

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 12/10/2025
NAME OF PROVIDER OR SUPPLIER Garden City Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1310 West Granger Modesto, CA 95350	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>Based on interview and record review, the facility failed to maintain one of four sampled residents' privacy (Resident 1) when licensed nurse (LN) 3 used her personal phone to take a photograph of Resident 1. This failure resulted in a violation of Resident 1's privacy, potentially negatively affecting his psychosocial well-being. Findings: Findings: A review of Resident 1's clinical document titled, admission RECORD, (contains clinical and demographic data) indicated Resident 1 had been admitted to the facility with diagnoses which included dementia (a general term for a loss of brain function that is not a normal part of aging, causing significant problems with memory, thinking, and social abilities). A review of Resident 1's clinical document titled, Progress Note, dated 9/2/25, by LN 3, indicated LN 3 was informed by a NOC shift (6:30 a.m. through 7 p.m.) nurse that Resident 1's arm was tied to the bed during the Intravenous (IV - plastic tube placed in the vein to deliver medication) line placement. LN 3 informed the NOC nurse that she needed to untie Resident 1's arm from the bed because it was a form of a restraint (devices that limit a resident's movement). LN 3 took a picture with her personal phone before the arm was untied from the bed. During an interview with the Administrator (ADM) on 12/5/25 at 10:34 a.m., the ADM confirmed LN 3 had taken a picture of Resident 1's right arm on LN 3's personal phone. The ADM stated that the importance of not taking pictures on staff's personal phone was that the phone may not be encrypted (coded to protect against unlawful access) and could have been accessed by people who were not employed by the facility. A review of the facility policy titled, Resident Rights, revised 2/2021, indicated, . Employees shall treat all residents with kindness, respect, and dignity . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to . a dignified existence . privacy and confidentiality .</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055185	If continuation sheet Page 1 of 3

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review the facility failed to ensure one of four sampled residents (Resident 1) environment was free of accident hazards when Resident 1's right wrist remained in an arm positioning device (a medical tool that holds a patient's arm in a specific, stable, and extended position during the procedure and does not allow for movement) following a mid-line insertion (medical procedure of placing a thin, flexible tube (catheter) into a large vein in the upper arm, with the tip terminating just below the armpit). This failure had the potential for injury related to the arm positioning device being secured to Resident 1's bedframe, potentially negatively affecting Resident 1's health, safety, and emotional well-being. A review of Resident 1's clinical document titled, admission RECORD, (contains clinical and demographic data) indicated Resident 1 had been admitted to the facility with diagnoses which included a fall, abnormal gait, and impaired mobility (any unusual walking pattern that deviates from a normal, smooth, and coordinated stride). A review of Resident 1's clinical document titled, Order Details, dated 8/31/25, indicated, . May insert midline ., During an interview with certified nursing assistant (CNA) 1 on 11/14/25 at 4:34 p.m., CNA 1 stated she received a shift report from CNA 2 regarding Resident 1's current health condition. CNA 1 explained that when she and CNA 2 went into Resident 1's room, CNA 1 stated she saw the Resident 1's arm in a positioning device. CNA 1 further explained she informed licensed nurse (LN) 1 about the arm positioning device. CNA 1 stated the arm positioning device was still on Resident 1 when she changed his brief (adult diaper) in the morning. CNA 1 explained she removed the arm positioning device to change Resident 1 and when she was done changing him, she put the arm positioning device back on Resident 1. During an interview with LN 1 on 11/14/25 at 4:39 p.m., LN 1 stated she first became aware of the arm positioning device at approximately on 9/1/25 at 6:00 a.m. when she passed medications. LN 1 explained she did not remove the arm positioning device. LN 1 further explained she informed the oncoming day shift nurse (LN 3) of the device. During an interview with CNA 2 on 11/14/25 at 5:26 p.m., CNA 2 confirmed that during shift change (a set of nurses are done working and a new set of nurses start working) he discussed the arm positioning device with CNA 1 and stated he asked CNA 1 if she would inform the nurse. CNA 2 explained CNA 1 told her he would inform the nurse. CNA 2 further stated CNA 1 had informed LN 1 about the arm positioning device. During an interview with LN 2 on 11/18/25 at 10:53 a.m., LN 2 stated she was aware of the arm positioning device when LN 4 (from an outside agency) requested assistance from LN 2. LN 2 explained she saw the arm positioning device on Resident 1's right wrist as she held Resident 1's left arm to assist LN 4. LN 2 further explained LN 4 required assistance due to Resident 1's agitation and aggression. LN 2 stated she had not realized the arm positioning device had still been in place because Resident 1's right wrist was covered. During an interview with LN 3 on 11/21/25 at 11:49 a.m., LN 3 stated that at change of shift on 9/1/25, LN 1 informed her that the arm positioning device on Resident 1's right wrist was still in place. LN 3 explained she informed LN 1 the arm positioning device should not still be on and told LN 1 to remove the device. LN 3 further explained that around 9 a.m., CNA 3 asked her why Resident 1's right arm was secured to the bedframe, LN 3 informed CNA 3 Resident 1's right arm should not be secured to the bedframe. LN 3 stated she went to take a picture of Resident 1's right arm in the arm positioning device so she could inform the administrator. LN 3 stated LN 1 tried to prevent her from taking the picture and managed to unsecure the arm positioning device before she could take the picture. LN 3 further stated she informed the administrator regarding the arm positioning device. During an interview with CNA 3 on 12/2/25 at 1:47 p.m., CNA 3 confirmed she informed LN 3 about the arm positioning device. CNA 3 stated Resident 1's right arm was secured to the bedframe, and he could not move his right arm freely. A record review of Resident 1's clinical document titled, Progress Notes, dated 9/2/25, indicated, . During report on 9/1/25 this write was informed by [night nurse] [Resident 1's] arm was [in an arm positioning device] . Informed [night nurse] [Resident 1] can not be in [arm positioning device] . Informed [night] nurse she needed to [remove arm positioning device] . At 0900 [9 a.m.,] CNA asked this writer why [Resident 1's] arm was [in arm positioning device] . Informed CNA [night] nurse was supposed to [remove arm positioning device] . This writer went to room. [Resident 1's] right arm was in [arm positioning device secured to his bed] . During an interview with an outside Clinical Nurse Officer (CNO) on 12/2/25 at 10:41 a.m., the CNO stated the arm positioning device should not have been left on a Resident 1. The CNO explained an arm positioning device was used for a limited amount of time during mid-line insertion to help keep the arm in place. The CNO further explained that once the mid-line was inserted and secured the arm positioning device should have</p>		