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	02/12/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure 4 of 37 sampled residents (Resident 12, Resident 54, Resident 71, and Resident 79) were provided with reasonable accommodation of needs when;1. Resident 12, Resident 54 and Resident 79's call light (device used to contact staff for assistance) was not within reach; and,2. Resident 71 was not provided with a communication board (Communication boards help people communicate with others by using symbols, pictures, or photos).This deficient practice placed Resident 12, Resident 54, Resident 79 and Resident 71 at increased risk for unmet care needs, delayed staff response, and had the potential to impact their psychosocial well-being.Findings:1. Review of Resident 12's admission Record indicated, Resident 12 was admitted to the facility with diagnoses including Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks), seizures (abnormal electrical brain activity leading to sudden muscle limpness/drop attacks, brief jerks, and/or intense stiffening), abnormalities of gait and mobility (difficulty in walking and mobility), and fracture of the right shoulder blade.Review of Resident 54's admission Record indicated, Resident 54 was admitted to the facility with diagnoses including Epilepsy (recurrent, unprovoked seizures caused by abnormal electrical brain activity), nontraumatic intracranial hemorrhage (a life-threatening ruptured blood vessel bleeding into the brain, causing sudden pressure and potential damage) and dysphagia (difficulty swallowing).Review of Resident 79's admission Record indicated, Resident 79 was admitted to the facility with diagnoses including traumatic subdural hemorrhage (a life-threatening emergency where blood collects between the brain's surface and the outer membrane) dementia, and abnormal posture.1a. During a concurrent observation and interview on 2/9/26 at 11:18 AM with Resident 12 in Resident 12's room, Resident 12 was lying in his bed and Resident 12's call light was observed hanging from Resident 12's left side bed rail. Resident 12 tried to grab the call light and he was unable to grab the call light from the bedside rail.During a concurrent observation and interview on 2/9/26 at 11:18 AM with Licensed Nurse (LN) 4 in Resident 12's room, LN 4 stated Resident 12's call light was not within reach. LN 4 stated that if Resident 12 could not reach or use the call light to ask for help, Resident 12 would be at risk for falls, injury by hitting his head, and unmet needs. LN 4 further stated that Resident 12 had a fall in the past.A record review of Resident 12's Care Plan, in the section titled focus initiated on 6/12/23, indicated, .ADL Self Care Performance Deficit. The section titled Interventions initiated on 6/12/23, indicated . [Resident 12] requires 1-2 staff participation to reposition and turn in bed.A record review of Resident 12's Care Plan, in the section titled focus initiated on 6/12/23, indicated, . [Resident 12] is at risk for falls. The section titled interventions initiated on 3/24/24, indicated, .Advise to call for assistance and use call light.Keep call light within reach.1b. During an observation on 2/9/26 at 9:12 AM with Resident 54 in Resident 54's room, Resident 54 was lying in her bed and Resident 54's call light was observed hanging from the bedside top drawer, out of reach. During a concurrent observation and interview on 2/9/26 at 9:12 AM with CNA 1 in Resident 54's room, CNA 1 confirmed the call light for resident 54 was hanging from Resident 54's bedside top drawer. CNA 1 stated the call light should be within reach of Resident 54 for safety. CNA 1 further stated since Resident 54 was nonverbal and did not have a call light within reach something bad could have (continued on next page)

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

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	055185	A. Building B. Wing	02/12/2026

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	happened to Resident 54 in case of an emergency.During a record review of Resident 54's Care Plan, in the section titled focus initiated on 11/4/22, indicated [Resident 149] has ADL self-care performance Deficit r/t cognitive impairment. The section titled interventions initiated on 6/26/23, indicated . [Resident 54] requires extensive assistance. dependent to reposition self and turn in bed .During a record review of Resident 54's Care Plan, in the section titled focus initiated on 11/4/22, indicated [Resident 54] has a potential for falls. The section titled interventions initiated on 11/4/22, indicated Keep call bell in reach and answer promptly.During a record review of Resident 54's Care Plan, in the section titled focus initiated on 4/16/24, indicated [Resident 54] is at risk for impaired communication. The section titled interventions initiated on 4/16/24, indicated Use hand signals and gestures to assist with communication .1c. During an observation on 2/9/26 at 9:15 AM with Resident 79 in Resident 79's room, Resident 79 was lying in her bed and Resident 79's call light was observed to be on the floor next to Resident 79's bed. Resident 79 did not have a call light within her reach.During a concurrent observation and interview on 2/9/26 at 9:15 AM with CNA 1 in Resident 79's room, CNA 1 confirmed the call light for Resident 79 was on the floor next to Resident 79's bed. CNA 1 stated Resident 79's call light should have been within reach. CNA 1 picked up the call light from the floor and placed it within reach of Resident 79.During a record review of Resident 79's Care Plan, in the section titled focus initiated on 12/14/23, indicated, [Resident 79] has an ADL self-care deficit. The section titled Interventions initiated on 12/14/23, indicated . [Resident 79] dependent for assist with transfers.During a record review of Resident 79's Care Plan, in the section titled focus initiated on 12/14/23, indicated, . [Resident 79] is at risk for falls. The section titled Interventions initiated on 12/14/23, indicated .Call light within reach. Continue to remind [Resident 79] to call for assist.During an interview on 2/11/26 at 1:02 PM with the Director of Nursing (DON), the DON stated to anticipate the needs of residents and know residents' needs, the call light should be within reach of residents. The DON stated residents care could be delayed, and residents could fall trying to reach for the call light when the residents call light was not within reach. A review of facility's policy titled, Answering the Call Light, dated October 2010, indicated, .The purpose of this procedure is to respond to the resident's requests and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 2. Review of Resident 71's admission Record indicated, Resident 71 was admitted to the facility with diagnoses including unspecified dementia (severe memory loss, impaired thinking, and reduced social abilities) and history of fall.During a concurrent observation and interview on 2/9/26 at 12:05 PM with Resident 71 in Resident 71's room, by writing on a piece of paper, Resident 71 was asked if he could hear. Resident 71 stated he could not hear, and he did not have a hearing aid (a small, electronic, battery-powered medical device designed to improve hearing and speech comprehension by amplifying sound for individuals with hearing loss worn in or behind the ear). Resident 71 stated it would have been better if he was able to understand staff when staff tried to communicate with him. Resident 71 stated he had an appointment to get a new hearing aid a few weeks ago. Resident 71 stated he had notified the staff at the facility that he could not hear since his old hearing aid did not work. Resident 71 further stated the facility did not provide him with a communication board or any other type of communication device.During a concurrent observation and interview on 2/9/26 at 12:07 PM with CNA 1 in Resident 71's room, CNA 1 stated Resident 71 was deaf (having limited or no hearing; having permanent loss or absence of hearing) and Resident 71 could not hear. CNA 1 stated Resident 71's hearing aid had been ordered. CNA 1 confirmed Resident 71 did not have a communication board or any other type of communication device. CNA 1 stated when communicating with Resident 71, CNA 1 tried his best by speaking loud. CNA 1 further stated during conversation with Resident 71, CNA 1 was not sure if Resident 71 understood CNA 1.During a concurrent observation and interview on 2/9/26 at 12:30 PM with LN 4, in Resident 71's room, LN 4 confirmed Resident 71 did not have a functioning hearing aid or a communication board or any other type of communication device in his room. Resident 71 stated he could not hear LN 4 when LN 4 stood close to Resident 71's ears and notified Resident 71 of the time (continued on next page)

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	055185	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lunch would be served. LN 4 repeated lunch time three more times to Resident 71 in presence of LN 11. Resident 71 stated he could not hear LN 4. LN 4 confirmed Resident 71 could not hear her when she spoke loud and close to Resident 71' ears. LN 4 stated Resident 71 should have a communication board to feel comfortable and be able to communicate properly with staff. During an interview on 2/9/26 at 2:53 PM with CNA 2, CNA 2 stated he had used verbal cues to communicate with Resident 71 for the past two months. CNA 2 stated it was difficult to communicate with Resident 71 since Resident 71 did not have a hearing aid, communication board, or any other type of communication device. CNA 2 stated Resident 71 should have a communication board when communicating with staff. CNA 2 further stated that without having a communication board Resident 71 could be unable to communicate with staff when Resident 71 was in pain.During an interview on 2/10/26 at 8:30 AM with LN 10, LN 10 stated Resident 71 did not have a communication board or any other type of communication device in his room. LN 10 stated Resident 71 had hearing problems. LN 10 stated Resident 71 should have a communication board for better communication. LN 10 further stated Resident 71 would not be able to understand what staff was telling him if there was no communication board in case of an emergency.During a record review of Resident 71's Care Plan, in the section titled focus initiated on 12/21/24, indicated [Resident 71] is at risk for impaired communication related to highly impaired hearing to bilateral ears. The section titled goal initiated on 12/21/24, indicated . Will be successful using communication board . The section titled interventions initiated on 12/21/24, indicated .Hearing impairment-highly impaired. Requires increased volume. Increase volume of voice and speak distinctly.During an interview on 2/11/26 at 1:02 PM with the Director of Nursing (DON), the DON stated Resident 71 had difficulty hearing and Resident 71 should have a communication board to be able to communicate with staff per his care plan. The DON stated by not having a communication board Resident 71 could have had his treatments delayed.A review of facility's policy titled, Hearing Impaired Resident of, undated, indicated, .Evaluate and address avoidable obstacles to effective communication.Provide pencil and paper or tablet to communicate in writing, if the resident is able.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure consistent implementation of its Advance Directive (a legal document that outlines the preferences for medical treatment if the resident become unable to communicate or make decisions for one's self) process for nine of 37 sampled residents (Residents 142, 138, 78, 137, 139, 103, 105, 117, and 3); when Section D of the Physician Orders for Life-Sustaining Treatment (POLST) (POLST, a signed medical order reflecting a resident's life-sustaining treatment preferences) was incomplete and/or the documentation regarding Advance Directive status was inconsistent with other facility records.These failures resulted in the facility being unable to verify who participated in the POLST discussion and was unable to demonstrate that assistance in establishing Advance Directives was offered to the residents and documented in their health records, which could have resulted in the residents' desired life sustaining treatment in the case of an emergency not being honored.Findings:During a review of the sampled residents' Physician Orders for Life-Sustaining Treatment (POLST), the facility's document titled, Resident Services (reflecting the Advance Directive status), and the facility's case management Progress Notes (care coordination documentation), the following were noted:1. For Resident 142, a review of Resident 142's Physician Orders for Life-Sustaining Treatment (POLST), dated 1/29/26, Section D indicated, Discussed with, was left blank and the box that indicated, No Advance Directive, was selected. A review of the facility's document titled, Resident Services, dated 2/1/26, indicated Resident 142 was interested in executing an Advance Directive. A review of an undated case management note titled, Progress Notes, indicated, AHCD (Advance Health Care Directive): Declined.2. A review of Resident 138's Physician Orders for Life-Sustaining Treatment (POLST), dated 2/5/26, Section D indicated, Discussed with, was left blank, and the section that indicated an Advance Directive status was left blank.3. A review of Resident 78's Physician Orders for Life-Sustaining Treatment (POLST), dated 1/20/26, Section D indicated, Discussed with was left blank.4. A review of Resident 137's Physician Orders for Life-Sustaining Treatment (POLST), dated 1/30/26, Section D indicated, Discussed with was left blank and the box that indicated, No Advance Directive, was selected. A review of the facility's document titled, Resident Services, dated 2/1/26, indicated Resident 137 had executed an Advance Directive and was going to bring in a copy of the Advance Directive. A review of a case management note titled, Progress Notes, dated 2/3/26 at 4:26 PM, indicated, AHCD: Declined.5. For Resident 139, a review of Resident 139's Physician Orders for Life-Sustaining Treatment (POLST), dated 2/5/26, Section D indicated, Discussed with, was left blank and the box that indicated, No Advance Directive, was selected. A review of the facility's document titled, Resident Services, dated 2/8/26, indicated Resident 139 had executed an Advance Directive, had provided the facility with a copy, and would bring in a copy of the Advance Directive. A review of case management notes, Progress Notes, dated 2/11/26 at 9:19 PM, indicated, AHCD: Per patient she does have one, states she will provide copy.6. For Resident 103, a review of Resident 103's Physician Orders for Life-Sustaining Treatment (POLST), dated 1/12/26, Section D indicated, Discussed with, was left blank.7. For Resident 105, a review of Resident 105's Physician Orders for Life-Sustaining Treatment (POLST), dated 12/13/25, Section D indicated, No Advance Directive, was selected. A review of the facility's document titled, Resident Services, dated 10/26/25, indicated, Refused, but did not specify who refused to complete the document. A review of an undated case management note titled, Progress Notes, indicated, AHCD: daughter already has a copy.8. For Resident 117, a review of Resident 117's Physician Orders for Life-Sustaining Treatment (POLST), dated 1/11/26, Section D indicated, Discussed with, was left blank and the box that indicated, No Advance Directive, was selected. A review of the facility's document titled, Resident Services, dated 1/14/26, indicated Resident 117 was interested in executing an Advance Directive. A review of an undated case management note titled, Progress Notes, indicated, AHCD: no, declined.9. A review of (continued on next page)

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	055185	A. Building B. Wing	02/12/2026

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's Physician Orders for Life-Sustaining Treatment (POLST), dated 2/7/26, Section D indicated, Discussed with, was left blank. During a concurrent interview and record review on 2/11/26 at 2:46 PM with the Director of Nursing (DON), the POLST(s) and Advance Directive documentation for Residents 142, 138, 78, 137, 139, 103, 105, 117, and 3, were reviewed. The DON stated the POLST(s) should have been completed in their entirety. During a review of Resident 142's POLST, the DON acknowledged Section D was incomplete, as the area indicated whether the discussion occurred with the resident (if the resident has capacity (person is able to understand medical information and make their own healthcare decisions)) or the legally recognized decision-maker, was not selected. The DON was not able to locate evidence that assistance was offered to Resident 142 to formulate an Advanced Directive. The DON stated the facility could not verify who made the decision reflected on the POLST. The DON stated similar findings may be present in other residents' records. The DON further stated the facility should have ensured the Advance Directive discussions were conducted with the resident or responsible party and documented upon admission. During an interview on 2/11/26 at 4:10 PM with Licensed Nurse (LN) 16, LN 16 stated he admitted new residents during his shift and was familiar with the POLST form. LN 16 stated the POLST form needed to be completed from Sections A through D before the physician signed the document. LN 16 stated the POLST was supposed to be completed with the resident if the resident has the capacity; if the resident did not have capacity, the family was contacted to complete the form. LN 16 stated in the event of an emergency or change in condition, nurses reviewed the POLST and any available Advance Directives and determined the resident's treatment preferences. LN 16 stated if a resident had an Advance Directive, he asked the resident or responsible party to provide a copy. Upon receipt, the copy was given to social services and uploaded into the system. LN 16 stated that if a resident did not have an Advance Directive, he did not offer assistance with establishing one but encouraged the resident to discuss it with their family. LN 16 stated, we don't have any Advance Directive form here in the facility, and stated he was not aware whether the facility had a blank Advance Directive form available to offer to residents. LN 16 stated the admitting nurse was responsible for ensuring the POLST was completed. Following the interview, LN 16 consulted with the DON regarding availability of blank Advance Directive forms. LN 16 stated the DON instructed that if a resident did not have an Advance Directive, the resident or responsible party should have been directed to the social worker for assistance. During a joint concurrent interview and record review on 2/12/26 at 8:30 AM with the Administrator, Director of Marketing, Clinical Resource Nurse, and the Social Services Director regarding completion of the sampled residents' POLST forms, the facility's document titled, Resident Services, and the social work documentation of Advance Health Care directives (AHCD), were reviewed. The facility's team acknowledged inconsistency in documentation related to Advance Directive status between the Physician Orders for Life-Sustaining Treatment (POLST), Resident Services document, and the AHCD documentation. The facility further acknowledged that the process of offering assistance with Advance Directives to residents without one, required improvement. During a review of the facility's policy titled, Advance Directives, revised on 9/22, indicated, .Determining Existence of Advance Directive.Prior to or upon admission of a resident, the social services director or designee inquires of the resident .or.legal representative, about existence of any written Advance Directives.If the Resident Does not have an Advance Directive.the facility staff will offer assistance in establishing Advance Directives.nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.information about whether or not the resident has executed an Advance Directive is displayed prominently in the medical record.

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	055185	A. Building B. Wing	02/12/2026

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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. Based on interview and record review, the facility failed to ensure medications were handled, destroyed, and documented in accordance with accepted standards of practice and facility's policy with a census of 101 residents when:1. Destruction and disposition of non-controlled (non-opioid) prescription medications were not co-signed and witnessed by two licensed nurses;2. Medications labeled as hazardous (medications that pose health risks with repeated unsafe handling) were not handled safely during medication administration for Resident 146; and3. Resident 86's narcotic medication, Morphine (a controlled prescription drug) was not accurately documented in the electronic Medication Administration Record (MAR - a legal record of medications administered to a resident) when removed from the Controlled Drug Record (CDR - a paper record sheet for accountability and tracking of narcotic removal with nurses initial, date, and time).These failures compromised medication accountability and created the potential for unsafe medication handling, administration practices, and risk of drug diversion (unlawful drug loss).FINDINGS:1.Review of the facility's non-controlled medication destruction log, titled Medication Disposition Log for July 2025 through January 2026, revealed that medication destructions were documented without a witness signature to verify the destruction process. During a concurrent interview and record review on 02/10/26 at 11:47 a.m. with the Director of Nursing (DON), the facility's non-controlled medication destruction logs for July 2025 through January 2026 were reviewed. The DON confirmed she signed the section indicating the medications were destroyed; however, no witness signature was documented to verify the destruction. The DON agreed that medication destruction should be witnessed to ensure accountability and to reduce the risk of drug diversion. A review of the facility policy titled Discarding and Destroying Medications, revised October 2014, indicated, .10. The medication disposition record will contain the following information: .h. Signature of witnesses.2. Review of Resident 146's admission RECORD indicated Resident 146 was admitted to the facility with multiple diagnoses, including benign prostatic hyperplasia without lower urinary tract symptoms (prostate disease) and mood disorder (mental health condition that primarily affects your emotional state). During an observation and interview on 02/09/26 at 9:05 a.m., the Licensed Nurse (LN 2) was observed in the hallway administering medications to Resident 146. LN 2 handled two medications (Finasteride, drug used for prostate disease, and Divalproex, drug used for mood disorders) labeled as hazardous without wearing gloves and dispensed them into a small container. LN 2 acknowledged that gloves were required when handling hazardous medications and stated she forgot to wear them. During an interview on 02/10/26 at 11:50 a.m., the Director of Nursing (DON) stated staff are expected to wear gloves when handling hazardous medications to protect themselves and ensure safe handling practices. The DON stated it was essential that gloves be used when handling hazardous medications to promote staff and resident safety. A review of the facility policy titled, Hazardous Drugs, revised April 2019, indicated, Hazardous pharmaceutical drugs are handled according to practice standards so as to minimize staff and resident exposure. 9. Staff are trained on and required to wear personal protective equipment (PPE) specific to the risk of exposure and activities performed. During a 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 4/2023, last accessed via https://www.cdc.gov/niosh/docs/2023-130/2023-130.pdf?id=10.26616/NIOSHPUB2023130 and https://www.cdc.gov/niosh/docs/2023-130/default.html , 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Further review of the document indicated to use single glove for handling intact tablet form and double glove for handling oral liquid form of the hazardous medications as directed. 3. Review of Resident 86's admission RECORD indicated Resident 86 was admitted to the facility with multiple diagnoses, including muscle weakness, chronic low back pain, depression, and anxiety. Review of Resident 86's Controlled Drug Record (CDR) titled Controlled Substance Accountablilty Sheet, with date range of January 2026 to February 2026, indicated Morphine removal and use for treatment of pain. A comparative review of Resident 86's CDR with Medication Administration Record (MAR) record for the same time period revealed the following discrepancies:1/13/26 - CDR removal documentation present; no MAR documentation. 1/29/26 - No CDR removal documentation; MAR documentation present at 1330 (1:30 p.m.).2/02/26 - No CDR removal documentation; MAR documentation present at 1149 (11:49 a.m.).2/02/26 - No CDR removal documentation; MAR documentation present at 1651 (4:51 p.m.).During a concurrent interview and record review on 02/12/26 at 10:43 a.m. with the Director of Nursing (DON), the CDR and MAR of Resident 86 for January 2026 to February 2026 were reviewed. The DON confirmed nursing staff did not complete the required documentation when removing and administering the resident's-controlled medication. The DON stated accurate documentation was necessary to ensure medication accountability and reconciliation of controlled substances. The DON also stated that incomplete or inaccurate documentation increased the risk of medication discrepancies and potential drug diversion. A review of the facility policy titled, Controlled Substances, revised November 2022, indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.

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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. Based on observation, Interview and record review the facility failed to ensure safe medication storage practices in the medication carts, Medication refrigerators and medication rooms with resident census of 101 when:1. South hall medication refrigerator stored undated and outdated medications with extensive frost build up and not meeting the temperature range per policy.2. South hall medications cart 3 stored undated and outdated medications.3. North hall medication cart for IV (Into the Vein) stored unlabeled IV solutions.4. North hall medication refrigerator stored discontinued, unlabeled, outdated medications, and co-mingled medication container with different routes of administration, and the storage practices did not follow manufacturer specification for storage temperature.5. South hall medication cart 4 stored undated and outdated medications.These failed practices could contribute to use of medications with lower potency and/or inadvertent use of discontinued drugs.Findings:1.During a concurrent interview with Licensed Nurse 5 (LN 5) and inspection of medication refrigerator in south station, on 2/9/26, at 9:55 a.m., the top section (freezer) had excessive frost and temperature monitoring log posted on the door indicated temperatures outside of the range listed on the log as follow:2/1/26 Temperature recorded 34 degrees Fahrenheit (a temperature scale)2/2/26 Temperature recorded 34 degrees Fahrenheit 2/3/26 Temperature recorded 32 degrees Fahrenheit 2/4/26 Temperature recorded 32 degrees Fahrenheit 2/6/26 Temperature recorded 34 degrees Fahrenheit 2/9/26 Temperature recorded 34 degrees Fahrenheit Further review of the log sheet indicated Refrigerated drugs must be stored at a temperature between 36 and 46 degrees F (or Fahrenheit) in the event of equipment malfunction, all drugs should be removed and taken to another refrigerator . LN 5 stated the refrigerator temperature were recorded twice a day by nursing staff who had key to the refrigerator and was not sure who was responsible for defrosting the refrigerator. During a concurrent interview with LN 5 and inspection of medication refrigerator in the south hall, on 2/9/26, at 9:55 a.m., the refrigerator stored insulin (drug in injection form for diabetes, the blood sugar disease) and eye drop medications as follow:i. Insulin Aspart (short-acting insulin) vial was open with no marking for open date and was dispensed on 12/15/25. The label on the box indicated Store refrigerated (36- 46-degree Fahrenheit) until first use then store either refrigerated or at room temperature . and discard after 28 days. Avoid freezing .ii. Insulin Glargine (long-acting insulin) vials with open date of 12/31/25 and 1/1/26; the label on the box indicated Refrigerate (36- 46-degree Fahrenheit) until first use. Avoid freezing . after first use store at room temperature and discard after 28 daysiii. Eye drop called Latanoprost (glaucoma medication) with open date of 10/7/25. The label on the box indicated unopened bottle under refrigeration at 36 to 46-degree Fahrenheit). Opened bottle may be stored at room temperature up to 77-degree Fahrenheit for 6 weeks.LN 5 stated marking the open date and expiration date was to be done when new drugs were first opened to be used. 2. During a concurrent interview with LN 5 and inspection of medication cart 3, in the south hall, on 2/9/26, at 10:28 a.m., the cart stored multiple open and undated medications as follows:i. Multiple open, undated inhalation medication known as DuoNeb (two medications for treating shortness of breath) were out of the foil wrap. The label on the packet indicated Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week.ii. Open and undated Breo Ellipta (combination of fluticasone and Vilanterol, for treatment of asthma) inhaler. The label on the box indicated Discard the inhaler 6 weeks after opening the moisture-protective foil tray or when the counter reads 0 (after all blisters have been used) whichever comes first.iii. Open and undated Incruse Ellipta (or umeclidinium inhalation powder for chronic breathing issues) inhaler. The label on the box indicated Discard the inhaler 6 weeks after opening the moisture-protective foil tray or when the counter reads 0 (after all blisters have been used) whichever comes first.iv. Three outdated inhaler (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	02/12/2026

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	medication known as Advair (combination of two drugs in one, fluticasone and Salmeterol for treatment of asthma breathing issues) with open date marked as 10/30/25, 11/25/25, and 12/16/25. The label on the container indicated Discard inhaler 1 month after opening the foil pouch or when the counter reads 0, (after all blisters have been used) whichever comes first. LN 5 acknowledged the finding and stated she will remove the products and get replacements. 3. During a concurrent interview with the Assistant Director of Nursing (ADON) and inspection of IV medication cart in North station, on 2/9/26, at 11:25 a.m., the cart stored two unlabeled IV bags marked as emergency kit or Ekit) supply as follows:i. Sodium Chloride (salt) solution one liter IV bag.ii. Dextrose and Sodium chloride solution (D5W/NACL- sterile sugar and salt solution) one liter.The ADON stated the bags were part of emergency supply and should not have been in the IV cart without a resident name. ADON stated once removed from the Ekit, it should be used or returned to Ekit if not used. 4. During a concurrent interview with LN 9 and the inspection of North hall medication room refrigerator, on 2/9/26, at 2:35 p.m., the eye drops and injectable medications were co-mingled in the same crowded areas in addition to the following medications storage irregularities:i. Four vials of a controlled drug (drug with abuse potential) and a hormone called testosterone 200mg/ml (mg/ml is milligram per milliliter is unit of strength, the shot is a hormone medication) was stored among other non-controlled drugs. The resident was no longer on it, and it was never ordered while at the facility. LN 9 could not explain why the product was stored in the facility's refrigerator.ii. Insulin Degludec (or Tresiba, an ultra-long-acting insulin) in pen form was stored with no resident label.iii. Insulin Glargine (or Lantus, a long-acting insulin) marked with open date of 12/31/25 and expiration of 1/27/26 was stored in active storage areas.iv. Multiple opened eyedrops not following manufacturer requirement for storage as follows: Timolol eye drop (eye drop for glaucoma); drug box label indicated keep at controlled room temperature of 39-to-77-degree Fahrenheit.Bromfenac eye drop (anti inflammation eye drop); drug label on the box indicated to store at controlled room temperature between 68-77-degree Fahrenheit.Prednisolone eye drop (steroid eye drop); drug label on the box indicated to store between 46-to-75-degree Fahrenheit in an UPRIGHT position.Brimonidine/timolol (combination eye drop for glaucoma); the drug label on the box indicated to store at controlled room temperature between 68-77-degree Fahrenheit. v. Six vials of multi-dose lorazepam (or Ativan ,anxiety or seizure medication) injection were stored in the active storage areas. LN 9 stated the resident was no longer using it. The electronic record indicated it was discontinued on 12/9/25.LN 9 acknowledged the findings.5. During a concurrent interview with LN 4 and inspection of the medication cart 4 in south hall, on 2/9/26, at 2:59 p.m., the medication cart stored outdated and undated medications as follows:i. Fluticasone plus Vilanterol inhaler (or Breo Ellipta, an inhalation drug to treat asthma) was dated 11/29/25 when first opened. The label on the box indicated Discard the inhaler 6 weeks after opening the moisture-protective foil tray.ii. Multiple open, undated inhalation drug known as DuoNeb (two medications for treating shortness of breath) were out of the foil wrap. The label on the packet indicated Unit-dose vials should remain stored in the protective foil pouch at all times. Once removed from the foil pouch, the individual vials should be used within one week.LN 4 acknowledged the findings.In an interview with the Director of Nursing (DON), in her office, on 2/10/26, at 11:47 a.m., the DON stated the multidose medication containers such as insulin should have been dated when first opened along with actual expiration date. The DON stated she needed to consult the pharmacy on keeping the open eye drops in the refrigerator or not. The DON stated that when temperature was not in-range, the nurse needed to notify the management. The DON stated she needed to educate the nurses on how to handle out of range temperatures. The DON also stated the discontinued controlled drugs such as testosterone and Ativan should have been removed from the active storage areas and returned to the DON office for destruction. The DON stated the crowded refrigerator was replaced with a new one and medications were safely organized.Review of the facility's policy, titled Medication Labeling and Storage, dated 4/2019, the policy indicated The facility stores all medications and biologicals in locked compartments under proper temperature . The policy indicated (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	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications are stored in an orderly manner . Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurse's station or other secured location . Controlled substances . and other drugs subject to abuse are separately locked . The policy further indicated Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Review of the facility's policy, titled Storage of medications, dated 8/2014, the policy indicated Orally administered medications are kept separate from externally used medications . Eye medications are stored separately per facility policy. The policy further indicated Medications and biologicals are stored in their appropriate temperature and humidity according to United States Pharmacopeia guidelines (authoritative, science-based standards for the strength, quality, purity, and packaging of medicines and enforced by Food and Drug Administration) for temperature ranges. Medication requiring storage at room temperature are kept as temperature ranging from 59 to 77 F.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure safe infection prevention practices and provide a clean and sanitary environment with a census of 101 residents when:1. Two water dispensers located at the nurse's stations were found dirty,2. Urinal was not labeled for Resident 9, Resident 98 and Resident 116,3. A pill cutter (a small, handheld device designed to accurately divide pills or tablets into smaller, more manageable doses) was found with unknown powder and dust inside,4. A glucometer (a device for measuring the concentration of glucose in the blood) was cleaned with bare hands using bleach wipes. These failures had the potential to spread disease and illness amongst the residents residing in the facility, negatively impacting their health and well-being.Findings: During a concurrent observation and interview on 2/10/26 at 8:38 a.m., with Licensed Nurse (LN) 6, in the South Nurses Station, a water dispenser was observed having brown, yellow and white residue around the water dispensing nozzle, brown residue in the drip tray and dust around the water dispenser. LN 6 stated the water dispenser was functioning and staff and residents at the facility drank water from the water dispenser. LN 6 confirmed that the water dispenser was dirty and the water dispenser should have been cleaned. LN 6 further stated residents could get sick from water contamination by drinking water from the dirty water dispenser. LN 6 stated she did not know when the water dispenser was cleaned last. During a concurrent observation and interview on 2/10/26 at 8:48 a.m., with LN 8, in the North Nurses Station, a water dispenser was observed having brown and white residue around the water dispensing nozzle, brown residue in the drip tray and dust on the back of the water dispenser. LN 8 stated staff and residents at the facility drank water from the water dispenser. LN 8 confirmed that the water dispenser was dirty and the water dispenser should have been cleaned. LN 8 further stated residents could get sick from food and water contamination by drinking water from the dirty water dispenser. LN 8 stated she had not seen anyone clean the water dispenser in the past. During an interview on 2/10/26 at 4:14 p.m., with LN 2, LN 2 stated Residents and staff drank water from the water dispensers at both North and South Nurses station. LN 8 stated that any staff member who saw the water dispenser was dirty should have cleaned the water dispenser. LN 8 stated housekeeping staff were primarily assigned to clean the water dispenser. LN 8 stated she did not know if there was a cleaning log for the water dispensers. LN8 stated residents could get sick by drinking water from dirty water dispensers. During an interview on 2/11/26 at 8:58 a.m., with the Director of Maintenance (MTD), the MTD stated residents drank water from the North and South Nurses station water dispensers. The MTD stated he was in process of cleaning the water dispensers at the North and South Nurses station. The MTD stated there was no cleaning log to indicate when the water dispensers were last cleaned. The MTD stated the water dispensers had white water stain and calcium build up and there was potential for pathogens (microorganisms including bacteria, viruses, fungi, and parasites that cause diseases by invading a host, evading immune responses, and utilizing host resources to replicate) to grow in the water dispenses. The MTD stated residents could get sick by drinking water from dirty water dispensers. During an interview on 2/11/26 at 9:16 a.m., with LN 7, LN 7 stated residents and staff drank water from the water dispensers located in the North and South Nurses station. LN 7 stated he did not see when the water dispensers were last cleaned. LN 7 stated he did not check the water dispensers, and (continued on next page)

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	055185	A. Building B. Wing	02/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he did not know how long the water dispensers had calcium residue. LN 7 stated residents could have got sick by drinking water from dirty water dispensers. During an interview on 2/11/26 at 1:05 p.m., with the Director of Nursing (DON), the DON stated residents drank water from the water dispensers located in the North and South Nurses station. The DON stated the maintenance staff was responsible for cleaning the water dispensers. The DON stated residents could have had nausea and vomiting and be at risk for illness by drinking water from the dirty water dispensers. 2.A review of Resident 9's clinical record titled, admission RECORD, indicated, Resident 9 was admitted to the facility with diagnosis of, but not limited to difficulty in walking, abnormal posture, retention of urine (not being able to empty the bladder completely), and generalized muscle weakness. During a concurrent observation and interview, on 2/9/26, at 9:29 AM, in Resident 9's room, a white-colored plastic urinal with a light blue lid hanging on the grab bar on the right side of the bed was observed. The urinal was unlabeled. Resident 9 stated that staff labeled his urinal with his room number or his name. Resident 9 stated further that he preferred it labeled for his own sake and knew the urinal was his. Resident 9 stated, I don't want to use someone's urinal. During an interview on 2/9/26 at 9:53 AM, in Resident 9's room, Certified Nurse Assistant (CNA) 3 confirmed that the white-colored plastic urinal hanging on the grab bar had no label. CNA 3 stated that based on her recent training, the urinal needed to be labeled with Resident 9's name. CNA 3 stated further the importance of proper identification to prevent cross-contamination. CNA 3 stated that the facility did not follow the protocol, which was unacceptable and posed an infection control issue. A review of Resident 98's clinical record titled, admission RECORD, indicated, Resident 98 was admitted to the facility with diagnosis of, but not limited to diabetes mellitus (a condition where the body cannot control blood sugar levels), generalized muscle weakness, abnormalities of gait and mobility, and fall. During an observation on 2/9/26, at 12:46 PM, a white plastic urinal with yellow urine, uncovered by its light blue lid, was observed hanging on the grab bar on the right side of Resident 98's bed. It was not labeled. During an interview on 2/9/26, at 12:50 PM, in Resident 98's room, with Social Service Director (SSD), the SSD confirmed that the urinal was not labeled. The SSD stated that usually, either a Certified Nursing Assistant (CNA) or a licensed nurse (LN) would label it. The SSD stated further that there was a risk of cross-contamination if the urinal was not labeled because without a label, it was unclear who had used it. A review of Resident 116's clinical record titled, admission RECORD, indicated, Resident 116 was admitted to the facility with diagnosis of, but not limited to generalized muscle weakness, abnormalities of gait and mobility, acquired (something that develops later in life) absence of right leg below knee, presence of artificial (made by people, not naturally occurring) left leg and diabetes mellitus (a condition where the body cannot control blood sugar levels). During an observation and interview on 2/9/26, at 10:33 AM, in Resident 116's room, two white plastic urinals were observed. One urinal lay on top of the mattress at the foot of the bed, opening covered with a light blue lid and empty. The other urinal was on the bedside table next to an (continued on next page)

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	055185	A. Building B. Wing	02/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	uncovered water pitcher and a dark blue container for snacks. Resident 116 stated that placing the urinals at the side of bed was better. When asked about labeling the urinals with room numbers, Resident 116 stated that the staff were not consistent in doing so. During an interview on 2/9/26, at 10:35 AM, LN 2 confirmed that one urinal lay on top of the mattress at the foot of the bed, while another urinal was on the bedside table next to an uncovered water pitcher in Resident 116's room. LN 2 stated that urinals were not supposed to be like that and should be placed at the side of the bed inside a urinal holder. LN 2 stated further that the urinal should be labeled with the resident's name. LN 2 stated the importance of following the process due to the risk of infection control concerns. During an interview on 2/10/26 at 11:19 AM, with the Director of Staff Development (DSD), the DSD stated that urinals should not have been placed on top of the bedside table alongside a clean water pitcher. The DSD stated further that urinals should be labeled with the resident's room number, as this is the standard procedure. The DSD confirmed that placing urinals on top of the bedside table alongside clean water pitchers was not a hygienic practice and was unacceptable. During an interview on 2/10/26 at 4:48 PM, with Infection Preventionist (IP), the IP stated that he expected urinals to be labeled with the resident's name. The IP stated further the importance of this practice to ensure that no one else would use it and that staff would know whose urinal it was, even if the resident moved to a different room. The IP stated that not labeling the urinal could mix it with others, potentially allowing an infection from one resident to be transmitted to another. The IP stated further that this practice was unacceptable and not in line with the process. The IP stated that they had already started an in-service training education for all staff, including CNAs and nurses. During an interview on 2/12/26, at 9:10 AM, with the Director of Nursing (DON), the DON stated that she agreed with the staff that labeling urinals with the resident's room number or the initial letter of their name was best practice and should continue. The DON stated further that if a urinal was not labeled, it would be difficult to identify the owner, emphasizing the importance of labeling to prevent cross-contamination. Review of a facility policy and procedure titled, Infection Prevention and Control Program, revised 1/25, 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 [illnesses that can spread from one person to another] and infections. The IPCP provides a system for preventing, . and controlling infections and communicable diseases for all residents [Resident 9, Resident 98, Resident 116], staff, volunteers, visitors, and other individuals providing services . Prevention of Infection . instituting measures to avoid complications and disseminations . educating staff and ensuring that they adhere to proper techniques and procedures . following established general . guidelines such as those of the Centers for Disease Control . 3. During a concurrent interview with Licensed Nurse 4 (LN 4) and inspection of the medication cart 4 in south hall, on 2/9/26, at 2:59 p.m., the medication cart stored a pill cutter device that looked unclean with white dust inside and around the blade. LN 4 stated the pill cutter should be cleaned after each use to prevent cross-contamination. 4. During a medication observation and interview with Licensed Nurse 3 (LN 3), on 2/9/26, at 4:30 p.m., LN 3 with gloved hand, used a glucometer to measure Resident 66's blood sugar. When out of the (continued on next page)

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	055185	A. Building B. Wing	02/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room, she removed her gloves and placed the glucometer on top of the medication cart. LN 3 with no gloves pulled a bleach wipe and cleaned the outer surface of the glucometer. LN 3 then used a second wipe to wrap the glucometer and let it sit on top of the cart. When LN 3 was questioned on need to use gloves to clean and sanitize the glucometer, LN 3 stated she forgot to put gloves on and was not focused. In an interview with facility's infection preventionist (IP), on 2/12/26, at 11:20 a.m., the IP stated he expected the nursing staff to use gloves while cleaning a contaminated glucometer. The IP stated use of bare hands can spread germs to the nurse and spread among residents. The IP stated the facility's policy and staff education, and infection surveillance emphasized the use of gloves when cleaning and sanitizing resident care devices. In an interview with the Director of Nursing (DON), in her office, on 2/10/26, at 12:30 p.m., the DON stated she expected the staff to follow infection control practices they were trained on to prevent spread of infection in the facility. Review of the facility's policy titled Infection Prevention and Control Program, dated 12/2023, the policy indicated An infection prevention and control program 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. The policy on Important facets of infection prevention indicated Instituting measures to avoid complication or dissemination; educating staff and ensuring that they adhere to proper techniques and procedures. Following stablished general and diseases-specific guidelines, such as those at the Center for Disease Control.

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	055185	A. Building B. Wing	02/12/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and document informed consent (giving permission for medical care after fully understanding it) for psychotropic medications (drugs that affect how a person thinks, feels, or acts) use for 1 of 37 sampled residents (Resident 148) when Resident 148's medical record lacked evidence that Resident 148 was informed of the purpose, risks, benefits, side effects, alternatives, and provided consent for two antidepressant medications (medications that help improve mood) and one sleep aid medication (medication to help induce sleep).This failure had the potential to result in Resident 148 receiving psychotropic medications without understanding avoidable adverse outcomes including adverse drug effects (unwanted or harmful reactions caused by a medication) and a decline in functioning and/or quality of life.Findings:A review of Resident 148's admission RECORD, indicate Resident 148 was admitted to the facility with diagnosis of, but not limited to major depressive disorder (a serious condition that causes long-lasting feelings of sadness and loss of interest) and insomnia (trouble falling asleep or staying asleep).A review of Resident 148's clinical record titled, [Name of Facility] Order Summary Report, dated 1/31/26, in the section titled, Order Summary, indicated, . buPROPion [a medication] . for depression . Rexulti [a medication] for depression . traZODone [a medication that treats depression but can also be used to treat insomnia] for insomnia . A review of Resident 148's clinical record titled, [Name of Company] MEDICATION ADMINISTRATION RECORD, dated 2/1/26 through 2/28/26, in the section titled, Schedule for [DATE], indicated Resident 148 received Bupropion from 2/1/26 through 2/11/26, Rexulti on 2/4/26, 2/5/26, 2/9/26, 2/10/26, 2/11/26, and Trazodone from 2/1/26 through 2/11/26.During a concurrent interview and record review on 2/11/2 at 9:50 AM with the Assistant Director of Nursing (ADON), Resident 148's Electronic Health Record (EHR) was reviewed for Psychotherapeutic Drug Informed Consents. The ADON verified Resident 148's clinical record titled, PSYCHOTHERAPEUTIC DRUG INFORMED CONSENT FORM, dated 2/9/26, and was signed by the Medical Doctor (MD) for the antidepressant medication Rexulti; however, Resident 148 had not signed the consent form. The ADON reviewed the clinical record titled, PSYCHOTHERAPEUTIC DRUG INFORMED CONSENT FORM, which indicated that the MD had signed the form on 2/9/26 for the sleep aid medication Trazodone; however, Resident 148 had not signed the form. The ADON reviewed the clinical record titled, PSYCHOTHERAPEUTIC DRUG INFORMED CONSENT FORM, which indicated that the MD had signed the form on 2/9/26 for the antidepressant medication Bupropion; however, Resident 148 had not signed the form. The ADON stated that the psychotropic informed consent should have been signed immediately by the MD and Resident 148 and verified by the admitting nurse or whoever entered the psychotropic medication orders in the EHR.During an interview on 2/12/26 at 8:55 AM with Director of Nursing (DON), the DON stated that licensed nurses were expected to obtain informed consent for psychotropic medications before treatment was started for Resident 148. The DON further stated that it was important for Resident 148 to be informed about the psychotropic medications, that he acknowledged understanding, and agreed to the treatment.A review of the facility policy and procedure titled, Psychoactive/Psychotropic Medication Use, dated 4/25, indicated, . Informed Consent . The Resident . has the right to be informed in advance, by the physician . of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. Prior to administration of a psychotropic medication, the prescribing clinician will obtain informed consent from the resident . and document the consent in the medical record. A licensed nurse must verify informed consent has been obtained from the resident . prior to administering psychotropic medication . The facility must record the signed written consent in the resident's medical record. The facility must verify the presence of written informed consent in the resident's medical record before initiating treatment with psychotropic medication.

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	055185	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure the safety of bedside medication storage and use in one out of seven residents (Resident 63) observed for medication administration based on facility's policy and medical doctor's orders when Resident 63 was self-administering a nasal spray medication that was stored at her bedside without a physician's order or the facility staff being aware of the use.This failed practice and use of medication without a doctor's order could contribute to unsafe medication use in a room shared with another resident and possible drug-drug interaction with prescribed medications.Findings:During a concurrent interview with Resident 63 and a medication administration observation with Licensed Nurse 1 (LN) 1 on 2/9/26 at 8: 45 a.m., LN 1 administered a total of 16 morning medications to Resident 63. The medications included five blood pressure medications among others. Resident 63's bedside table stored two unlabeled bottles of a nasal spray called oxymetazoline (a used to relieve nasal and sinus congestion/pressure caused by colds, hay fever, and allergies). Resident 63 stated she ordered the nasal sprays from an online retailer and did not wait for the facility to call the doctor and order the medication. Resident 63 stated she did not notify the facility, and no one questioned her that she had the medication at her bedside. Resident 63 stated she had been using the nasal spray for about 4 or 5 days.During an interview with LN 1, on 2/9/26 at 2:40 p.m., LN 1 stated she did not realize the nasal spray was at Resident 63's bedside table. LN 1 reviewed Resident 63's electronic medical record and confirmed there was no doctor's order for use of the nasal spray. LN 1 stated the doctor needed to know what other medications the resident was talking as she was on many medications that could interfere with the use or effectiveness of the medication.During an interview with Director of Nursing (DON), in her office, on 2/10/26 at 12:30 p.m., the DON stated she spoke to Resident 63 and explained to her that she needed to notify the facility if she used her own medication. The DON stated the nursing staff should have noticed the bedside use of medications. The DON stated there was a risk of inadvertent use by another resident or possible interaction with other medication when a medication was used but not ordered or assessed by the medical doctor or the care team. A review of facility's policy titled, Self-Administration of Medications, dated 2/2021, the policy indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined it is clinically appropriate and safe for the residents to do so. The policy further indicated Self-administered medications are stored in a safe and secure place which is not accessible by other residents. Any medication found at bedside that are not authorized for self-administration are turned over to the nurse in charge for return to family or responsible party.A review of information on oxymetazoline nasal spray via DailyMed (the official U.S. National Library of Medicine (NLM) database providing comprehensive, up-to-date, and authoritative information on over 1 million marketed s and acts as a trusted, searchable repository for FDA (Food and Administration)-approved medication labels), last accessed on 2/18/26 via https://dailymed.nlm.nih.gov/dailymed/Info.cfm?setid=89c165ba-3ad5-49b5-a5bb-423dc8e15bad, indicated the product is a decongestant (reduce swelling and congestion of nasal vessels) and gave a warning on the use in setting of high blood pressure. The product could further contribute to high blood pressure.

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	02/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure a home-like environment for two of 37 sampled residents (Resident 116 and Resident 127) when:Resident 116's drawer handle was broken; and,Resident 127's walls were not maintained and painted evenly.These failures had the potential to negatively impact Resident 116 and Resident 127's home-like environment.Findings: 1. A review of Resident 116's clinical record titled, admission RECORD, indicated, Resident 116 was admitted to the facility with diagnoses of, but not limited to generalized muscle weakness, abnormalities of gait and mobility (difficulty walking and moving) absence of right leg above the knee, presence of artificial left leg, and diabetes mellitus (a condition where the body cannot control blood sugar levels). During a concurrent observation and interview on 2/9/26, at 10:33 AM, in Resident 116's room, the bedside cabinet on the left upper side of Resident 116's bed was observed with a broken handle. Resident 116 stated that he reported the broken drawer handle to the staff several times, but they took no action. During an interview on 2/9/26, at 10:35 AM, with Licensed Nurse (LN) 2, LN 2 confirmed that the bedside cabinet had a broken handle and needed to be fixed. During an interview on 2/10/26, at 11:05 AM, with Resident 116, in his room, Resident 116 stated that the broken handle on his bedside cabinet drawer still had not been fixed, despite his previous complaints. Resident 116 stated that his bedside drawer was important because it was where he kept his personal belongings and valuables. Resident 116 stated further, he used a small screw to open and close the drawer until it can be fixed. Resident 116 stated that if he had been at home, he could have fixed it in 5 minutes. During an interview on 2/10/26, at 11:22 AM with Director of Staff Development (DSD), the DSD observed that the bedside cabinet drawer handle was still broken and stated the importance of addressing the issue promptly. The DSD stated further that to create a homelike environment, staff were expected to follow the process for concerns like this and staff needed to write identified issues in the maintenance log to ensure they got fixed. During an interview on 2/10/26 at 11:24 AM, LN 2 stated that she forgot to write the issue about the broken bedside cabinet drawer handle in the maintenance log and instead reported it verbally to the maintenance staff. During an interview on 2/12/26, at 8:38 AM with Director of Nursing (DON), the DON stated that she expected the staff to follow the proper process for reporting Resident 116's broken bedside cabinet drawer handle. The DON stated further the importance of writing such issues in the maintenance log to ensure they were addressed promptly. Review of a facility policy and procedure titled, Homelike Environment, undated, indicated, Policy Statement – Patients [Resident 116] are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.Staff shall provide person-centered care that emphasizes the patients' [Resident 116] comfort, independence, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and personal needs and preferences.The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting.clean, sanitary and orderly environment. 2. Review of Resident 127's clinical record, admission RECORD indicated Resident 127 was admitted to the facility with diagnoses that included insomnia (sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early and being unable to return to sleep) and abnormalities of gait and mobility. During a concurrent observation and interview on 2/10/26, at 2:37 p.m., with Resident 127, Resident 127's wall had a 1 inch (a unit of measure) length by 1 inch width sized paint chip and a mismatching white paint on the wall that was 17 inches in length by 5 inches in width. Resident 127 pointed at the wall and stated, the walls are chipped and the paint does not match. During a concurrent observation and interview on 2/12/26, with the Director of Maintenance (MTD), the MTD verified the condition of Resident 127's walls included a 1 inch length by 1 inch width sized paint chip and a mismatching white paint on the wall that was 17 inches in length by 5 inches in width, the MTD stated Resident 127's room should have been warm and welcoming. The MTD further stated that Resident 127's room should have been clean, maintained, and ready for him and that he had just changed rooms the day before. During a review of the facility policy and procedure (P&P) titled, Homelike Environment revision date 2/2021, the P&P indicated, .The facility staff and management maximizes, to the extent possible, the characteristics of facility that reflect a personalized, homelike setting. These characteristics include.clean, sanitary and orderly environment.inviting colors and décor.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 37 sampled residents (Resident 7) was appropriately discharged when Resident 7 was discharged back to a General Acute Care Hospital (GACH) for insurance purposes.This deficient practice resulted in an inappropriate GACH admission.Findings:A review of Resident 7's clinical record titled, admission RECORD indicated Resident 7 was admitted on [DATE], with diagnoses that included but not limited to type 2 diabetes (the body's inability to control sugar levels), shortness of breath, and muscle weakness.A review of Resident 7's clinical record titled, Progress Notes dated 10/2/25, at 12:25 p.m., documented by Licensed Nurse (LN) 1 indicated, .Writer notified by Admin [administrator] that resident needed to get sent out back to GACH d/t [due to] insurance purposes no clinical [health] changes noted family aware MD aware .A review of Resident 7's untitled GACH document dated 10/2/25, at 12:31 p.m., indicated, .patient presents from rehab without medical complaints. Patient sent back due to what seems to be a medical billing problem after being discharged from our hospital yesterday.During an interview on 2/11/26, at 10:41 a.m., with LN 1, LN 1 stated, Resident 7 was sent back to the GACH due to insurances purposes. LN 1 further stated there was no clinical reason for returning the resident back to the GACH.During a concurrent interview and record review on 2/11/26 at 12:10 p.m., with the Director of Nursing (DON), Resident 7's clinical record titled, Progress Notes was reviewed. The DON stated Resident 7 was stable and had no clinical indication to be sent back to GACH.During an interview on 2/11/26 at 3:18 p.m., with Resident 7, Resident 7 stated if she had to be sent back to the GACH for no clinical reason, that would upset her.During a concurrent interview and record review on 2/12/26 at 11:10 a.m., with the Administrator (ADM) the facility policy and procedure (P&P) titled, Transfer or Discharge with a revision date 3/2025, was reviewed. The ADM verified Resident 7's discharge on [DATE] did not follow the facility's P&P.During a review of the facility's P&P titled, Transfer or Discharge revision date 3/2025, the P&P indicated, .Each resident is permitted to remain in the facility, and not be transferred or discharged unless:. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in this facility.the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by this facility.the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.the health of the individuals in the facility would otherwise be endangered.the facility ceases to operate.the resident has failed, after reasonable and appropriate notice, to pay for a stay at this facility.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - clinical assessment tool used in nursing homes) diagnostic assessments were accurately documented for 2 out of 5 residents reviewed for unnecessary medications, when Resident 2 and Resident 105 received medications for physician-documented conditions that were not coded on the MDS.This failure had the potential to compromise safe and accurate resident assessment and nursing plans of care. Findings:Review of Resident 2's admission RECORD indicated Resident 2 was admitted to the facility with multiple diagnoses, including dementia (cognitive decline where the specific type and severity are not clearly defined or documented) and atrial fibrillation (type of irregular and fast heart rhythm that occurs in sudden and temporary episodes).Review of Resident 2's History and Physical (H&P), dated 6/9/25, indicated the resident was admitted to the facility with diagnoses including hypothyroidism (low thyroid hormone) and osteoporosis (brittle bone disease) for which medications were prescribed. Resident 2's diagnosis section of the MDS, dated [DATE], did not reflect or document the thyroid and bone disease diagnoses while the resident was receiving medications to treat both conditions.Review of Resident 105's admission RECORD indicated Resident 105 was admitted to the facility with multiple diagnoses including dementia and heart disease. Review of Resident 105's admission records from Hospital A, dated 10/20/25, titled Progress Notes, SNF [skilled nursing facility] admission History and Physical, indicated Resident 105 was admitted to the facility with a diagnosis of deep vein thrombosis (DVT - a blood clot that forms in a vein deep inside the body, usually in the lower leg, thigh, or pelvis), for which medication was prescribed. Resident 105's diagnosis section of the MDS, dated [DATE], did not reflect or document the DVT diagnosis while the resident was receiving medication for the condition.During a concurrent interview and record review on 02/11/26 at 4:26 p.m. with the MDS Nurse Coordinator (MDSC), the Active Diagnoses section of the MDS were reviewed for both Resident 2 and Resident 105. The MDSC confirmed there were missing medical diagnoses for both Resident 2 and Resident 105 on their MDS's. The MDSC stated that it was important to be accurate in transcribing the resident's medical history because it can affect the resident's quality measures and any missed diagnosis can have a different plan of care that can potentially affect the resident.During a concurrent interview and record review on 02/12/26 at10:43 a.m. with the Director of Nursing (DON), the Active Diagnoses section of MDS were reviewed for both Resident 2 and Resident 105. The DON confirmed that Resident 2 and Resident 105's diagnoses were not accurately documented in the MDS assessments. The DON stated MDS assessments must be completed accurately. The DON also stated that inaccurate documentation can affect the quality of care provided to residents.A review of the facility policy titled Comprehensive Assessments, revised on March 2022, indicated, . 8. A significant error is an error in an assessment where: . the resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment. 9. A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review the facility failed to ensure residents received pain management interventions in accordance with assessed pain levels for 1 out of 5 residents reviewed for unnecessary medications, when staff administered PRN (as needed) pain medication for Resident 86 despite documented pain assessments indicating a pain level of 0 (a 0-10 pain scale with 0 being no pain, to 10 being the worst pain). This failure had the potential to result in unnecessary medication administration, increased risk for adverse medication effects, and inaccurate pain assessment.Findings:Review of Resident 86's admission RECORD indicated Resident 86 was admitted to the facility with multiple diagnoses, including muscle weakness, chronic low back pain, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).Review of Resident 86's Medication Administration Record (MAR - a legal record of medications administered to a resident) for January 2026 through February 2026 indicated the resident had a physician order for Morphine (opioid pain medication) PRN (as needed) for severe pain. MAR entries documented for Resident 86's pain level were 0 at the time Morphine was administered on the following dates:01/11/26 - Pain level documented as 0; Morphine administered PRN at 0535 (5:35 a.m.).01/24/26 - Pain level documented as 0; Morphine administered PRN at 2350 (11:50 p.m.).01/30/26 - Pain level documented as 0; Morphine administered PRN at 1732 (5:32 p.m.).02/02/26 - Pain level documented as 0; Morphine administered PRN at 1651 (4:51 p.m.).02/08/26 - Pain level documented as 0; Morphine administered PRN at 0241 (2:41 a.m.).02/08/26 - Pain level documented as 0; Morphine administered PRN at 1305 (1:05 p.m.).During a concurrent interview and record review on 02/12/26 at 10:11 a.m. with Licensed Nurse (LN) 6, January 2026 and February 2026 MARs for Resident 86 were reviewed. LN 6 confirmed that staff administered PRN Morphine to Resident 86 when the documented pain level was 0. LN 6 stated staff are expected to assess pain levels prior to administering medication. LN 6 further stated the physician's order specified use for severe pain, which she described as a pain level in the range of 7 to 10. LN 6 stated assessing an accurate pain level of the resident prior to administration of pain medication was important because opioid medication may place the resident at risk for oversedation (extreme tiredness).During a concurrent interview and record review on 02/12/26 at10:43 a.m. with the Director of Nursing (DON), January 2026 and February 2026 MARs for Resident 86 were reviewed. The DON confirmed PRN Morphine was administered to Resident 86 when the documented pain level was 0. The DON stated staff received training on accurate MAR documentation to prevent documentation discrepancies. The DON further stated that assessing pain prior to administering medication was necessary to ensure resident safety.A review of the facility policy titled Pain Assessment and Management, revised October 2022, indicated, .5. During pain assessment gather the following information. (2) Intensity of pain (as measured on a standardized pain scale) .