STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555208	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Gardens Care Center	4525 W. Tulare Ave. Visalia, CA 93277

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37697 Based on interview and record review, the facility failed to revise and implement an appropriate plan of care for falls for one of three sampled residents (Resident 1). This failure had the potential to cause serious harm. Findings: During a concurrent interview and record review on 3/26/24 at 11:57 a.m. with Director of Nursing (DON), Resident 1 ' s Electronic Medical Record (EMR), was reviewed. The EMR indicated Resident 1 had a fall in which he hit his head on 3/16/24. Resident 1 was sent to the acute hospital and returned with an acute (new) to subacute (not new) fracture (break) of L3 (lumbar-area of the spine). DON stated Resident 1 had previous falls in the facility including a fall earlier in the month (no specific date given). DON stated Resident 1 can walk but is generally confused. During a review of Resident 1 ' s ADMISSION RECORD (AR), dated 3/26/24, the AR indicated Resident 1 diagnosis including Shortness of breath, Hypotension (low blood pressure), Abnormality (abnormal) of gait and walking, Unspecified Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), History of falling. During a review of Resident 1 ' s NURSING - FALL RISK OBSERVATION/ASSESSMENT (NFROA - an assessment tool for risk of falls), dated 1/24/24, the NFROA indicated Resident 1 had a score of 28 (high risk for falls). During a review of Resident 1 ' s Minimum Data Set (MDS- an assessment tool), under Brief Interview for Mental Status (BIMS - an assessment tool for cognition [the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses], dated 1/26/24, the BIMS indicated, Resident 1 had a score of 99 (unable to assess). During an interview on 3/26/24 at 12:18 p.m. with Resident 1, Resident 1 stated, My mind is really bad. Resident 1 stated he could not remember what year it was, where he currently was or the name of the facility, he was in. Resident 1 stated he remembered falling because, I [Resident 1] did something I was not supposed to. Resident 1 was not able to state what it is he did that he was not supposed to. Resident 1 stated he had gotten up from bed to get some clothes from his closet when he slipped and fell to the floor. Resident 1 stated, My head bounced on the floor three times. I had three big knots on my head. I don ' t remember much after that. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s MDS, under the section Functional Abilities and Goals (FAAG - an assessment tool to determine the amount of assistance a resident needs), dated 1/26/24, the FAAG indicated Resident 1 required partial moderate assistance from staff with rolling left to right, sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer. During an interview on 3/26/24, at 12:35 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to Resident 1 when he fell on [DATE]. LVN 1 stated Resident 1 is confused and had a history of falls. Resident 1 could not transfer himself out of bed. LVN 1 stated on 3/16/24, he was confused and got out of bed to try and put some pants on. LVN 1 stated Resident 1 hit his head on his roommate ' s bed. LVN 1 stated she heard a bang from Resident 1 ' s room and found him on the floor with two goose egg bumps on his head and a third bump behind his ear (no indication of what side). LVN 1 stated staff were always catching Resident 1 trying to get up on his own. LVN 1 stated before the fall on 3/16/24, He [Resident 1] would continuously get up on his own throughout the shift and we know this because he [Resident 1] would be in his wheelchair without his oxygen that we placed [on him]. During a review of Resident 1 ' s Progress Notes (PN), the PN indicated the following: a. On 1/25/24, the facility IDT (Interdisciplinary Team - a group of various professionals that meet to discuss resident issues) met regarding Resident 1 ' s fall on 1/24/24. The IDT indicated interventions for Resident 1 in the prevention of falls would be to have his bed in the lowest position, keep the call light within reach, and do visual checks (no indication of how often and for how long). b. On 2/14/24, the facility IDT met regarding Resident 1 ' s fall on 2/13/24. The IDT indicated interventions for Resident 1 in the prevention of falls would be to have his bed in the lowest position, keep the call light within reach, and do visual checks (no indication of how often and for how long). c. On 3/18/24, the facility IDT met regarding Resident 1 ' s fall on 3/16/24. The IDT indicated interventions for Resident 1 in the prevention of falls would be to have his bed in the lowest position, keep the call light within reach, and do visual checks (no indication of how often and for how long). During a concurrent interview and record review on 3/26/24 at 1:43 p.m. with DON, Resident 1 ' s Fall Care Plan (FCP), dated 1/5/24 was reviewed. DON reviewed the FCP and stated the only new intervention in place since 1/2024 for Resident 1 ' s falls is to have mattresses placed to each side of his bed on 3/18/24. DON stated the FCP should have been revised and what could have been done is Resident 1 could have been moved closer to the nurse ' s station so staff could keep a closer eye on him. DON stated the purpose of the IDT and creating care plans is to discuss a course of events and determine appropriate interventions for the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 3/2018, the P&P indicated, Based on previous evaluations and current data, staff may identify interventions related to the resident ' s specific risks and causes in the attempt to reduce falls and minimize complications from falling. Resident centered fall prevention plans should be reviewed and revised as appropriate. Fall-risk interventions should promote maximum resident freedom of movement and independence while balancing protecting the resident from falls.If the resident continues to fall, the situation should be reevaluated to determine whether it would be ap-propriate to continue or change current interventions.