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	05/14/2026

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the Certified Dietary Manager (CDM) met state education qualifications to supervise Food and Nutrition Service (FNS) operations. Specifically, the CDM lacked the required six hours of in-service training on California dietary service requirements per Title 22 (Section 72035) of the California Code of Regulations and CA Health and Safety Code (HSC) 1265.4(b) Pathway 4. This failure had the potential to adversely affect the facility's ability to ensure the nutritional, health, and safety needs of the residents.Findings:During a review of HSC 1265.4(a), current as of January 01, 2025, HSC 1265.4(a) indicated, (a) A licensed health facility, as defined in subdivision (a), (b), (c), (d), (f), or (k) of Section 1250, shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. The dietetic services supervisor shall receive frequently scheduled consultation from a qualified dietitian.During an interview on 5/11/26 at 9:40 a.m. with Registered Dietitian (RD), RD stated he worked part-time at the facility, usually every week on Tuesday's or more when needed.During a concurrent interview and record review on 5/13/26 at 11:55 a.m. with the CDM, in the presence of the RD, the varying educational pathways listed in HSC 1265.4(b) were reviewed. CDM stated she was a Certified Dietary Manager as indicated in pathway number (#) 4 of HSC 1265.4. During a concurrent interview and record review on 5/13/26 at 12 p.m. with CDM, in the presence of the RD, pathway number (#) 4 of HSC 1265.4 was reviewed further. Pathway #4 HSC 1265.4 indicated, (4) Is a graduate of a dietetic services training program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. CDM stated she did not have six hours of in-service training on the specific California dietary service Title 22 regulations.During a review of the facility's Job Description (JD), provided for the CDM, dated 1/17/25, the JD indicated, This position must provide supervision for the Dietary Department, ensuring quality food. The Dietary Supervisor will direct and assist the preparation and service of regular meals and therapeutic diets, order food and supplies, maintain area and equipment in sanitary condition, and assure the smooth operation with other nursing facilities departments.Ensures continued compliances with all federal, state and local regulations.Education and/or Experience: Must be a graduate of an approved dietary manager's course that meet the state and federal care regulations.During a review of Title 22, 72035. Dietetic Service Supervisor. Dietetic service supervisor means a person who has completed the training requirements specified in section 1265.4(b) of the Health and Safety Code.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure three of three sampled staff, one Registered Nurse (DON) and two Licensed Vocational Nurses (LVN 2, and LVN 4) had a competency evaluation to demonstrate skill profeciencies for management of:1. wound vac (vaccum, a medical device that uses negative pressure therapy to speed up wound healing, it involves a vacuum pump, a drainage canister, and specialized foam dressing that is applied over the wound bed that removes fluid, reduces swelling and increases blood flow to stimulate tissue growth) dressing change prior to performing this task.2. colostomy (a surgical procedure where an opening is made in the colon and brought to the surface of the abdomen to allow stool to exit the body) bag.These failures had the potential for negative health outcomes for residents with wound vac's and colostomies which could include severe complications including infection, bleeding, skin damage, pain, and tissue damage to the wound.Findings:1.During a review of Resident 57's Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact), dated 4/16/26 the BIMS indicated Resident 57's score was 13.During a review of Resident 57's Order Summary Report (OSR), dated 5/5/26, the OSR indicated, Cleanse abdominal wound with dakins [a diluted, hospital-grade [bleach] antiseptic used to clean wounds] quarter strength gauze, leave in place for 2 minutes, then remove gauze and apply black foam for wound vac [a medical device that uses controlled suction to speed up the healing of severe, large, or slow-to-heal wounds] -125mm/hg [millimeters of mercury] pressure, every shift every 3 day (s) for abdominal wound.During a concurrent interview and record review on 5/12/26 at 3:54 p.m. with Director of Nursing (DON), Resident 57's Treatment Administration Record (TAR), dated May 2026 was reviewed. The MAR indicated, Resident 57 had her wound vac changed on 5/6/26 and 5/9/26. DON stated on 5/6/26 LVN 4 changed Resident 57's wound vac and on 5/9/26 the DON changed Resident 57's wound vac. DON stated she does not have competencies in her file or LVN 4's file prior to performing a wound vac dressing change.2. During a review of Resident 9's Order Summary Report (OSR), dated 2/27/26, the OSR indicated, Colostomy bag change every week and PRN (as needed) for leakage/soilage.During a concurrent interview and record review on 5/13/26 at 12:26 p.m. with LVN 2, Resident 9's TAR, dated 4/26 was reviewed. The TAR indicated, colostomy bag was changed on 4/11/26 by LVN 2. LVN 2 stated she has not had any training or skill check off for colostomy care. During an interview on 5/14/26 at 12 p.m. with DON, DON stated she does not have competencies for staff on colostomy care.During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing dated August 2022, the P&P indicated, Staff must demonstrate the skills and techniques necessary to care for residents needs.Skin and wound care.competency requirements and trainings for nursing staff are established and monitored.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure meal preferences were honored for one of 21 sampled resident (Resident 20). This failure had the potential for decreased meal intake, weight loss, resident dissatisfaction and a reduced quality of life.Findings:During a review of Resident 20's Care Plan Report (CPR), dated 1/29/25, the CPR indicated, [Resident 20] is at risk for malnutrition [not getting enough nutrients or fluids to maintain healthy body function].Interventions.Cater to food preferences.During a review of Resident 20's Meal Ticket (MT), dated 5/11/26, the MT indicated, Resident 20 disliked gravy and sauces.During a concurrent observation and interview on 5/11/26 at 12:25 p.m. in the dining room with Resident 20, Resident 20 was sitting at a table eating lunch. Resident 20's lunch plate had pasta, green beans and chicken covered in a creamy white sauce. Resident 20 stated he was not going to eat the meat.During a concurrent observation and interview on 5/11/26 in the dining room with Certified Dietary Manager (CDM), Resident 20's lunch plate consisted of pasta, green beans and chicken covered with a creamy white sauce. CDM stated the white sauce on the chicken was alfredo sauce. CDM stated Resident 20 did not like sauces and the alfredo sauce should not have been on his plate.During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, dated July 2017, the P&P indicated, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team.When possible staff will interview the resident directly to determine current food preferences.If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain safe and sanitary food handling practices when:1.Food delivery boxes were stored directly on the floor in the dry food storage room posing a risk for contamination.2. Clean foodservice preparation equipment was stored directly on shelving with rust and chipped paint exposing food-contact surfaces to risk of physical and cross- contamination (Physical contaminants are foreign objects that may inadvertently enter the food).3. The foodservice operation did not follow the manufacturer's guidelines for the cleaning/sanitizing product that was in use for food contact surfaces, impeding effective cleaning and sanitizing processes. The U.S. Food and Drug Administration (FDA) Food Code 2022 indicated it is critical to sanitization that the sanitizers are used consistently with the EPA [U.S. Environmental Protection Agency] registered label.These failures to adhere to professional standards for food service safety and sanitary conditions placed the highly susceptible (The FDA Food Code, dated 2022, defined Highly susceptible population as Persons who are more likely than other people in the general population to experience foodborne disease because they are: (1) Immunocompromised.or older adults; and (2) Obtaining food at a facility that provides services such as.health care, or .nursing home.) residents at an increased risk of foodborne illness. Findings:1.During an observation on 5/11/26 at 9/32 a.m. with the Certified Dietary Manager (CDM) in the kitchen, delivered boxed food items were placed directly on the floor. In the dry food storage area; an opened shipping box containing containers of thickened Dairy drink, a Frito Lay shipping box, and a box of individual sized bottled waters were stored directly on the floor. During an interview on 5/11/26 at 10:54 a.m. with Registered Dietitian (RD), RD stated he reviewed food codes and it said food deliveries cannot be stored directly on the floor. During a review of the facility's policy and procedure (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated, All food and food containers are to be stored 6 [inches] off the floor and on clean surfaces in a manner that protects it from contamination. During a review of FDA Food Code (FDAFC), dated 2022, the FDAFC indicated, Food shall be protected from contamination by storing the food: .where it is not exposed to.contamination and at least 6 inches above the floor.During a review of the FDAFC, dated 2022, the FDAFC indicated, Employees are verifying that foods delivered to the food establishment are placed into appropriate storage locations such that they are maintained at the required temperatures, protected from contamination. (FDA Food Code 2022, 2-103.11)2. During an observation on 5/11/2026 at 11:14 a.m. in the kitchen, stainless steel pans were faced down and stored on a bottom shelf of a metal work-table and in contact with areas where chipped and missing paint, rust, and corrosion were present. During a concurrent observation and interview on 05/13/2026 at 11:46 a.m. with RD in the kitchen, a table located by the exterior door had a bottom shelf with pots and pans turned over in which the food contact surface was placed on the extensively rusted frame. RD stated the shelving needed to be replaced as it was a source of cross-contamination. During review of the FDAFC, dated 2022, the FDAFC indicated, Nonfood-Contact Surfaces.that require frequent cleaning shall be constructed of a corrosion-resistant, nonabsorbent, and smooth material. 3. During an observation on 5/11/2026 at 11:30 a.m. in the kitchen, a Dietary Aide (DA) 1 took a cloth from a red bucket that contained a liquid solution and ran one side of the cloth over the food contact counter to wipe up spilled juice. DA 1 used a test strip to check the concentration of the liquid solution located in the red bucket that she had just used. DA 1 matched the color of the test strip to the color-coded vial and stated it was at the correct concentration to sanitize. During an interview on 5/11/2026 at 11:31 a.m. with RD in the kitchen, the RD stated the liquid in the solution was SmartPower Sink and Service Cleaner Sanitizer. The RD stated cleaning and sanitizing was done in one step with this product. During an interview on 5/11/26 at 12:15 p.m. with RD and CDM, RD stated they did not purchase separate detergents that were typically used in green buckets because their cleaner-sanitizer cleaned and sanitized at the same (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time in a single application. CDM stated she trained the kitchen staff to wipe down a food preparation counter with a cloth from a red bucket containing the cleaner-sanitizer product which was done in one step. Both RD and CDM stated it saved on labor and staff time as they did not have to clean before sanitizing at any point within their foodservice operation as the SmartPower Sink and Service Cleaner Sanitizer from Ecolab did both in one applied application. CDM was asked if Ecolab had provided any training for them on use of the product and CDM stated no, I did the training. RD stated it was just not realistic to require staff to pre-clean a food contact surface prior to sanitizing at any frequency within their foodservice operation, as we do not do that at our homes.During a review of the manufacturer's SMARTPOWER SINK & SURFACE CLEANER SANITIZER Frequently Asked Questions (FAQ) from Ecolab, dated 2020, the FAQ indicated, Are the ingredients approved for food-contact sanitizing? Yes, all ingredients in SMARTPOWER Sink & Surface Cleaner Sanitizer have been reviewed by the EPA [Environmental Protection Agency] and have been cleared under 40 CFR 180.940(a) for use in food-contact surface sanitizing solutions and are approved for use on food-contact surfaces.and is acceptable for use as directed on the product label, Is cleaning still required before sanitizing? Yes, soils still need to be removed to allow SMARTPOWER Sink & Surface Cleaner Sanitizer to come in contact with hard non-porous surfaces. This requires two-steps with one product. To ensure proper cleaning and sanitizing procedures, follow application-specific instructions from training materials. For hard surfaces, one side of a towel or a wipe should be used to clean and the other side of the towel or wipe should be used to sanitize.During a review of the FDAFCA, dated 2022, the FDAFCA indicated, Food Contact with Equipment and Utensils. Pathogens can be transferred to food from utensils that have been stored on surfaces which have not been cleaned and sanitized. They may also be passed on by consumers or employees directly, or indirectly from used tableware or food containers. Some pathogenic microorganisms survive outside the body for considerable periods of time. Food that comes into contact directly or indirectly with surfaces that are not clean and sanitized is liable to such contamination. The handles of utensils, even if manipulated with gloved hands, are particularly susceptible to contamination. (3-304.11)During a review of the FDAFCA, dated 2022, the FDAFCA indicated, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. The objective of cleaning focuses on the need to remove organic matter from food contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. (4-601.11)During a review of the FDAFCA, dated 2022, the FDAFCA indicated, Further, for the purpose of wiping up food spills from surfaces in situations where full cleaning and sanitizing is not required (such as when a soft drink overflows onto the side of a cup or onto a countertop) the use of dry cloths and disposable towels is also acceptable as long as the cloth or towel is used for no other purpose. Again, this does not constitute a proper cleaning and sanitizing procedure for a food contact surface, when such is called for in 4-6 and 4-7 of the Food Code. (3-304.14)During a review of FDAFCA, dated 2022, the FDAFCA indicated, Alternative active ingredients are permitted as long as they are listed in 40 CFR [Code of Federal Regulations] 180.940 and used in accordance with the EPA-registered label use instructions for food contact surface sanitizers. (4-501.114)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement their policies and procedures (P&P) and/or the P&P lacked sufficient guidance to staff to ensure safe and sanitary storage, handling, and consumption when:1.Food items brought in from the outside for residents were not consistently labeled, dated, and monitored to ensure safe food storage and consumption. This failure posed a risk to food quality and/or safety, and may result in residents not receiving their intended food due to misidentification.2. The staff failed to ensure food stored in refrigerators did not exceed 41 degrees Fahrenheit (F - the standard maximum safe temperature for cold food storage to guide staff). This failure resulted in the risk of foodborne illness from spoiled food.3. The staff failed to ensure the resident refrigerator was clean and sanitary when extensive debris was noted. This failure resulted in an unsanitary resident refrigerator, creating a risk of food contamination and gastrointestinal illness. Findings:1. During a concurrent observation and interview on 5/11/26 at 3:30 p.m. with Certified Nursing Assistant (CNA) 1 in a storage room located outside of the facility next to the Certified Dietary Manager's (CDM) office, a refrigerator used to store food brought in from outside of the facility for residents was noted. CNA 1 stated there were six bottles of unopened Ensure (nutritional supplement) in which the lid was labeled with a marker that indicated 16. CNA 1 stated the 16 was a room number. CNA 1 stated they were supposed to label the bottles of Ensure with a resident's name and did not. During a concurrent observation and interview on 5/11/26 at 3:33 p.m. with the Actives Director (AD), in the resident's refrigerator storage room, inside the refrigerator were two opened jelly jars labeled with a marker as [NAME] Rec 9/30. AD stated Rec 9/30 meant that was the date the jars of jelly were placed in the refrigerator. AD stated she was responsible for monitoring the refrigerator to ensure safe food storage. AD stated the jars of jelly could safely be stored in the refrigerator based on the manufacturer's date placed on unopened jars of jelly. AD stated staff were also supposed to put an open date but there was not an open date. When AD was asked what an open date would mean in terms of how long the jars of jelly could be stored, AD stated she did not know. AD observed two packages of six, unopened, individual sized containers of apple sauce per package labeled by the manufacturer as Best by [DATE] [1/25/2026]. AD stated the applesauce was expired and should have been thrown out. AD confirmed six, unopened, bottles of Glucerna (nutrition supplement) dated by the manufacturer as 1 May 2026. AD stated that was an expiration date and the bottles of Glucerna should have been discarded.During a review of the facility's P&P titled, Food for Residents from Outside Sources, dated 2023, the P&P indicated, Policy: Food brought in from outside the facility kitchen for residents consumption will be monitored. 5. Prepared foods, beverages, or perishable food that requires refrigeration, can be stored for the resident in the facility kitchen, the refrigerator within the nurses' station, or in the resident's personal refrigerator. In the Food & Nutrition Services Department, the policy on food storage will apply. Otherwise, if unopened, refrigerated or frozen items will be disposed of by the expiration date on the container. If opened, the food must be sealed, dated to the date opened and disposed of in 2 days after opening.During a review of signage posted on the front of the resident's refrigerator, undated, the signage indicated, Resident Refrigerator: Any items put into this refrigerator should be labeled with 1. Residents Name (not room #), 2. Today's Date., all outdated items or items that do not have names and dates will be thrown out along with containers. Please let family members know about this so that they can bring items accordingly.During a review of Food Safety and Inspection Service, U.S. Department of Agriculture (USDA), dated 4/23/25, USDA indicated, A 'Best if Used By/Before' date indicates when a product will be of best flavor or quality. It is not a purchase or safety date.2. During a concurrent observation and interview on 5/11/26 at 3:27 p.m. with CNA 1 in the resident's refrigerator storage room, inside the refrigerator was a single temperature thermometer. CNA 1 stated the internal thermometer indicated 50 degrees Fahrenheit (F). During a concurrent observation and interview on 5/11/26 at (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3:45 p.m. with Registered Dietitian (RD) in the resident's refrigerator storage room, the RD removed two opened jelly jars that were stored in the refrigerator and inserted a digital thermometer into the jelly jars. The RD stated the internal temperature of the jelly was 50.5 degrees F. The RD was asked if the food was stored safely and RD stated no, certainly not. During a review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2023, the P&P indicated, 1. Refrigerator - 41 F or lower. To keep food at a specific temperature, the air temperature in the refrigerator usually must be about 2 F lower.3. During a concurrent observation and interview on 5/11/26 at 3:40 p.m. with the AD, in the resident's refrigerator storage room, there was a single refrigerator with three shelf spaces. There was extensive debris on the third shelf space inside the resident's refrigerator. AD stated the refrigerator was not maintained in a clean manner. During a review of signage posted on the front of the residents refrigerator, undated, the signage indicated, The refrigerator will be cleaned daily.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to follow standard practice for infection control when:1. Six of Six sampled residents (Resident 68, Resident 23, Resident 13, Resident 59, Resident 1, and Resident 71) were not provided hand hygiene prior to meals. This failure had the potential to spread infection to residents.2. Two of two sampled Licensed Vocational Nurses (LVN 1 and LVN 2) did not clean and disinfect glucometers (small portable medical device used to measure the approximate concentration of glucose in the blood) after use. This failure had the potential to spread disease causing organisms to residents and staff.Findings:1. During an interview on 5/11/26 at 1:06 p.m. with Resident 68, Resident 68 stated staff do not offer or provide hand hygiene prior to meals.During a review of Resident 68's Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact), dated 5/4/26, the BIMS indicated, Resident 68 had a score of 14.During a review of Resident 68's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/4/26, the MDS indicated, Resident 68 needed assistance with personal hygiene (washing and drying face and hands).During an observation on 5/12/26 at 12:19 p.m. in Resident 23's room, Certified Nursing Assistant (CNA) 2 entered the room and delivered Resident 23's lunch tray. Resident 23 started eating his meal. CNA 2 did not offer or provide hand hygiene to Resident 23.During an observation on 5/12/26 at 12:21 p.m. in Resident 13's room, CNA 2 entered the room and delivered Resident 13's lunch tray. CNA 2 did not offer or provide hand hygiene to Resident 13. During an observation on 5/12/26 at 12:22 p.m. in Resident 59's room, CNA 2 entered the room and delivered Resident 59's lunch tray. CNA 2 did not offer or provide hand hygiene to Resident 59. During an observation on 5/12/26 at 12:23 p.m. in Resident 1's room, CNA 2 entered the room and delivered Resident 1's lunch tray. Resident 1 started eating. CNA 2 did not offer or provide hand hygiene to Resident 1. During an interview on 5/12/26 at 12:28 p.m. with CNA 2, CNA 2 stated she did not offer or provide hand hygiene to Resident 23, Resident 13, Resident 59, and Resident 1 prior to delivering their lunch meal tray. CNA 2 stated she should have offered and provided hand hygiene.During an interview on 5/12/26 at 12:31 p.m. with Resident 59, Resident 59 stated he had only been offered hand hygiene prior to meals once. Resident 59 stated staff offered him hand hygiene for the first time on 5/11/25 (during survey). Resident 59 stated he had his wife bring him hand sanitizer from home so he would be able to clean hands before meals.During a review of Resident 59's BIMS, dated 4/20/26, the BIMS indicated, Resident 59 had a score of 13.During a review of Resident 59's MDS, dated 4/20/26, the MDS indicated, Resident 59 needed partial/ moderate assistance with personal hygiene.During an interview on 5/12/26 at 12:39 p.m. with Resident 71, Resident 71 stated staff do not offer or provide hand hygiene prior to meals being served.During a review of Resident 71's BIMS, dated 4/22/26, the BIMS indicated, Resident 71 had a score of 15. During a review of Resident 71's MDS, dated 4/22/26, the MDS indicated, Resident 71 needed partial/ moderate assistance with personal hygiene.During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene Policy for Patients Before and After Meals, (undated), the P&P indicated, To prevent the spread of infections and promote resident health by ensuring proper hand hygiene before and after meals in accordance with infection control best practices.All residents must perform hand hygiene before and after meals. Nursing staff and caregivers are responsible for assisting residents who require help with hand hygiene.Residents who can independently wash their hands should be encouraged to.Nursing staff must assist residents who are unable to wash their hands by: Providing hand wipes or sanitizer, or assisting with handwashing at a sink if needed.2. During an observation on 5/13/26 at 11:25 a.m. in Resident 18's room, Licensed Vocational Nurse (LVN) 1 checked Resident 18's blood glucose (sugar) level using a glucometer. LVN 1 took the used glucometer back to the medication cart in hallway, near (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 18's room. LVN 1 placed the glucometer on the medication cart, applied gloves and wrapped the glucometer in a disinfectant wipe. LVN 1 did not wipe down the glucometer prior to wrapping in the disinfectant wipe. LVN 1 placed the wrapped glucometer on the medication cart.During an observation on 5/13/26 in the hallway near Resident 18's room, LVN 1 applied gloves, picked up the glucometer that was sitting on the medication cart, removed the glucometer from the disinfectant wipe, and placed the glucometer in a medication cart drawer.During an observation on 5/13/26 at 11:44 a.m. in Resident 48's room, LVN 2 was using a glucometer to check Resident 48's blood glucose. The glucometer had an Error code. LVN 2 explained to Resident 48 that she would get a new glucometer and try again. LVN 2 walked to the medication cart sitting outside of Resident 48's door, applied gloves, wrapped the used glucometer in a disinfectant wipe. LVN 2 did not wipe down the glucometer prior to wrapping in the disinfectant wipe. LVN 2 placed the wrapped glucometer on the medication cart. During an observation on 5/13/26 at 11:48 a.m. in Resident 48's room, LVN 2 entered Resident 48's room with a new glucometer and checked Resident 48's glucose level. LVN 2 walked to the medication cart sitting outside of Resident 48's door, applied gloves and wrapped the used glucometer in a disinfectant wipe. LVN 2 did not wipe down the glucometer prior to wrapping in the disinfectant wipe. LVN 2 placed the glucometer on the medication cart.During an observation on 5/13/26 at 11:59 a.m. in the hallway near Resident 48's room, LVN 2 applied gloves, picked up both glucometers that were sitting on the medication cart and removed them from the disinfectant wipes. LVN 2 then placed both glucometers in medication cart drawer.During an interview on 5/13/26 at 12 p.m. with LVN 2, LVN 2 stated she did not physically wipe the glucometers to clean and disinfect them after use. LVN 2 stated she just wrapped them in a disinfectant wipe. LVN 2 stated it was the facility policy to wrap the glucometers in disinfectant wipes for two minutes.During an interview on 5/13/26 at 3:37 p.m. with LVN 1, LVN 1 stated that she did not clean the glucometers by using a wiping motion. LVN 1 stated she only wrapped the glucometer in a disinfectant wipe and let it sit. LVN 1 stated she should have cleaned the glucometer and not just wrapped it. LVN 1 stated it was facility policy to wrap the glucometers in a disinfectant wipe.During a review of the facility's P&P titled, Blood Sampling-Capillary (Finger Sticks), dated September 2014, the P&P indicated, The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to intended for reuse are cleaned and disinfected between resident uses.8. Follow the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices.During a review of the Manufacturers' Guidelines (MG) titled, EVENCARE G3 Blood Glucose Monitoring System, (undated), the MG indicated, Cleaning and Disinfecting Procedures for the Meter.The EVENCARE G3 Meter should be cleaned and disinfected between each patient.To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter including the front and back surfaces until visibly clean.To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes.Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipes direction for use.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the minimum square footage as required by regulation in four of 27 facility bedrooms. This had the potential to affect the care and safety of residents.Findings:During a concurrent observation and interview on 5/13/26 at 9:29 a.m. with Administrator, the facility's multiple occupancy rooms were observed and measured. Administrator stated the following rooms did not provide the minimum square footage (sq. ft.) as required by regulation (80 sq. ft. per resident for multi-occupation rooms):room [ROOM NUMBER] measured 315 square feet (s/f) and had 4 resident beds.room [ROOM NUMBER] measured 286 s/f and had 2 resident beds.room [ROOM NUMBER] measured 286 s/f and had 4 resident beds.room [ROOM NUMBER] measured 390 s/f and had 4 resident beds.Administrator stated he knew it was a deficiency of the minimum 80 square footage per bed.During an interview on 5/14/26 at 10:15 a.m. with Resident 43, Resident 43 stated if there were 3 residents in the room it would be easier to get in and out.Requested a copy of previous room waiver, unable to provide.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, the facility failed to uphold the rights of one of four sampled residents (Resident 14) when Resident 14 wanted his curtains closed. This failure resulted in Resident 14 being unable to exercise his preferences.Findings:During an interview on 5/11/26 at 10:19 a.m. with Resident 14, in resident Resident 14's room, Resident 14 stated that Certified Nursing Assistant (CNA) 3 came into Resident 14's room and opened the individual's privacy curtains. Resident 14 asked CNA 3 to shut the curtains. CNA 3 stated that she likes the curtains open. Resident 14 was very upset stating, Resident 14 feels taken advantage of because he can't close the curtains himself.During an interview on 5/11/26 at 10:56 a.m. with CNA 3, CNA 3 stated she likes the curtains open and CNA 3 did not ask Resident 14 if he would like his curtain closed. CNA 3 stated she should have asked Resident 14 if he wanted his curtains opened and honored his wishes.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 8/2009, the P&P indicated, Resident are entitled to exercise their rights and privileges to the fullest.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. Based on interview, and record review, the facility failed to implement one of two sampled resident (Resident 9) physician order for colostomy (a surgical procedure where an opening is made in the colon and brought to the surface of the abdomen to allow stool to exit the body) bag change every week. This failure had the potential to result in resident's care not being met with the likely of infection to the colostomy site.Findings:During a review of Resident 9's Order Summary Report (OSR), dated 2/27/26, the OSR indicated, Colostomy bag change every week and PRN (as needed) for leakage/soilage.During a concurrent interview and record review on 5/13/26 at 12:26 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 9's TREATMENT ADMINISTRATION RECORD (TAR), dated 4/26 through 5/26 was reviewed. The TAR indicated, for the month of May the colostomy bag was not changed. The TAR indicated, for the month of April the colostomy bag was changed only on 4/11/26. LVN 2 stated the colostomy bag should be changed every week per physician's orders and staff should be monitoring the site.During a review of the facility's policy and procedure (P&P) titled Colostomy.Care, dated 2010, the P&P indicated, The following information should be recorded in the residence medical record.the date and time the colostomy . care was provided.the name and title and the individual(s) who provided the colostomy. care.how with the resident tolerated the procedure. the signature and title of the person recording the data.During a review of the facility's policy and procedure (P&P) titled PHYSICIAN ORDERS, ACCEPTING TRANSCRIBING AND IMPEMENTING (NOTING), undated, the P&P indicated, All physicians orders are being complete.

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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. Based on observation, interview, and record review the facility failed to ensure one of two sampled resident (Resident 5), had a comprehensive (complete) care plan (CP). This failure had the potential to result in Resident 5 not having measurable objectives and timetables to meet the residents physical needs. Findings:During a review of Resident 5's admission Record (AR), dated 2/3/26, the AR indicated, SEIZURE (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) .TRAMATIC BRAIN INJURY.During a concurrent observation and record review on 5/12/26 at 12:32 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 5 was sitting in the hallway in his wheelchair with a soft helmet on his head. LVN 3 stated Resident 5 wear's a soft helmet on his head to protect himself. LVN 3 stated Resident 5 is to wear the helmet out of bed. LVN 3 stated Resident 5 does not have a CP to indicate why Resident 5 is wearing a helmet, how long the helmet should be on, if Resident 5's skin or head should be evaluated for skin breakdown. LVN 3 stated there is nothing in Resident 5's Medical Record that indicates the soft helmet.During a concurrent interview and record review on 5/12/26 at 12:42p.m. with Director of Nursing (DON), DON, Resident 5's CP, undated was reviewed. DON stated there is no CP for the soft helmet. The soft helmet is not recorded anywhere in Resident's 5 medical records. DON stated the CP would inform staff why Resident 5 has a soft helmet and what interventions needs to be followed.During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents physical.and functional needs is developed and implemented for each resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the failed to follow its policy and procedure (P & P) tilted Elopements, for one of four sampled resident (Resident 38) when Resident 38 exited the building unsupervised. This failure had the potential for Resident 38 to cause harm to self or an injury.Findings:During an observation on 5/12/26 at 12:26 p.m. in residents hallway, Resident 38 with an alarm on back of wheelchair, pushed exit door open and self-propelled her wheelchair out of exit door. During an interview on 5/12/26 at 12:30 p.m. with Resident 54, Resident 54 stated you need to have staff with you when you go outside.During a concurrent observation and interview on 5/12/26 at 12:35 p.m. at 12:35 p.m. with Resident 38 and Certified Nursing Assistant (CNA) 1 at exit door hallway, CNA 1 was pushing Resident 38's wheelchair from outside into residents hallway with an audible alarm. CNA 1 stated Resident 38 should not be outside without staff. CNA 1 stated the Resident 38 pushed forward in her chair setting off the chair alarm.During an interview on 5/14/26 at 11: 20 a.m. Director of Nursing (DON), DON stated there should be monitoring in place for residents who want to go outside.During a review of Resident 38's Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact), dated 2/27/26, BIMS indicated, Resident 38 is a 3.During a review of the facility's P &P titled Elopements, dated 2/2007, the P & P indicated, Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to ensure there was accurate and consistent communication between departments regarding adaptive equipment for one of one sampled resident (Resident 51). This failure had the potential to result in unnecessary and/or unmet implementation of adaptive equipment per Resident 51's assessment and/or physician's orders, to meet Resident 51's specialized nutritional needs and enhance quality of life.Findings: During an observation on 5/11/26 at 12:20 p.m. in the dining room, Resident 51 had a clear cup with one blue colored handle and a blue lid, containing a red colored liquid. Resident 51's tray card indicated, Adap. [adaptive] Equip [equipment]: 2-Handle Cup with Lid.During a concurrent observation and interview on 5/11/26 at 12:38 p.m. with Occupational Therapist (OT) in the dining room, Resident 51's lunch plate, cup and tray card remained on the dining table. OT stated the one handled cup did not match the tray card that indicated a 2-Handle Cup.During a concurrent interview and record review on 5/11/26 at 12:40 p.m. with OT, Resident 51's Physician's Dietary - Diet Order for: Resident: [name of Resident 51], dated 4/9/26 was reviewed. The diet order indicated, . slow sip covered mug [delivers a fixed measured dose of fluid per sip]. OT stated there was not a physician's order for a two handled cup. OT stated the cup he observed for Resident 51 in the dining room was a slow sip covered mug to control the flow rate and limit the volume of liquid per sip to prevent aspiration (liquid going into the lungs) and/or choking. OT stated Resident 51 was assessed for the need of a slow, sip mug (cup) but not for a two handled cup.During a concurrent interview and record review on 5/13/26 at 2:05 p.m. with the Certified Dietary Manager (CDM), in the presence of the Registered Dietitian (RD), Resident 51's current tray card was reviewed. The CDM stated she was informed Resident 51 did not have a two handled cup during the lunch meal on 5/11/26. The CDM stated the blue handles on the cup are removable and fall off when being washed. CDM stated kitchen staff should follow Resident 51's individualized directions for adaptive equipment listed on her tray card that indicated two handled cup. CDM stated the diet aide should have placed another sippy cup that had two handles attached onto Resident 51's meal tray. CDM stated Resident 51 told her she did not need nor liked a two handled cup.During a concurrent interview and record review on 5/13/26 at 2:10 p.m. with RD, Resident 51's electronic health record (EHR) was reviewed. RD stated there was an order for a slow sip covered mug, dated 12/4/25 that was discontinued and ordered again on 4/9/26. RD stated there was no physician order for a two-handled cup for Resident 51. The RD stated Resident 51's tray card should always match their current medical orders, as the tray card is the sole reference used by kitchen staff to prepare meal trays.During a concurrent interview and record review on 5/13/26 at 2:15 p.m. the CDM, in the presence of the RD, CDM stated that the facility's process for communicating orders related to Food & Nutrition Services (FNS) department required nursing staff to complete a paper communication slip. This process is used despite nursing staff having the ability to enter adaptive equipment orders directly into the Nutrition Management kitchen software that generates individualized tray cards for residents. CDM reviewed communication slips received for Resident 51 and stated there was no communication slip for a two handled cup nor for a slow sip covered mug.During a concurrent interview and record review on 5/13/26 at 2:20 p.m. with CDM, in the presence of the RD, the options located in Nutrition Management available to nursing staff to select from were reviewed. The options included, Two-Handled Flow Rate Cup and Slow Flow Cup. Nutrition Management under the heading traycard[sic]. specific to Resident 51 indicated, EHR Diet Orders: .Directions: .slow sip covered mug. Start Date Apr [April] 09, 2026.Meal Service Details: Adaptive Equipment: 2-Handle Cup with Lid. CDM stated the EHR Diet Orders header was automatically populated from interfacing with Resident 51's EHR. CDM stated the Meal Service Details, could have been entered by another department, but the software did not note who entered the information.During an interview on 5/13/26 at 12:22 p.m. with RD, RD stated that inconsistent (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interdepartmental communication had the potential to impede implementation of ordered adaptive equipment, potentially impacting a resident's nutritional, health, and safety needs.During a review of the facility's policy and procedure (P&P) titled, Tray Card System, dated 2023, the P&P indicated, Policy: Each meal tray at breakfast, lunch, and dinner will have a tray card which designates the resident's name, diet, food dislikes, food requests, allergies, beverage preference, and portion size. Procedure: The FNS Director is responsible for the tray card system.Tray Card System Used: Nutrition Management.During a review of the facility's P&P titled, Self-Feeding Devices, dated 2023, the P&P indicated, Policy: Residents will receive self-feeding devices to maintain or improve their ability to eat or drink independently. Procedure: 1. The PT [Physical Therapist], OT [Occupational Therapist], or ST [Speech Therapist], and/or designated person will evaluate residents for the need of a self-feeding device. 2. Devices commonly used (see list on the following page, 5.12), such as divider plates and feeding cups, will be kept in stock. A physician's order is recommended. 3. The Food & Nutrition Services Department will store self-feeding devices. Residents needing devices will receive them with each meal or snack, on their meal trays. Tray cards and diet profile will record which device is needed. During a review of the facility's policy and procedure (P&P) titled, Commonly Used Self-Feeding Devices 5.12, dated 2023, the P&P indicated, Insulated Mug: Used for residents who may have coordination problems. Does have a spouted lid for drinking or for a straw. Nosey Cup: This is a cup that has a special cutout that helps maintain proper head and neck positioning when swallowing (e.g. drinking without neck extension). The facility did not define a no slow sip covered mug, Two-Handled Flow Rate Cup, or Slow Flow Cup description listed to provide safe and accurate guidance to staff.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure a [NAME] followed standardized texture modified recipes for seven of 56 residents (Resident 7, Resident 8, Resident 21, Resident 26, Resident 31, Resident 49, and Resident 56) as a method to maintain nutritive value. This failure had the potential to result in texture modified food with less nutritive value than planned, placing residents on a pureed diet at risk for nutritional impairment. Findings:During a concurrent observation and interview on 5/11/26 at 11:19 a.m. with Cook, in the presence of the Registered Dietitian (RD), in the kitchen, [NAME] stated she placed seven pieces of bread in the food processor. [NAME] added an unmeasured quantity of milk into the food processor. Next, [NAME] added an unmeasured quantity of thickener into the food processor, in which the [NAME] determined the need to add an additional amount of unmeasured thickener. [NAME] stated she prepared six servings of pureed bread.During an interview on 5/11/26 at 11:22 a.m. with Cook, [NAME] stated she was unable to state how much milk and how much thickener she placed in the food processor to prepare pureed bread because she did not measure the ingredients. [NAME] stated she looked for the pureed bread to be a pudding-like texture. During a concurrent observation and interview on 5/11/26 at 11:41 a.m. with [NAME] in the kitchen, in the presence of the RD, [NAME] stated she measured six servings of pasta at 4 ounces (unit on measure) per serving and placed it into the food processor. [NAME] was observed to pour an unmeasured amount of milk obtained from a stainless-steel pan into the food processor. [NAME] visually checked the texture of the food and add thickener to the food processor from an unlabeled pitcher. [NAME] transferred the pureed pasta to a separate container and placed it in the steamtable for lunch meal service for residents. [NAME] stated she was not sure how much milk and thickener she added to the food processor during pureed preparation of the pasta because she did not measure the ingredients.During a concurrent observation and interview on 5/11/26 at 11:49 a.m. with Cook, in the presence of the RD, in the kitchen, [NAME] added milk to the remaining pureed pasta that was left in the food processor and then blended further. [NAME] stated she did not measure the additional amount of milk added to the food processor. [NAME] stated she was processing the pureed bread further for blenderized (liquid diet) diet orders and she just looked for the right consistency. During a review of the facility's recipe titled, Recipe: Pureed.Starch (Rice, Pasta, Polenta, Potatoes, etc.), dated 2025, the pureed recipe indicated, Serves 6: .Warm milk 6 to 12 oz [ounce] (3/4 to 1 1/2 cups), If needed: Stabilizer: instant potato, non-fat dry milk, breadcrumbs, toast, instant cream of rice or farina, or commercial instant food thickener, 0 to 6 Tbsp [Tablespoon]. Directions: 3. Gradually add warm milk. See above for recommended amounts of liquid, starting with the smaller amount and adding in more as needed to achieve the desired consistency. Add stabilizer to increase the density of the pureed food if needed. If using commercial food thickener, check the can for directions on usage, otherwise see above for recommended amounts of stabilizer. During an interview on 5/13/26 at 11:20 a.m. with RD, RD stated the [NAME] should have followed standardized recipes for all texture-modified foods and diet orders. During a review of the facility's Diet Type Report, dated 5/13/26, the report indicated, the following residents were on Diet Texture: Pureed, Resident 7, Resident 21, Resident 26, Resident 31, and Resident 56.During a review of the facility's Diet Type Report, dated 5/13/26, the report indicated the following residents were on Diet Texture: Blenderized, Resident 8 and Resident 49.During a review of the facility's policy and procedure (P&P) titled, Meal Planning, dated 2023, the P&P indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's orders and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the Facility Registered Dietitian prior to the beginning of each quarterly menu cycle. Menus are planned to consider:.Skills of the Food & Nutrition Services employees in preparing food.Procedures: 1. The facility's diet manual and the diets ordered by the (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	05/14/2026

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician should mirror the nutritional care provided by the facility.4. Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation.

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	05/14/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure one of 18 sampled residents (Resident 57) had accurate wound records due to unclear physician's order (PO). This failure resulted in Resident 57 having documentation that did not accurately represent the care provided.Findings:During a review of Resident 57's Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests the cognition is intact), dated 4/16/26 the BIMS indicated Resident 57's score was 13.During a review of Resident 57's Order Summary Report (OSR), dated 5/5/26, the OSR indicated, Cleanse abdominal wound with dakins [a diluted, hospital-grade [bleach] antiseptic used to clean wounds] quarter strength gauze, leave in place for 2 minutes, then remove gauze and apply black foam for wound vac [a medical device that uses controlled suction to speed up the healing of severe, large, or slow-to-heal wounds] -125mm/hg [millimeters of mercury] pressure, every shift every 3 day (s) for abdominal wound.During a concurrent interview and record review on 5/12/26 at 3:54 p.m. with Director of Nursing (DON), Resident 57's Treatment Administration Record (TAR), dated May 2026 was reviewed. The TAR indicated, Resident 57 had her wound vac changed on 5/6/26 and 5/9/26 with an initial sign off for each shift. DON stated the staff are only changing it once a day and it should be signed off once a day. The TAR should not have two staff signatures for each shift.During an interview on 5/13/26 at 11:18 a.m. with Physician 1, Physician 1 stated the wound vac is to be changed once every three days.During an interview on 5/13/26 at 12:40 p.m. with Resident 57, Resident 57 stated the staff only changes the wound vac once every three days.During a review of the facility's policy and procedure (P&P) titled, DOCUMENTATION ACCURACY IN THE HEALTH RECORD, dated November 2023, the P&P indicated, Clinical records should accurately reflect the care given by each member of the health care team.