STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056423	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Post Acute	661 West Poplar Porterville, CA 93257

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 35649 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 51) was assessed and determined to be competent to self-administer medication. This failure had the potential for medication administration error and serious health risk. Findings: During a concurrent observation and interview on 10/14/24 at 11:34 a.m. with Resident 51 in Resident 51's room, a bottle of eye drops was on top of the bedside table. Resident 51 stated the nurse leaves the eye drops there so he can put the eye drops in his eyes. Resident 51 stated he had the eye drops in his room for over two months. During a concurrent observation and interview on 10/14/24 at 11:40 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 51's room, LVN 1 removed the bottle eye drops from Resident 51's bedside table and stated Resident 51 was not to have the eye drops at the bedside. LVN 1 stated it was not acceptable to have the eye drops on Resident 51's bedside table. During a concurrent interview and record review on 10/16/24 at 8:58 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC) 1, Resident 51's medical record was reviewed. MDSC 1 was unable to find documentation of a physician order for Resident 51 to self-administer the eye drop medications. During a concurrent interview and record review on 10/16/24 at 5:05 p.m. with MDSC 2, Resident 51's medical record was reviewed. MDSC 2 was unable to find IDT documentation addressing Resident 51's ability to self-administer medication. During a review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated 2021, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 35649 Based on interview and record review, the facility failed to: 1. Notify the physician for the discontinuation of the restorative therapy (therapeutic and rehabilitative techniques provided by specially trained restorative nursing assistant [RNA]) for one of one sampled resident (Resident 21). This failure had the potential for Resident 21 to not meet his full potential for mobility. 2. Notify the physician for the swelling and purplish discoloration of the left big toe and wounds on the left big toe for one of one sampled resident (Resident 2). This failure had the potential for Resident 2's wounds to be untreated. Findings: 1. During a review of Resident 21's Admission Record (AR), dated 2/21/20, the AR indicated, Resident 21 was admitted with diagnosis including post-laminectomy syndrome (chronic pain following spinal surgery), cord compression (happens when pressure on the spinal cord stops the nerves from working normally causing back pain, arm or leg weakness, and difficulty walking) and muscle weakness. During a concurrent observation and interview on 10/14/24 at 3:48 p.m. with Resident 21 in Resident 21's room, Resident 21 was in supine (flat in back) position. Resident 21 stated he could not move himself and required staff assistance due to spinal cord injury and muscle weakness. During a concurrent interview and record review on 10/15/24 at 11:40 a.m. with Director of Rehabilitation Services (DRS), Resident 21's Physical Therapy Notes, dated 3/21/24 was reviewed. DRS stated Resident 21 was on a telehealth therapy (physical therapy provided by the physical therapist assistant onsite under the supervision of a licensed therapist virtually). DRS stated Resident 21's last therapy was on 3/21/24. DRS was unable to find documentation Resident 21 was placed on a Restorative Nursing Assistant (RNA) program. DRS stated the licensed therapist determines whether the resident meets the criteria to continue with rehabilitation therapy. During a concurrent interview and record review on 10/15/24 at 11:46 a.m. with Director of Staff Development (DSD), Resident 21's RNA Therapy Notes, dated 11/30/23 was reviewed. DSD stated Resident 21's RNA was established on 11/30/23. DSD stated because of Resident 21's refusal to participate in the RNA program, the restorative therapy was discontinued. DSD was unable to provide documentation physician was notified when the RNA therapy was stopped. DSD stated since then Resident 21 had not been on any therapy or received range of motion (how far and in what direction one can move a joint or muscle) exercises. Facility policy and procedure was requested related to physician documentation, none was provided. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent observation and interview on 10/14/24 at 8:57 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 2's room, Resident 2's left big toe was red and swollen. The skin at the back was purplish in color, swollen, and with a cut on the soft tissue of the left big toe. Another wound was found on the joint of the left big toe. The left foot was dry and scaly. CNA 1 stated any abnormality on the skin condition was reported to the nurse, but she was not sure if the nurse had been notified about Resident 2's wounds. CNA 1 stated during resident shower days we observed the residents' skin and any abnormality to the skin, we notify the nurse and document the skin findings on the person-figure of the shower form. During a concurrent interview and record review on 10/15/24 at 9 a.m. with MDSC 1, Resident 2's Nursing Assessment, dated 10/15/24 was reviewed. MDSC 1 was unable to find documentation of a nursing assessment related to Resident 2's wounds on the left toe. MDSC 1 stated there should be a nursing assessment done daily as well as weekly nursing summary. A review of Resident 2's Weekly Nursing Assessments, dated 10/1/24, 10/7/24, and 10/14/24 did not indicate the nurse performed a weekly nursing assessment of the wounds on the left big toe. MDSC 1 also did not find a nursing documentation physician was notified about Resident 2's wounds on the left big toe. During a review of the facility's policy and procedure (P&P) titled Skin Assessment: Best Practice, dated 9/8/22, the P&P indicated, Weekly Skin Assessment: A weekly skin assessment is completed once a week and describes the current condition of the patient's skin. Facility policy and procedure on physician notification was requested, none was provided.

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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. 42148 Based on observation, interview, and record review, the facility failed to maintain a homelike environment for two of 15 sampled residents (Resident 46 and Resident 162). This failure resulted in these residents living in an unkempt environment. Findings: a. During a concurrent observation and interview on 10/14/24 at 3:39 p.m. with Resident 162 in Resident 162's restroom, a dark brown ring was on the inside of the toilet bowl. Resident 162 stated she did not know the last time her toilet had been cleaned. During a concurrent observation and interview on 10/15/24 at 8:32 a.m. with Maintenance Supervisor (MS) and Housekeeping staff member (HSM) in Resident 162's restroom, MS and HSM observed the toilet and confirmed there was a dark brown ring on the inside of the toilet bowl MS and HSM stated the toilet was stained and should be replaced. During a concurrent observation and interview on 10/15/24 at 8:56 a.m. with Administrator in Resident 162's restroom, Administrator stated the toilet was stained and should be replaced. b. During a concurrent observation and interview on 10/15/24 at 11:22 a.m. with Administrator and MS in Resident 46's room, there were broken and missing tiles with a sticky black substance in the corner entrance of the restroom. Administrator stated, It looks like they [staff] started to finish it and never did. It does look bad and should have been fixed. MS stated the restroom should not have broken and missing tiles and it should be fixed. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment. 2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a personalized, homelike setting. These characteristics include: a. clean, sanitary, and orderly environment.

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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. 48901 Based on observation, interview, and record review, the facility failed to follow their policy and procedures (P&P) titled, Certifying Accuracy of the Resident Assessment, for one of one sampled resident (Resident 35). This failure had the potential to not meet Resident 35's dental needs. Findings: During a concurrent observation and interview on 10/15/24 at 8:43 a.m. with Resident 35 in Resident 35's room, Resident 35 pointed to his upper tooth and complained of pain. During a concurrent interview and record review on 10/17/24 at 9:01 a.m. with Minimum Data Set (resident assessment tool) Consultant (MDSC) 2, Resident 35's MDS, Section K (Swallowing/Nutritional Status), dated 8/15/24 was reviewed. The MDS indicated Resident 35 had Broken or loosely fitting full or partial denture and no natural teeth or tooth fragment(s). MDSC 2 stated Resident 35's MDS was incorrect. During a review of Resident 35's COMPREHENSIVE SKILLED REVIEW NOTE [CSRN], dated 1/15/24 was reviewed. The CSRN indicated, III. SOCIAL SERVICES. [Resident 35] has his own teeth with some missing. During a review of the facility's P&P titled, Certifying Accuracy of the Resident Assessment, dated 11/2019, the P&P indicated, Policy Statement.Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. Policy Interpretation and Implementation. 2. Any person who completes any portion of the MDS assessment. is required to sign the assessment certifying the accuracy of that portion of that assessment. 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 35649 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 3) had a psychiatric and a Preadmission Screening and Resident Review (PASRR- a federal requirement to help ensure placement in nursing facility was appropriate) Level 2 evaluation after a PASRR Level 1 indicated the need for evaluation of his mental disorder. This failure had the potential for Resident 3 to be inappropriately placed in a nursing home and had the potential to not receive the mental health treatment needed. During a concurrent interview and record review on 10/15/24 at 10:15 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC) 1, Resident 3's PASRR Level 1 Screening, dated 1/15/24 was reviewed. Resident 3's PASRR Level 1 indicated Level 1 Screening: Positive. Section III Serious Mental Disorder: Yes Diagnosis: Schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), major depressive disorder (condition that causes a persistently low or depressed mood, and a loss of interest in activities that once brought joy). Prescribed Psychotropic (drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) Medication: Yes: Hydroxyzine Hydrochloride (medication to treat anxiety)10 milligram (mg) tablet. MDSC 1 stated Resident 3 had no psychiatric evaluation and no PASRR 2 follow up for the PASRR Level 1 evaluation dated 1/15/24. MDSC 2 provided Resident 3's PASRR 2 evaluation dated 6/2020. During a concurrent interview and record review on 10/15/24 at 10:25 a.m. with MDSC 2, Resident 3's Physician's Order, dated 10/2024 was reviewed. MDSC 2 was unable to find documentation of a physician's referral to a psychiatrist for a psychiatric evaluation after a positive Level 1 PASRR. During a concurrent interview and record review on 10/15/24 at 10:30 a.m. with MDSC 2, Resident 3's Physician Progress Notes were reviewed. MDSC 2 was unable to find documentation of a physician progress notes regarding psychiatric evaluation. MDSC 2 stated there was nothing she could find. During a review of the article of the Department of Health Care Services (DHCS) titled, PreAdmission Screening and Resident Review (PASRR), Level 2 Screening Process dated 9/2024, the article indicated, If the Level 1 Screening is positive, a PASRR Level 2 Evaluation will be performed. A Level 2 Evaluation is a person-centered evaluation that is completed for anyone identified by the Level 1 Screening as having, or suspected of having, a PASRR condition, i.e., serious mental illness (SMI), intellectual disability (ID), developmental disability (DD), or related condition (RC). The Level 2 Evaluation helps determine the most appropriate placement of an individual, considering the least restrictive setting, and whether specialized services are needed. The Level 2 Evaluation has three main goals: Confirm whether the individual has an SMI or ID/DD or RC; Assess the individual ' s need for Medicaid certified nursing facility (NF) services; and (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess whether the individual requires specialized services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to complete and provide two of two newly admitted sampled residents (Resident 51 and Resident 109) and/or their representatives a summary of the baseline care plan (BCP-the minimum healthcare information to care for each resident upon admission) within 48 hours of admission. This failure had the potential for unmet care needs. Findings: 1. During a review of Resident 51's Admission Record (AR), the AR indicated, Resident 51 was admitted on [DATE] with diagnoses including acute osteomyelitis (inflammation and swelling in the bones) left ankle and foot, Type 2 diabetes mellitus (DM- chronic condition with persistent high blood sugar levels) with diabetic neuropathy (nerve damage in the legs and feet in people with diabetes) and other skin ulcers. During a review of Resident 51's Operative Report (OR), dated 9/20/24, the OR indicated, Post-Op [after surgery] Diagnosis: Left first toe gangrene [dead tissue caused by an infection or lack of blood flow]. Procedure: Transmetatarsal amputation [surgical removal of a part of the severely infected foot] of left first toe. During a concurrent interview and record review on 10/16/24 at 5 p.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC) 1, Resident 51's BCP, dated 9/26/24, was reviewed. The BCP was not complete. MDSC 1 stated Resident 51 and/or patient representative was not provided a summary of the BCP for post-operative care. 2. During a review of Resident 109's AR, the AR indicated, Resident 109 was admitted on [DATE] with diagnoses including, Aftercare following surgical amputation, Diabetes Mellitus with diabetic neuropathy, and cellulitis [bacterial infection of the skin and underlying tissues] left upper limb. During a review of Resident 109's OR, dated 9/26/24, the OR indicated, Procedure: Amputation of the third, fourth, and fifth toes left foot at transmetatarsal level. During a concurrent interview and record review on 10/16/24 at 5:11 p.m. with MDSC 1, Resident 109's BCP, dated 10/1/24, was reviewed. The BCP was not complete. MDSC 1 stated Resident 109 and/or patient representative was not provided a summary of the BCP for post-operative care. During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, dated 2001, the P&P indicated, A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission .4. The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.

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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. 48901 Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, for one of 18 sampled residents (Resident 22). This failure had the potential to not meet Resident 22's physical, psychosocial (related to thought or behavior), and functional needs. Findings: During a review of Resident 22's Order Listing Report (OLR), dated 8/23/24, the OLR indicated, admitted under the care of [Name of Hospice]. During a review of Resident 22's Minimum Data Set (MDS-resident assessment tool), dated 8/23/24, the MDS Section O (Special Treatments, Procedures, and Programs), indicated Resident 22 received hospice care while Resident 22 was in the facility. During a concurrent interview and record review on 10/16/24 at 3:32 p.m. with MDS Consultant (MDSC) 2, Resident 22's Care Plans (CP) were reviewed. MDSC 2 stated there was no End of Life or Hospice CP for Resident 22 and there should have been a CP developed after Resident 22 was admitted to hospice. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Interpretation and Implementation. 8. The interdisciplinary team should review and update the care plan: a. When there has been a significant change in the resident's condition. c. At least quarterly, in conjunction with the required quarterly MDS assessment. 47444

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48901 Based on interview and record review, the facility failed to ensure to one of 11 sampled residents (Resident 5) were administered medications according to physician orders. This failure had the potential for Resident 5 to have adverse medication outcomes. Findings: During a review of Resident 5's Care Plan (CP), dated 8/9/17, the CP indicated Resident 5 had hypertension (High blood pressure). The CP indicated, Interventions/Tasks.Give anti hypertensive [sic] medications as ordered. During a review of Resident 5's CP, dated 11/21/20, the CP indicated, Resident 5 has alteration in comfort related to shoulder and knee pain. The CP indicated, Interventions/Tasks. Administer pain medications as ordered. During a review of Resident 5's Medication Administration Record (MAR), dated 10/2024, the MAR indicated the following: a. AmLODPine Besylate [medication to lower blood pressure] Tablet 5 MG [milligrams] Give 1 tablet by mouth one time a day for HTN [hypertension-high blood pressure] hold if SBP [systolic blood pressure - the pressure in blood vessels when the heart contracts] is less than 110 or DBP [diastolic blood pressure - the pressure in blood vessels when the heart is at rest between beats] is less than 60. Resident 5 was administered AmLODPine on 8/14/24 with a blood pressure of 103/63. b. HYDROcodone-Acetaminophen [medication for severe pain] Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth one time a day for severe pain [pain level of 7-10]. Resident 5 was administered HYDROcodone-Acetaminophen Oral Tablet 5-325 MG on [DATE], 3, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 2024 for pain level of 0 (no pain) and 10/5/24 for pain level of 2 (pain level of 1-3 mild). During an interview on 10/16/24 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated severe pain was a pain level of seven to 10. LVN 2 stated she would administer severe pain medication for a pain level less than seven if it is scheduled and patient requested it. LVN 2 stated she would hold the anti-hypertensive medication with holding parameters for SBP < (less than)110 if the SBP is 103 because she would not want the Resident's blood pressure to drop. During an interview on 10/16/24 at 10:45 a.m. with LVN 3, LVN 3 stated she would not be following physician's order if she administered the pain medication for pain level less than 7. During a review of the facility's policy and procedures (P&P) titled, Administrating Medications, dated April 2019, indicated, Policy Statement. Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 4. Medications are administered in accordance with prescriber orders, including any required time frame.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47444 Based on observation, interview, and record review, the facility failed to ensure one of 18 sampled residents (Resident 7) was provided activities of her choice. This failure resulted in Resident 7 not participating in person centered activities. Findings: During a review of Resident 7's Admission Record (AR), dated 10/17/24, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including major depressive disorder (mental disorder that affects how a person feels, thinks, and acts), Alzheimer's Disease (brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform everyday tasks) and need for assistance with personal care. During a review of Resident 7's Minimum Data Set (MDS - an assessment tool), dated 7/18/24, the MDS section F - Preferences for Customary Routine Activities, indicated, it was very important to Resident 7 to do things with groups of people, do her favorite activities, and go outside to get fresh air when the weather is good. During a review of Resident 7's MDS, dated [DATE], the MDS section GG - Functional Abilities and Goals indicated Resident 7 used a wheelchair and needed maximum assistance for mobility activities. During review of Resident 7's Activity Assessment (AA), dated 7/22/24, the AA indicated, it was very important to Resident 7 to listen to music she liked, be around animals, participate in group activities, participate in her favorite activities, and go outside to get fresh air when the weather is good. Resident 7's other interests included spending time with family and word puzzles. During a concurrent observation and interview on 10/16/24 at 10 a.m. with Resident 7 in Resident 7's room, Resident 7 was sitting in bed with the television turned off. Resident 7 stated she likes to read the Bible a little each day. Resident 7 stated she used to love to knit and do needle point but had not done that in a while. She enjoyed seeing the kittens outside her window and they reminded her of her cat at home. Resident 7 stated she wished the staff would come take her outside or to the activities room, but she only goes out of the room to therapy or for a shower. During a concurrent interview and record review on 10/17/24 at 9:49 a.m. with MDS Consultant (MDSC) 2, Resident 7's medical record was reviewed. No activities CP was found in Resident 7's medical record. MDSC 2 stated there was no activities CP for Resident 7 and there should be one. (continued on next page)

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Gateway Post Acute	661 West Poplar Porterville, CA 93257

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/17/24 at 9:55 a.m. with Director of Activities (DOA), Resident 7's Activities Notes (ANs) and CP's, dated 8/12/24, 8/25/24, 9/1/24, 9/29/24, and 10/13/24 were reviewed. The ANs indicated, Resident 7 refused activities participation on 8/12/24. The DOA stated the expectation was that Resident 7 would receive visits from activities staff, two times per week and stated she was unable to find any AN's between 7/22/24 - 8/12/24 that indicated Resident 7 was offered activities. The staff should document progress (AN) notes for activity visits or Resident 7's refusal of participation. DOA stated she was responsible for developing the activities CP. DOA stated activities CP was not done for Resident 7. DOA stated the activities CP should reflect Resident 7's refusal to participate, what was being done to help encourage Resident 7 to participate and should be individualized to include activity preferences. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person Centered, dated March 2022, the P&P indicated, A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT), with input from the resident, and his/her family or legal representative. 2. The Comprehensive person-centered care plan should be developed within the seven (7) days of the completion of the required MDS assessment. (Admission, Annual, or significant change in status), and should be completed within 21 days of admission. 6. The comprehensive, person-centered care plan should: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing that the resident desires or that is possible. During a review of the facility's P&P titled, Documentation, Activities, dated January 2020, the P&P indicated, The activity director/coordinator is responsible for maintaining appropriate departmental documentation. Policy Interpretation and Implementation 1. Record keeping is a vital part of the activity programs. 2. The following records, at a minimum, are maintained by the activity department personnel: . d. Activity progress notes; and e. Individualized activities care plan or activities portion of the comprehensive care plan. 3. The activity director/coordinator is responsible for ensuring that activity documentation is completed and maintained.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47444 Based on observation, interview and record review, the facility failed to ensure one of 18 sampled patients (Patient 15) was provided quality care when: 1. A Care Plan (CP) for pain management was not developed. 2. The admission Nursing - Pain Observation and Assessment (NPOA) was incomplete, and reassessment was not done. These failures resulted in Patient 15 experiencing unrelieved pain and a feeling of isolation. Findings: 1. During a review of Patient 15's Admission Record (AR), dated 10/16/24, the AR indicated, Patient 15 was admitted to the facility on [DATE] with diagnoses including, hemiplegia (partial or complete paralysis of one side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following Cerebral Infarction (stroke - disrupted blood flow to the brain) affecting right side, muscle weakness, and need for assistance with personal care. During a review of Patient 15's History and Physical Examination (H&P), dated 8/9/24, the H&P indicated This resident [Patient 15] has the capacity [ability] to understand and make decisions. During a concurrent observation and interview on 10/15/24 at 10:02 a.m. with Patient 15 in Patient 15's room, Patient 15 was laying supine (on back) in bed, room lights out and blinds closed. Patient 15 stated he had a tremendous amount of pain and does not get out of bed very often. Patient 15 stated it was important to him to be able to get up and go outside but, he was in so much pain he could not get up to the wheelchair and leave his room. During a concurrent interview and record review on 10/16/24 at 1:52 p.m. with Registered Nurse Consultant (RNC) 2, Patient 15's Physicians Progress Note (PPN), dated 8/20/24, was reviewed. The PPN indicated, HPI [history of present illness]: . Patient [Patient 15] admitted to SNF [skilled nursing facility]. Patient [Patient 15] was asked to be seen by the interdisciplinary team to optimize therapy, pain control, and discharge planning. RNC 2 stated Patient 15 was admitted to the facility on [DATE] for therapy and pain control after having a stroke. During a concurrent interview and record review on 10/16/24 at 2:30 p.m. with RNC 2, Patient 15's Care Plan (CPs), was reviewed. RNC 2 stated Patient 15 did not have a CP for pain management and needed one. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, A comprehensive, person-centered care plan for the resident should be developed by the interdisciplinary team (IDT), with input from the resident, and his/her family or legal representative. 2. The Comprehensive person-centered care plan should be developed within the seven (7) days of the completion of the required MDS assessment. (Admission, Annual, or significant change in status), and should be completed within 21 days of admission. 6. The comprehensive, person-centered care plan should: a. Include measurable objectives and time frames; b. Describe the services that are to be furnished in an attempt to assist the resident attain or maintain that level of physical, mental, and psychosocial wellbeing that the resident desires or that is possible. During a review of the facility's P&P titled, Pain Assessment and Management, dated October 2022, the P&P indicated, Purpose The purposes [sic] of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines 1. The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Defining Goals and Appropriate Interventions 1. The pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the sources, type and severity of pain. 2. Pain management interventions shall address the underlying causes of the resident's pain. 2. During a concurrent interview and record review on 10/16/24 at 2:35 p.m. with RNC 2, Patient 15's Nursing - Pain Observation/Assessment (NPOA), dated 8/7/24 was reviewed. The NPOA did not indicate type of pain, duration, frequency, and whether the pain was continuous or intermittent. The NPOA indicated: A. Location- right and left front lower legs. B. Current Pain Level 4. Moderate pain [numeric pain scale 1-10, 0: No pain, 1: Very mild pain, barely noticeable, 2: Minor pain, 3: Noticeable and distracting pain, 4: Moderate pain, 5: Moderately strong pain, 6: Moderately strong pain that interferes with normal daily activities, 7: Severe pain that dominates your senses, 8: Intense pain, 9: Excruciating pain, 10: Unspeakable pain]. C. What makes the pain better? na [not applicable]. What is the level of pain at its least? 4. Moderate pain. D. What makes the pain worse? na. What is the level of pain at its worst? 4. Moderate pain. E. Effects of pain on ADLs [activities of daily living - basic tasks people do each day to be safe, healthy, and clean including but not limited to bathing, dressing, and using the toilet.] 1. Sleep and rest UTD [unable to determine]. 2. Social activities UTD. 3. Appetite UTD 4. Physical activity and mobility UTD. 5. Emotions UTD. 6. Emotions UTD. 7. Initmacy [sic] UTD. F. Medications/Treatments/Modalities [1. Describe all methods of alleviating pain and their effectiveness: NA [not applicable] (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RNC 2 stated the NPOA was incomplete and did not accurately represent the condition of Patient 15. RNC 2 stated if the pain assessment had been completed it would have triggered the physician to be notified and new orders could have been given to better address Patient 15's pain. During a concurrent interview and record review on 10/16/24 at 2:43 p.m. with RNC 2, Patient 15's Medication Administration Record (MAR), dated 8/2024, 9/2024 and 10/2024, were reviewed. The MAR indicated, Patient 15 received Oxycodone HCL [a medication used to treat moderate to severe pain] 5 MG [milligrams] 1 tablet by mouth as needed for pain Patient 15 received Oxycodone daily for pain scale ratings of seven through nine. RNC 2 stated based on review of the MAR, Patient 15's daily use of pain medication, and the NPOA, there needs to be additional pain management care interventions to address Patient 15's pain. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated October 2022, the P&P indicated, Purpose The purposes [sic] of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. Assessing Pain. 5. During the pain assessment gather the following information as indicated from the resident (or legal representative).c. Characteristic of pain: (1) Location of pain; (2) Intensity of pain (as measured on a standardized pain scale); (3) Characteristics of pain (e.g. [for example], aching, burning, crushing, numbness, burning, etc.); (4) Pattern of pain (e.g., constant or intermittent); and (5) Frequency, timing and duration of pain; d. Impact of pain on quality of life; e. Factors such as activities, care or treatment that precipitate [cause] or exacerbate [make worse] pain; f. Factors and strategies that reduce pain . h. Physical and psychosocial issues (physical examination of the site of the pain, movement, or activity that causes the pain, as well as any discussion with resident about any psychological or psychosocial concerns that may be causing or exacerbating the pain). j. The resident's goals for pain management and his or her satisfaction with the current level of pain control.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 48901 The facility failed to follow its policy and procedure (P&P) titled Repositioning for one of one Residents (Resident 22). This failure had the potential for Resident 22 to develop pressure ulcers. Findings: During a review of Resident 22's CP, dated 10/7/20, the CP indicated, [Resident 22] has potential for pressure ulcer development r/t Alzheimer's [a disease that destroys memory and other mental functions]. Interventions/Tasks. [Resident 22] requires monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed as requested. During a review of Resident 22's MDS Section GG, dated 8/23/24, the MDS GG indicated Resident 22 is dependent and unable to roll left or right on her own. During a concurrent interview and record review on 10/17/24 at 3:03 p.m. with RNC 2, Resident 22's TR, dated 8/2024 was reviewed. The TR indicated, on the following dates Resident 22 was not repositioned and turned during day shift: 8/1, 8/18, and 8/26. The TR indicated, on the following dates Resident 22 was not reposition and turned during night shift: 8/1, 8/2, 8/7, 8/8, 8/9, 8/11, 8/13, 8/14, 8/17, 8/18, 8/19, 8/22, 8/23, 8/27, 8/28, and 8/31. RNC 2 stated the way the turning and repositioning is being documented every shift is not consistent with the Repositioning policy and it also does not indicate the position which the resident was turned. RNC 2 stated if it [Resident 22's turn and reposition] is not documented it is not done. During a review of the facility's policy and procedure (P&P) titled, Repositioning, revised 5/2013, the P&P indicated, General Guidelines: 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief .3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .Interventions: 3. Residents who are in bed should be on at least every two-hour repositioning schedule.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 42148 Based on observation, interview, and record review, the facility failed to ensure an appropriate diet texture (consistency of food or the size of food pieces) was provided to one of 15 sampled residents (Resident 16). This failure had the potential to cause Resident 16 to choke on her food or have an adverse outcome. Findings: During a review of Resident 16's Admission Record (AR), dated 6/8/22, the AR indicated, Resident 16 had a diagnosis of dysphasia (difficulty swallowing) and feeding difficulties. During a concurrent observation and interview on 10/14/24 at 12:44 p.m. with FM 1 in Resident 16's room, Resident 16 was served lunch which included a regular textured meatball sandwich on a hoagie bun. Resident 16 was missing most of her top teeth. FM1 stated Resident 16 she does not wear her top dentures anymore because family was afraid she would swallow them. FM 1 stated, [Resident 16] pockets [holds food in her cheeks] her food and will hold on to big pieces. FM 1 stated Resident 16's food never comes chopped up and is always a regular texture. During a review of Resident 16's Order Summary Report (OSR), dated 10/1/24, the OSR indicated, CCHO [consistent Carbohydrates], diet Regular texture, thin liquids consistency. During a review of Resident 16's Care Plan (CP), dated 1/8/24, the CP indicated, Nutrition Status: [Resident 16] is at risk for weight loss, dehydration, skin breakdown and altered nutritional status r/t [related to] medical condition/dx [diagnosis]: Dysphasia. During a concurrent interview and record review on 10/16/24 at 1:58 p.m. with Speech Language Pathologist (SLP), Resident 16's Speech Therapy Evaluation (STE), dated 8/29/24 was reviewed. The STE indicated, Prior level of function: Intake/Diet Level = mechanical soft (foods that are easy to chew); Swallowing Abilities = Min[minimal]/Close supervision. Overall Abilities: Swallowing Abilities = Mild. Assessment Summary Clinical Impressions: Pt [Resident 16] has a moderate oropharyngeal dysphasia [inability to empty material from the throat into the stomach] with a mild aspiration [choking] risk. SLP services for dysphasia are warranted to assess/evaluate least restrictive oral intake.Risk Factors: Due to the documented physical impairments and associated functional deficits without skilled therapeutic intervention, the patient is at risk for: aspiration. Recommendations: Intake- solids= Mechanical Soft Textures. SLP stated Resident 16 is getting speech therapy because she tends to pocket bites of food. SLP stated Resident 16 is currently getting a regular textured diet and could benefit from a mechanical soft food texture. During an interview on 10/16/24 at 3:46 p.m. with Registered Dietician (RD), RD stated Resident 16 has recently been pocketing her food and was referred to Speech Therapy. RD stated she follows the speech therapist recommendations for diet changes and stated she had not seen any new recommendations to change Resident 16's diet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facilities policy and procedure (P&P) titled, Dysphasia-Clinical Protocol, dated 9/2017, the P&P indicated, Treatment/Management 2. The staff and physician will first try to identify and implement simple interventions to manage the situation; for example, cutting food into smaller pieces; 5. If a modified consistency diet or other restrictions are indicated, nursing will obtain an order for such restrictions from the physician. B. (1) Example of situations in which speech therapy interventions may be helpful include individual who have had a recent stroke with subsequent impaired chewing and swallowing.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on observation, interview, and record review, the facility failed to ensure the Infection Preventionist (IP-responsible for the implementation and review of the facility's infection prevention program) managed pain for one of one sampled resident (Resident 51) during wound dressing change on the open wound to the amputated left big toe and the vascular wound on the inner aspect of the left ankle. This failure resulted in Resident 51 experiencing pain as evidenced by facial expressions and pain level of nine out of 10 (0-no pain, 1-verbal, 3-mild pain,4-5 moderate pain, 6-9 severe pain, 10-excruciating pain). Findings: During a review of Resident 51's Admission Record (AR), the AR indicated Resident 51 was admitted to the facility on [DATE] with diagnoses which included acute osteomyelitis (inflammation and swelling in the bones) left ankle and foot, Type 2 diabetes mellitus (DM- chronic condition with persistent high blood sugar levels) with diabetic neuropathy (nerve damage in the legs and feet) and other skin ulcers. During a review of Resident 51's Operative Report (OR), dated 9/20/24, the OR indicated, Post-Op (after surgery) Diagnosis: Left first toe gangrene (dead tissue caused by an infection or lack of blood flow). Procedure: Transmetatarsal amputation (surgical removal of a part of the severely infected foot) of left first toe. During a concurrent observation and interview on 10/15/24 at 9:15 a.m. with IP in Resident 51's room, IP began cutting and removing Resident 51's dressing from his left foot. Resident 51 exhibited signs of pain with redness to his face, facial grimacing, clenching jaw, and tight fist to the left hand. IP did not assess Resident 51's pain level. Surveyor asked Resident 51 what his pain level was and Resident 51 reported a pain level of 9 out of 10. After IP removed the dressing on the left foot, Resident 51 had an amputation of the left big toe, and an open wound closed to the surgically removed left big toe. The wound sutures (stiches) appeared to have not closed and the sutures were noted to be embedded in the skin inside the open wound to the amputated left toe and on its side. The open wound was deep, red in color and skin abraded. IP stated Resident 51 was admitted with his wound in that condition. A second open wound located on the inner aspect of the left ankle was observed. IP stated it was a vascular wound (wound on the skin that is shallow, with a red base, covered by a yellow tissue resulting from poor blood circulation) about six centimeters (unit of measure) by six cm previously measured and documented on Resident 51's wound assessment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	IP started flushing (rinsing wound) the open wounds to the amputated left big toe with Daikin solution (wound cleanser) using a syringe. Resident 5's face was red while he clenched his jaw, and grimaced during the procedure. Resident 51 verbalized pain, but IP continued to flush and irrigate (run a stream of solution into the wound) the open wounds to the amputated left big toe and the vascular wound on the inner aspect of the left ankle. IP stated she would tell the other nurse to give you pain medication after treatment. IP continued to clean the wound with betadine solution (antiseptic to treat/kill skin infection). Resident 51 continued exhibiting signs of pain with redness in his face, facial grimacing, clenching his jaw, and his left hand. IP informed Resident 51 he would be medicated with pain medication after the treatment. Resident 51 told IP he had a new pain medication Morphine (narcotic pain medication). IP did not pause the treatment to address Resident 51's pain. IP applied dressings to the open wound on the amputated left big toe. IP placed the wound packing into the wounds on the amputated left big toe and the vascular wounds on the inner aspect of the left ankle. Resident 51 silently moaned, clenched his jaw, made facial grimaces, and his left hand was in a tight fist. IP asked Resident 51 to raise his left leg so IP could rewrap the foot with gauze dressing. Resident 51 exhibited pain as he raised his left leg up. IP did not pause the treatment and continued to apply the elastic bandage around the ankle and the left foot. IP did not assess Resident 51 after the dressing change on the open wounds to the amputated left big toe and the vascular wound to the inner aspect of the left ankle. During an interview on 10/15/24 at 9:22 a.m. with IP, IP stated Resident 51 showed signs of pain during the wound care treatment and she did not provide pain medication. During a concurrent interview and review on 10/15/25 at 9:26 a.m. with LVN 1, Resident 51's Medication Administration Record (MAR), dated 10/2024, was reviewed. The MAR indicated, Norco 10/325 milligram (mg) (narcotic pain medication) one tablet was given for pain at 4:53 a.m. LVN 1 stated Resident 1 had not received any other pain medication. During a review of Resident 51's Physician's Order Recap Report (PORP), dated 9/1/24-10/16/24, the PORP indicated the following: 10/13/24 -Hydrocodone Acetaminophen (narcotic pain medication)10/325 mg. Give one tablet by mouth every six hours as needed for pain. Discontinue on 10/15/24 at 12:32 p.m. 10/15/24 - Morphine Sulfate ER Tablet Extended Release (narcotic pain medication)15 mg. Give one tablet every 12 hours for pain. Discontinue on 10/15/24 at 12:34 p.m. During a review of Resident 51's Care Plan, dated 9/26/24, the care plan indicated Focus: Surgical incision: Resident has a surgical incision to left (L) great toe and is at risk for dehiscence (wound opening), delayed healing, and infection. Interventions: Monitor pain pre (before), during, and post treatment. Intervene PRN (as needed). 10/15/24 Focus: Skin: Resident has a venous stasis ulcer [refers to the vascular wound on the inner aspect of the left ankle caused from poor blood circulation] to left lower extremity and is at risk for further breakdown, and/or slow, delayed healing related to impaired circulation. Goal: Pain will be alleviated to a tolerable level. Intervention: Administer pain medication as ordered 10/14/24. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated 10/2022, the P&P indicated, Assessing Pain: 1. Assess the resident at [sic] admission and during ongoing assessments to help identify the resident who is experiencing pain or for whom pain may be anticipated during specific procedures, care, or treatment .Identifying the cause of pain: 2, In addition, common procedures such as moving the resident, physical therapies, or wound care can cause the resident pain.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47444 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 17) had complete pre-dialysis and post dialysis communication assessments. This failure had the potential for Resident 17 to have a change of condition that was not communicated and could result in negative health outcomes. Findings: During a review of Resident 17's Admission Record (AR), dated 10/17/24, the AR indicated Resident 17 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (ESRD - kidneys can no longer function properly) and dependence on renal dialysis (treatment that removes excess water and toxins from the blood when kidneys no longer function). During a review of Resident 17's Order Entry (OE), dated 8/20/24, the OE indicated, Dialysis Orders, Dialysis Center: [identification number] Days and time of treatment: M [Monday] - W [Wednesday] - F [Friday]. During a concurrent interview and record review on 10/17/24 at 10:13 a.m. with Director of Staff Development (DSD), Resident 17's Nursing - Hemodialysis Communication Observation/Assessments (HCOAs - consists of two assessments: Facility Pre-Dialysis and Dialysis Center) dated October 2024 were reviewed. The HCOAs indicated, I. Facility Pre-Dialysis [assessment] 1. Instructions Complete prior to dialysis session and send with the resident to the dialysis center. on: 10/2/24 was not done 10/4/24 was not done 10/9/24 in progress (only pre-assessment completed) 10/11/24 in progress (only pre-assessment completed) 10/14/24 was not done 10/16/24 was not done The HCOAs indicated, II. Dialysis Center [assessment] a. Instructions **Attention Dialysis Center** Please complete this section of the Dialysis Assessment and return with the patient or via fax to maintain regulatory communication requirements was not completed and returned to the facility on : 10/2/24, 10/4/24, 10/7/24, 10/9/24, 10/11/24, 10/14/24, and 10/16/24. (continued on next page)

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Gateway Post Acute	661 West Poplar Porterville, CA 93257

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DSD stated the facility are to send pre and post assessments forms with the resident to the dialysis center. The dialysis center was to fill out the documents and return with the resident. DSD stated the nurse assigned to care for the resident is responsible for completing the pre-dialysis assessment and obtaining the dialysis center post-dialysis assessment to be placed in resident's medical record. DSD stated the pre-dialysis assessment and obtaining the dialysis center post-dialysis assessment should be completed the same day that dialysis was performed. DSD stated it was important for these assessments to be complete to ensure communication between the facility and the dialysis center regarding the resident's condition including, level of consciousness, identification of any skin issues, medications and vital signs. During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, dated September 2010, the P&P indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Policy Interpretation and Implementation. 4. Agreements between this facility and the contracted ESRD facility [Dialysis Center] include all aspects of how the resident's care will be managed, including: b. how information will be exchanged between the facilities.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47444 Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) titled, Bed Safety and Bed Rails, for one of 18 sampled residents (Resident 55) when: 1. The bed rail and entrapment risk observation/assessment (BEAR) was inaccurate and incomplete. 2. The Interdisciplinary Team (IDT - team of health care professionals) was not involved in the review of use of bed rails. 3. There was no physician's order for continuous use of bilateral (right and left) bed rails. 4. There was no Care Plan (CP) for use of bilateral bed rails. This failure resulted in Resident 55's IDT had the potential to put Resident 51's safety and health at risk. Findings: 1. During a review of Resident 55's Admission Record (AR), dated 10/17/24, the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses including encephalopathy (general term for a brain disorder), muscle weakness, dysphasia (condition that affects a person's ability to understand and speak). During an observation on 10/14/24 at 9:22 a.m. outside of Resident 55's room, Resident 55 was sitting in bed with bilateral bed rails up and foam wedges between Resident 55 and bed rails. The bed rails were positioned halfway between the head and foot on each side of the bed (measuring approximately three feet in length) which left an open space at the head and foot of bed (measuring approximately one and a half feet each). During an observation on 10/16/24 at 7:10 a.m. in Resident 55's room, Resident 55 was lying in bed with bilateral bed rails up and foam wedges between Resident 55 and bed rails. During an observation on 10/17/24 at 8:05 a.m. outside of Resident 55's room, Resident 55 was lying in bed with bilateral bed rails up and foam wedges between Resident 55 and bed rails. During a concurrent interview and record review on 10/17/24 at 9:22 a.m. with MDS Consultant (MDSC) 2, Resident 55's Nursing - Bed Rail and Entrapment Risk Observation/Assessment (BEAR), dated 8/22/24 was reviewed. The BEAR indicated, Based on IDT review and Physician Consultation: Use of bed rails was recommended per family request no indication for bed rails was documented. MDSC 2 stated there should have been documentation which indicated the reason the family requested for use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a concurrent interview and record review on 10/17/24 at 9:22 a.m. with MDSC 2, Resident 55's BEAR, dated 8/22/24 was reviewed. The BEAR indicated, E. Section V Based on IDT Review and Physician consultation: . 7. IDT members participating in review(s) and date: (Enter full name and title), was blank. MDSC 2 confirmed the IDT members and physician consultation was not documented. MDSC 2 was unable to provide documentation of IDT review or physician consultation regarding the use of bilateral bed rails for Resident 55. 3. During a concurrent interview and record review on 10/17/24 at 9:22 a.m. with MDSC 2, Resident 55's Physicians Orders (PO), were reviewed. No PO for use of bilateral bedrails was found. MDSC 2 stated there is no PO for use of bilateral bedrails or foam wedges for Resident 55. MDSC 2 stated there should be a PO for the use of bilateral bedrails which indicated the specific reason for use. 4. During a concurrent interview and record review on 10/17/24 at 9:22 a.m. with MDSC 2, Resident 55's medical record was reviewed. MDSC 2 stated there was no care plan for use of bilateral bedrails or foam wedges and a care plan should have been initiated for Resident 51. During a review the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails, dated August 2022, the P&P indicated, Use of Bed Rails .3. the use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: .d. consultation with the attending physician.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 42148 Based on interview, and record review, the facility failed to employ a full time Director of Nursing (DON) for a facility licensed for 62-beds. This failure resulted in lack of oversight on the total operation of nursing services and provision of quality of care. Findings: During entrance conference on 10/14/24 at 9:15 a.m. with Administrator, Administrator stated, The facility does not have a director of nursing. 35649 During a concurrent interview and record review on 10/15/24 at 2:30 p.m. with Director of Staff Development (DSD), the facility Payroll Based Journal (PBJ) dated 9/5/24 and 9/17/24 was reviewed. DSD stated there was no DON for over a year now, and she was assigned to calculate the nursing staffing hours and submit the report to PBJ. DSD stated there was no DON to review the nursing staffing hours for accuracy. DSD stated the Administrator or Registered Nurse Consultant (RNC) 1 did not provide oversight and recheck the reports submitted. During an interview on 10/17/24 at 8:15 a.m. with Infection Preventionist (IP), IP stated the facility did not have a DON to provide her the guidance and direction she needed to manage infection control program, especially with antibiotic stewardship. IP stated whenever she needed to consult on infection control issues IP would call the County Health Department Nurse, or the Infection Control Consultant (ICC).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47444 Based on observation, interview, and record review, the facility failed to ensure one of three medication carts did not contain expired medication. This failure had the potential for a medication with reduced effectiveness to be administered to a resident. Findings: During a concurrent observation and interview on 10/16/24 at 10:18 a.m. with Licensed Vocational Nurse (LVN) 4 at Medication Cart 3 (MC3), an Advair Diskus Inhaler [medication used to treat difficulty breathing] was labeled with a discard date of 10/8/24. LVN 4 stated the inhaler should have been discarded by 10/8/24. LVN 4 stated it is the responsibility of the nurse who is assigned to the medication cart to check the expiration dates and dispose of any expired medications or supplies. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 2019, the P&P indicated, N. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47444 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was five percent or less when two medication errors were observed out of 25 medication administration opportunities, which resulted in a medication error rate of 8%. These failures had the potential for residents to not receive the therapeutic effects of the medication. Findings: 1, During a concurrent observation and interview on 10/16/24 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 4 outside of Resident 109's room, LVN 4 prepared Resident 109's medication for administration. LVN 4 took Resident 109's blood sugar and the blood sugar was 236 (normal range 60-99 mg/dl [milligram per deciliter]). LVN 4 stated Resident 109 had a insulin sliding scale (amount of insulin given is based on blood sugar level) order for insulin to be administered before all meals. LVN 4 stated Resident 109's blood sugar was 236 therefore he would receive four units of Humalog insulin. LVN 4 stated Resident 109 also was to receive six units of Humalog insulin before all meals. LVN 4 administered 10 Units of Humalog insulin to Resident 109. During a concurrent interview and record review on 10/17/24 at 8:15 a.m. with LVN 4, Resident 109's Physician's Orders (PO), dated 10/2024 were reviewed. No order for six Units of Humalog insulin solution 100 Unit per ml before all meals was found in Resident 109's POs. LVN 4 stated he gave Resident 109 an additional six units of insulin before each meal per Resident 109's request. LVN 4 stated there is no PO for Resident 109 to receive six units of Humalog insulin before each meals. LVN 4 stated he did not document the six units of Humalog insulin he gave Resident 109. During a concurrent interview and record review on 10/17/24 at 9:11 a.m. with Minimum Data Set Consultant (MDSC) 2, Resident 109's POs were reviewed. The MDSC 2 stated Resident 109 did not have an PO for Humalog insulin six units before each meal. During an interview on 10/17/24 at 11:13 a.m. with Director of Staff Development (DSD), DSD stated it was not acceptable for LVN 4 to give the additional six units of insulin even if Resident 109 requested it. DSD stated it was standard practice to get a PO before giving medication. DSD stated too much insulin could cause Resident 109 to become hypoglycemic (low blood sugar). 2. During an observation on 10/16/24 at 4:08 p.m. outside Resident 5's room, LVN 2 prepared Resident 5's medication for administration. LVN 2 administered two 325 milligram (mg) tablets of Tylenol (acetaminophen - medication used for mild to moderate pain) to Resident 5. During a review of Resident 5's Order Entry (OE), dated 3/30/22, the OE indicated, Tylenol Tablet 325 MG [milligrams] Give 2 tablets by mouth every 6 hours for Pain. During a concurrent interview and record review on 10/17/24 at 11:20 a.m. with DSD, Resident 5's Medication Administration Record (MAR), dated 10/16/24 was reviewed. The MAR indicated, Resident 5 was given two tablets of Tylenol 325 mg at on 10/16/24 at 12 p.m. DSD stated Resident 5's Tylenol that was given on 10/16/24 at 4:08 p.m. was administered two hours early. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Administering Medication, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescribe orders, including any required time frame.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 47444 Based on observation, interview, and record review, the facility failed to ensure one of 10 sampled residents (Resident 109) was free from a significant medication error. This failure had the potential for Resident 109 to adverse health outcomes. Findings: During a concurrent observation and interview on 10/16/24 at 11:12 a.m. with Licensed Vocational Nurse (LVN) 4 outside of Resident 109's room, LVN 4 prepared Resident 109's medication for administration. LVN 4 took Resident 109's blood sugar and the blood sugar was 236 (normal range 60-99 mg/dl [milligram per deciliter]). LVN 4 stated Resident 109 had a insulin sliding scale (amount of insulin given is based on blood sugar level) order for insulin to be administered before all meals. LVN 4 stated Resident 109's blood sugar was 236 therefore he would receive four units of Humalog insulin. LVN 4 stated Resident 109 also was to receive six units of Humalog insulin before all meals. LVN 4 administered 10 Units of Humalog insulin to Resident 109. During a concurrent interview and record review on 10/17/24 at 8:15 a.m. with LVN 4, Resident 109's Physician's Orders (PO), dated 10/2024 were reviewed. No order for six Units of Humalog insulin solution 100 Unit per ml before all meals was found in Resident 109's POs. LVN 4 stated he gave Resident 109 an additional six units of insulin before each meal per Resident 109's request. LVN 4 stated there is no PO for Resident 109 to receive six units of Humalog insulin before each meals. LVN 4 stated he did not document the six units of Humalog insulin he gave Resident 109. During a concurrent interview and record review on 10/17/24 at 9:11 a.m. with Minimum Data Set Consultant (MDSC) 2, Resident 109's POs were reviewed. The MDSC 2 stated Resident 109 did not have an PO for Humalog insulin six units before each meal. During an interview on 10/17/24 at 11:13 a.m. with Director of Staff Development (DSD), DSD stated it was not acceptable for LVN 4 to give the additional six units of insulin even if Resident 109 requested it. DSD stated it was standard practice to get a PO before giving medication. DSD stated too much insulin could cause Resident 109 to become hypoglycemic (low blood sugar). During a review of the facility's policy and procedure titled, Administering Medication, dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescribe orders, including any required time frame.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48901 Based on observation, interview, and record review, the facility failed to ensure two of three kitchen staff (Dietary Service Supervisor [DSS] and Kitchen [NAME] [KC])followed their policy and procedures (P&P) titled, DRESS CODE FOR WOMEN AND MEN, This failure had the potential for food contamination. Findings: During an observation on 10/14/24 at 9:03 a.m. in the kitchen, DSS and KC had a beard and mustache on their face. DSS and KC wore a beard restraint (net used to cover facial hair) which left their mustaches exposed. During an interview on 10/14/24 at 9:36 a.m. with DSS, DSS stated mustaches were okay to have exposed if the mustache was trimmed. During a review of the facility's policy and procedures (P&P) titled, DRESS CODE FOR WOMEN AND MEN, dated 2018, the P&P indicated, PURPOSE: Appropriate dress in the Food & Nutrition Department Personal hygiene and appropriate dress are a very important part of the total appearance of the Food & Nutrition Service Department. Appearance is very important in maintaining a high standard of food service.PROPER DRESS.Men.8. Beards and mustaches (any facial hair) must wear beard restraint.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35649 Based on observation, interview, and record review, the facility failed to implement infection control practices when: 1. The Infection Preventionist (IP) did not use appropriate personal protective equipment (PPE-refers to gowns, gloves, masks, face shields, goggles to protect the individual from injury or infection) and did not perform appropriate hand hygiene for one of one sampled Residents (Resident 51), 2. Conduct an effective infection control surveillance activity through data collection, data analysis, track, and trending for 57 of 57 residents residing in the facility. These failures had the potential to transmit infectious diseases. Findings: 1. During a concurrent observation and interview on 10/15/24 at 9:15 a.m. with IP in Resident 51's room a sign on the door indicated Enhanced Barrier Precaution (EBP- precautionary measure to reduce the spread of bacteria). IP put on an isolation gown and gloves before entering Resident 51's room. IP irrigated the open wound of the amputated left toe and the vascular wound (wounds caused by poor blood circulation) on the left ankle. IP did not remove gloves and opened the clean dressings and applied to the open wound on the left toe and the vascular wound on the left ankle. During a concurrent observation and interview on 10/15/24 at 9:22 a.m. with Resident 51 and IP in Resident 51's room, IP did not perform hand hygiene after dressing change. IP gathered the trash, placed in a trash bag, and while holding the trash with one hand, pulled the medication cart key out of her pocket and opened the medication cart. IP returned the bottles of antiseptic and rolls of gauze in a plastic bag inside the medication cart. IP walked out of the room into the hallway carrying the trash bag and then handed the trash bag to another staff member. IP did not perform hand hygiene. During an interview on 10/15/24 at 9:32 a.m. with IP and Administrator, IP stated she did not wear a face shield/goggle and she did not change gloves, and wash hands during the treatment and dressing change. During an interview on 10/17/24 at 2 p.m. with Infection Control Consultant (ICC), ICC stated nurses should use a face shield/goggle when there is a potential for a splash during a treatment or procedure. During a review of the facility's policy and procedure (P&P) titled, Personal Protective Equipment, revised 10/2018, the P&P indicated, 1. Personnel who perform tasks that may involve exposure to blood/body fluids are provided appropriate personal protective equipment (PPE) . 3. Not all tasks involve the same risk of exposure, or the same extent of protection. The type of PPE required for a task is based on a. the type of transmission-based precaution, b. the fluid or tissue to which there is a potential exposure, c. the likelihood of exposure . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 10/2023, the P&P indicated, 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors . Indications for hand hygiene: a. immediately before touching a resident . d. after touching a resident . f. before moving from work on a soiled body site to a clean body site on the same resident g. immediately after glove removal. 2. During an interview on 10/17/24 at 11:20 a.m. with IP, IP stated the Infection Control Surveillance Activities (ICSA), were on hand hygiene and cleaning of blood glucose meters (a medical device to check blood sugar level). IP stated she had not done any surveillance on cleaning blood glucose meters. During an interview on 10/17/24 at 11:30 a.m. with IP, IP stated she could only observe the day shift staff because I do not work nights. IP stated she did not know how to conduct infection control surveillance. IP stated she had no previous data collected, had not analyzed results of surveillance, and had no tracking and trending of hand hygiene surveillance. IP stated there was no Director of Nursing to provide guidance. Facility documents on the facility infection control surveillance program were requested from the IP, none were provided. During a review of the facility's P&P titled, Infection Control, revised 10/2018, the P&P indicated, The facility's infection control policies and procedures are intended to facilitate a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .6. Inquiries concerning our infection control policies and facility practices should be referred to the Infection Preventionist or Director of Nursing Services. During a review of the facility's P&P titled, Surveillance for Infections, revised 9/2017, the P&P indicated, The infection Preventionist will conduct ongoing surveillance for Healthcare Associated Infections (HAI) and other epidemiologically [relates to incidence, distribution , and control of diseases] significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions [infection control measures used when patients already have been confirmed or suspected infections] and other preventive measures . Gathering Surveillance Data: The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data . Interpreting Surveillance Data: 1. Analyze the data to identify trends .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35649 Based on interview and record review, the facility failed to implement Antibiotic Stewardship (pharmacy-driven initiative dedicated to improve antibiotic [medications to treat bacteria] / antifungal [medications to treat fungus] use in nursing homes). This failure had the potential for residents to receive antibiotic and/or antifungal medications unnecessarily, which could be detrimental to residents' health. Findings: 1. During an interview on 10/17/24 at 8:20 a.m. with Infection Preventionist (IP), IP stated she was responsible for the antibiotic stewardship program in the facility. IP stated the pharmacist did not participate in the antibiotic stewardship progrm. IP stated there were no antibiotic stewardship meetings. During a concurrent interview and record review on 10/17/24 at 9 a.m. with IP, the Infection Control Committee Meeting Attendance Records (ICCMAR), dated 8/2024, 9/2024, and 10/2024, were reviewed. The ICCMAR for the last three months did not include a pharmacist, a medical director, or a director of nursing in attendance. IP was unable to provide documentation of antibiotic stewardship was part of the infection control committee agenda. During a concurrent interview and record review on 10/17/24 at 9:19 a.m. with IP, the Infection Prevention and Control Surveillance Log (IPCSL-line-list of residents on antibiotics in relation to the signs and symptoms and diagnosis), dated 10/2024, was reviewed. Resident 160's IPCSL indicated, Urine Infection, Date of Onset: 10/4/24. Signs and Symptoms: Incontinence (inability to control the flow of urine), dysuria (painful urination), urgency (sudden and strong need to urinate). Treatment: Levoflaxin (antibiotic) 250 milligram (mg) daily times 10 days. IP stated she followed the McGreer Criteria (set of guidelines for antibiotic use) for suspected urinary tract infection (UTI). During a concurrent interview and record review on 10/17/24 at 9:20 a.m. with IP, Resident 160's Infection Screening Evaluation (ISE), dated 10/4/24 was reviewed. The ISE indicated Resident 160 was afebrile (no fever), with new onset confusion, urinary frequency, urinary incontinence, and urinary urgency. IP stated Resident 160's ISE triggered McGreer Criteria for UTI. During a concurrent interview and record review on 10/17/24 at 9:19 a.m. with IP, Resident 160's Urinalysis and Urine Culture results (UUC), was reviewed. IP was unable to find documentation of Resident 160's UUC. IP stated she notified the physician that Resident 160 did not have a urine culture, but physician advised her to continue the antibiotics. IP stated she referred to the urinalysis results sent from the hospital when Resident 160 was admitted on [DATE]. IP stated the urinalysis results were normal. IP stated there was no indication for the use of antibiotic, but she followed the physician's order. IP stated she did not consult anyone but agreed to continue Resident 160's antibiotic. IP stated this case should have been discussed in the antibiotic stewardship meeting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056423	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gateway Post Acute	661 West Poplar Porterville, CA 93257

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the McGreer Criteria Notes [undated], the notes indicated, UTI should be diagnosed when there are localizing genitourinary (kidneys and bladder) signs and symptoms and a positive urine culture result. Evidence suggests most of these episodes are likely not due to infection of a urinary source. 2. During a concurrent interview and record review on 10/17/24 at 9:36 a.m. with IP, Resident 159's IPCSL, dated 10/2024 was reviewed. The IPCSL indicated, Respiratory Infection, Date of Onset: 9/7/24, Signs and Symptoms: admitted with DX [diagnosis] Valley Fever [fungal lung infection], Treatment: Fluconazole [used to treat serious fungal infections] 200 milligram [mg] tablet daily. Comment: Indefinite treatment. IP stated Resident 159 came in with a diagnosis of valley fever. During a concurrent interview and record review on 10/15/24 at 9:38 a.m. with IP, Resident 159's laboratory tests were reviewed. IP was unable to provide documentation of laboratory test to confirm diagnosis of valley fever. During a concurrent interview and record review on 10/15/24 at 9:40 a.m. with IP, Resident 159's History & Physical (H&P), dated 9/7/24, was reviewed. IP stated Valley Fever was not mentioned in Resident 159's H&P. IP was unable to find a physician documentation regarding valley fever diagnosis. During an interview on 10/15/24 at 9:50 a.m. with IP, IP stated Resident 159 needed to be reevaluated for his valley fever. IP stated Resident 159 had been on fluconazole 200 mg since 9/7/24 and there was no physician evaluation and laboratory tests done to determine if Resident 159 was responding to treatment. IP stated there was also no referral for Resident 159 to see an infectious disease specialist. During a review of the facility's P&P titled, Antibiotic Stewardship, dated 12/2016, the P&P indicated, 1. The purpose is to monitor the use of antibiotics in our residents . 5. When a resident is admitted from an emergency department, acute care facility, or other care facility, the admitting nurse will review discharge and transfer paperwork for current antibiotic/anti-infective [used to treat or prevent infections] orders . During a review of the facility's P&P titled, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, dated 12/2016, the P&P indicated, 1. As part of the facility's antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the Infection Preventionist, or designee. 2. The IP or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings.