LN 4, the cart stored outdated, undated medications and unsafe storage practices as follows: i. Opened Bottle of Acidophilus Probiotic (a medication supplement) was stored at room temperature inside the cart when the product label indicated Refrigerate After Opening. ii. Opened and undated foil pouch for an inhalation medication called Ipratropium and Albuterol (or Duoneb, a breathing medication for shortness of breath) when the label on the pouch indicated Once removed from the foil pouch, the individual vials should be used within one week. iii. Opened and undated eye drop bottle called latanoprost (known as Xalatan, used to treat an eye disease called glaucoma) when the label indicated to discard 6 weeks after opening. iv. Two expired insulin pens called Novolog Flexpen (same as Lispro Insulin; in pen-like shape, an injectable drug used to treat diabetes or blood sugar disease) when the product label indicated to discard 28 days after opening and was marked with open dates of [DATE] which was more than 28 days of beyond use date. v. The narcotic bin stored a bottle with pills stashed in two plastic pouches and the outer label on the bottle was faded and unrecognizable with a handwritten marking [Resident's first name] lorazepam. LN 4 stated the facility had a Controlled Drug Record (or CDR) sheet that kept track of the count although the label and drug name was unrecognizable. The CDR indicated the medication was last used on [DATE]. LN 4 stated the bottle of pills was most likely resident's own pills that were brought to facility on [DATE]. LN 4 acknowledged the label did not clearly identify the pills and did not include any beyond use dates. 4b. During a concurrent interview and inspection of facility's medication refrigerator, located at South nursing station, on [DATE], at 11:35 AM, accompanied by LN 1, the medication refrigerator stored outdated, undated medications and unaccounted for controlled medication (medications that can cause physical and mental dependence) called Lorazepam (or Ativan, a medication used for anxiety or seizure) injection (Inj, or injection) vial as follows: i. There were three boxes of Hydrocortisone Acetate Suppositories (or Anusol-HC; used to treat hemorrhoids and itching/swelling in the rectum and anus) with expiration date of ,d+[DATE]. (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ii. There were three opened bottles of lorazepam in liquid form and no marking on when they were opened. The label on lorazepam box indicated Discard opened bottle after 90 days. iii. One single vial of Lorazepam Inj in a Ziplock bag had a label indicating EKIT EMC [facility name] . RX [redacted] . [DATE] . The vial did not have a resident name and there was no Emergency kit (Ekit) inside the refrigerator. Inside the refrigerator was a paper label, titled Refrigerated Emergency Drug Supply indicating Kit# 2092 and date sealed [DATE] with the whereabouts of the Refrigerated Ekit #2092 unknown. LN 1 acknowledged the findings and stated the single Ativan (lorazepam) vial most likely belonged to an EKit and she was not sure what happed to the kit and its other contents. LN 1 stated lorazepam liquid bottles were from hospice and the bottles were not dated when first opened. LN 1 stated to remove a controlled drug from an Ekit, the nursing staff should have called the pharmacy for a code before removing a controlled drug from the Ekit. LN 1 could not locate a document for Ekit removal. 5. During a concurrent interview and inspection of facility medication cart #2, located at North station hallway, on [DATE], at 1: 49 PM, accompanied by LN 7, the following unsafe storage practices were noted: i. Opened Bottle of Acidophilus Probiotic (a probiotic medication supplement) was stored at room temperature inside the cart when the product label indicated Refrigerate After Opening. ii. Two opened and undated foil pouches for an inhalation medication called Ipratropium and Albuterol (or Duoneb, a breathing medication for shortness of breath) when the label on the pouch indicated Once removed from the foil pouch, the individual vials should be used within one week. iii. One opened and undated eye drop bottle called latanoprost (known as Xalatan, used to treat an eye disease called glaucoma) when the label indicated to discard 6 weeks after opening. LN 7 acknowledged the findings and stated she was not sure when these products were opened. LN 7 stated she did not realize the probiotic label read to keep it in the refrigerator after opening. In an interview with DON, in her office, on [DATE], at 2:41 PM, the DON stated the facility's policy on use of Ekits was not followed. DON stated lorazepam, a controlled drug, required pharmacy permission for use and removal from Ekit. The DON stated the lorazepam pills with no label should have been disposed of and a fresh and accurate supply should have been provided to the resident with a doctor's order. The DON stated the storage areas and beyond use dates and the expiration dating should have been looked at and followed. A review of the facility's policy, titled Controlled Medications, dated 2019, the policy indicated .Medications included in the Drug Enforcement Administration (DEA, a federal agency that regulate and monitor drug use and abuse) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations . A review of the facility's policy, titled Infusion Therapy Products-General Information, dated 2019, the policy indicated .The infusion therapy products provider is contacted for information about the stability, storage, and/ or dilutent, If not available from . [Manufacturer package insert and Labeling, the handbook of injectable drugs] . (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy, titled Storage of Medications, dated 2019, the policy indicated .medications and biologicals are stored safely, securely, and properly following manufacturers recommendation or those of the supplier . The policy on section N indicated .Outdated, contaminated or deteriorated medications . are immediately removed from stock, disposed of according to procedures for medication disposal . Insulin bottles/Pens are to be dated when opened and discarded as per manufacturers recommendations . All ophthalmic and otic (ear medicine) medication to be dated upon opening and discarded 60 days after opening. Date open stickers can be attached to container that the medication is stored in .

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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43943 Based on observation, interview, and record review, the facility failed to ensure the kitchen's commercial can opener blade was clean and free from metal shavings. This failure could have resulted in food borne illness (vomiting, diarrhea, nausea) for 98 residents who ate food from the kitchen. Findings: During a concurrent observation and interview on 10/21/24, at 11:40 a.m., with the Dietary Director (DD), the commercial can opener was observed to have old metal shavings on the blade of the can opener. DD acknowledged the commercial can opener was not clean and it appeared to have curled up metal shavings on the blade that occurred after a can of food was opened. DD stated the can opener was supposed to be cleaned after each use and deep cleaned (ran through the dishwasher) once a week, although there was not a log in place to track the cleanings. DD stated the dirty can opener was a risk for infection and could have led to food borne illnesses for the residents. During an interview on 10/21/24, at 1:00 p.m., the COOK stated the commercial can opener should have been cleaned after each use and it was not acceptable to have metal shavings on the can opener blade because the bacteria (germs) could have built up on the blade and could have led to food borne illnesses. During a concurrent interview and record review on 10/22/24, at 8:52 a.m., with the Registered Dietitian (RD), the facility's Policy and Procedure (P&P) titled, Can Opener and Base, dated 2023, was reviewed. The P&P indicated, . the can opener must by thoroughly cleaned each work shift and, when necessary, more frequently . RD stated it was her expectation that the can opener was cleaned after each use and ran through the dishwasher after each shift (day and night shift). RD stated the metal pieces left on the can opener blade could have led to bacteria build up and caused residents to get sick. RD stated the P&P was not followed.

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	10/24/2024

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 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50778

Based on observation, interview, and record review, the facility failed to provide infection prevention and control measures to prevent the possible spread infection for a census of 98 when:

1. Appropriate Enhanced Barrier Precautions (EBP-infection control interventions to reduce the spread of germs through gown and glove use during high contact resident care activities) were not followed for Resident 300 and Resident 60 when accessing Peripherally Inserted Central Catheter (PICC-a tube inserted into a vein and guided into a large vein above the heart, used to administer intravenous medication) lines for intravenous (IV- an apparatus used to administer a fluid such as medication) antibiotics (medication used to treat bacterial infections); and,

2. Aseptic (free from contamination) technique was not used when reconstituting (adding a liquid diluent to a dry ingredient to make a specific concentration of liquid) IV antibiotics for Resident 300 and Resident 60; and,

3. Dirty cups were placed on the coffee cart with clean cups.

These failures exposed residents in the facility to germs with the potential of causing illness or death.

Findings:

1. During an observation on 10/22/24 at 1:57 p.m., Licensed Nurse (LN) 1 entered Resident 300's room with an IV antibiotic medication bag wearing only a facemask and gloves. An EBP precaution sign was posted outside the doorway of Resident 300's room.

During an observation on 10/23/24 at 12:50 p.m., LN 1 entered Resident 60's room with an IV antibiotic medication bag wearing only a facemask and gloves. An EBP precaution sign was posted outside the doorway of Resident 60's room.

During a concurrent interview and document review on 10/23/24 at 12:50 p.m., with LN 1, the Center for Disease Control and Prevention (CDC) Enhanced Barrier Precautions sign posted outside of Resident 60's room was reviewed. LN 1 read the sign out loud and stated the sign indicated the following: .Providers and staff must also: wear gloves and a gown for the following high contact resident care activites .Device care or use . LN 1 paused and then continued reading the sign aloud: .Central line . LN 1 confirmed a gown was not worn for Resident 60 on 10/22/24 nor for Resident 300 on 10/23/24, when the PICC line was accessed. LN 1 stated the risk of not wearing the correct PPE would be potential to spread infection to other residents.

During an Interview on 10/24/24 9:54 a.m., with the Infection Preventionist (IP), the IP stated EBP's were in place to prevent the potential spread of infection from one resident to another. The IP stated when staff saw the EBP sign they were supposed to follow the guidelines. The IP stated when a gown was not put on by staff, the EBP Policy was not followed, and therefore expectations were not met for Resident 300 and Resident 60 who received IV medication through a PICC line.

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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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/22/24 at 2:09 p.m. with the Director of Nursing (DON), the DON stated for residents in EBP rooms with signage outside the door, a nurse was to wear gown and gloves when accessing a PICC line. The DON stated, if the required personal protective equipment (PPE) was not worn, the Policy for EBP was not followed. During a review of a facility Policy and Procedure (P&P) titled Enhanced Barrier Precautions Policy Statement, dated 2001, indicated Enhanced barrier precautions (EBP's) are utilized to reduce the transmission of multi-drug resistant organisms (MDRO's) to residents .EBP's employ targeted gown and glove use .Gloves and gown are applied prior to performing the high contact resident care activity .Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: .device care or use (central line .). 2. During an observation on 10/23/24 at 12:50 p.m., LN 1 flipped the plastic top cap off the glass vial of a powdered medication. LN 1 then connected the vial of powdered medication to a bag of normal saline (a mixture of salt and water). LN 1 did not wipe the rubber stopper on the top of the glass medication vial with an alcohol wipe prior to connecting it to the bag of normal saline to reconstitute the medication. During an interview on 12/23/24 at 1:00 p.m., with LN 1, LN 1 confirmed she did not wipe the top of the vial that contained powdered medication prior to connecting it to the bag of normal saline. LN 1 stated she did not need to wipe the rubber stopper on the top of the medication vial after popping the disk off as it was sterile and a closed system. LN 1 confirmed an alcohol wipe was not used on the rubber stopper when reconstituting medication for Resident 300 on 10/22/24 or for Resident 60 on 10/23/24. During an interview on 10/24/24 4:04 p.m. with the DON, the DON stated the expectation was to use alcohol wipes when accessing vials through a rubber stopper for medication to be administered through an IV line. The DON stated the use of an alcohol wipe prior to accessing a medication vial was a standard of practice. Review of the CDC's online article titled Chemical Disinfectants Guideline for Disinfection and Sterilization in Healthcare Facilities (2008), dated 11/28/23, indicated, . Alcohol towelettes have been used for years to disinfect small surfaces such as rubber stoppers . (https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/chemical-disinfectants.html) 49823 3. During a concurrent observation and interview on 10/24/24 at 7:51 a.m., a coffee cart in the resident hallway near room [ROOM NUMBER] had dirty cups stacked on the coffee cart shelf near the clean cups and the coffee pot. Certified Nursing Assistant (CNA) 3 stated that the dirty cups should not be on the clean coffee cart. CNA 3 stated that the risk was the spread of infection. During an interview on 10/24/24 at 7:52 a.m. with LN 6, LN 6 stated that dirty cups should not be on the coffee cart. LN 6 stated that the risk was that a resident could grab a dirty cup to use for coffee. (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/24 at 12:45 p.m. with the Director of Nursing (DON) in the office, the DON stated that the expectation was that when the coffee cart was on the nursing units, dirty dishes were not placed on the coffee cart with the coffee pot and clean coffee cups. The DON stated that staff should place dirty cups on a separate cart. The DON stated that the risk was cross contamination (physical movement or transfer of harmful germs from one person, object, or place to another). The DON confirmed that the procedure was not followed. During a review of a facility policy and procedure (P&P) titled, Infection Prevention and Control Program, revised December 2023, indicated, .Policy Statement: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections .7. Prevention of infection . communicating the importance of standard precautions (the minimum infection prevention practices that apply to all patient care settings where health care is delivered, including hand hygiene, use of personal protective equipment [gloves, mask, gown, eyewear] .clean and disinfected environmental surfaces .) A review of an online document published by the United States Department of Agriculture (USDA) titled, Keep Food Safe! Food Safety Basics, last review dated 1/5/2024, indicated, .guidelines to keep food safe: clean - wash hands and surfaces often, separate - don't cross-contaminate .

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NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 40903 Based on interview and record review the facility failed to ensure the Antibiotic Stewardship Program (or ASP- a federally mandated program with goals of monitoring, optimizing antibiotic use, and reducing misuse of antibiotics) tracked and assessed antibiotic use based on facility policy for a resident census of 98. This failure could contribute to unsafe antibiotic use, monitoring, and increases the risk of developing resistance to germs that cause infections [when germs are not killed by an antibiotic] in the facility. Findings: During an interview with Infection Prevention nurse (IP), at facility's South station, on 10/24/24, at 9:49 AM, the IP stated when a new antibiotic was ordered, or a resident was admitted to the facility with an antibiotic order he was notified via the computer system or a text from the admitting staff. The IP stated he would then enter the antibiotic order and resident information into a spread sheet for tracking purposes. During a concurrent interview and record review with the IP of an ASP spread sheet, titled Infection Prevention and Control Surveillance log, at the facility's South station, on 10/24/24, at 10:19 AM, the IP stated the spread sheet was maintained by adding the residents who are on antibiotics to the sheet. The spread sheet logged the name of resident, admitted (date resident admitted to the facility), onset date (the date infection was noticed), site of infection (where the infection was), diagnosis, and the antibiotic name. The log did not include the duration of the antibiotic (or total days of antibiotic therapy), did not include date of culture (a sample sent to a lab to determine the type of germ causing the infection, if indicated), and did not include an outcome or stop date for the drug. The log's onset date and start date of antibiotic was not specified. The IP stated he documented the antibiotics started within the facility or from the hospital admission. The IP stated the duration of therapy was not documented and no follow up was done as the duration was ordered by a doctor. The IP stated the empiric use of antibiotics (empiric antibiotic use means the administration of antibiotics before lab results confirm the type of infection/germ) was not tracked and there was no follow up to de-escalate (Antibiotic de-escalation, a treatment strategy that involved reducing the use of antibiotics or switching to a narrower spectrum [less strong] antibiotic with a goal to provide effective treatment while avoiding the unnecessary use of antibiotics that could lead to resistance of the antibiotic use once the test results were available). The IP stated the criteria to assess development of an infection by nursing staff before calling the doctor was not used as noted on the spread sheet for LEOB criteria (Loeb's criteria, a set of minimum signs and symptoms that could be used in long-term care to help pinpoint the likliehood of an infection that may need antibiotics). During a concurrent interview and record review with the IP of laboratory reports on germs isolated from a sample sent to the laboratory, for date range of 6/24 to 8/24, the report indicated a total of 22 urine cultures (urine was tested for infection) and 9 blood cultures (blood was tested for infection) with infectious germs isolated. The IP stated the culture results were not documented in the antibiotic use tracking record and log. The IP stated the individual physician antibiotic prescribing patterns and data were not tracked or shared with other health care providers. (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 10/24/2024
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Director of Nursing, in her office on 10/24/24, at 3:45 PM, the DON stated the facility served a number of residents with post hospital long term IV (Intravenous; Into the Vein) antibiotic use. The DON stated it was important to monitor inhouse antibiotic use and work with doctors to optimize appropriate antibiotic use. Review of the facility's policy, titled Antibiotic Stewardship- Review and surveillance of antibiotic Use and Outcomes, last revised on 12/2016, indicated Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship. The policy indicated .As part of facility Antibiotic Stewardship Program, all clinical infections treated with antibiotics will undergo review by the infection preventionist or designee .The IP or designee will review antibiotic utilization as a part of antibiotic stewardship program and identify specific situations that are not consistent with appropriate use of antibiotic. Therapy may require further review and possible change if: the organism [germ] is not susceptible to antibiotic chosen; The organism is susceptible to narrower spectrum antibiotic .Therapy was started awaiting culture, but the culture results and clinical findings do not indicate continued need for antibiotics . The policy further indicated .All residents antibiotic regimen will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include .date symptom appeared .Start date of antibiotic; Pathogen [germ] identified; Site of infection; Date of culture; The stop date; Total days of therapy; Outcome; and Adverse events .