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	06/11/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its own policy when an allegation of abuse for one of three sampled residents (Resident 1) was not reported to Ombudsman, law enforcement, and state licensing agency. This failure had the potential to put residents at risk for abuse. Findings: During a review of the admission Record (AR) dated 6/12/25, the AR indicated, Resident 1 was admitted on [DATE] with the following diagnoses.metabolic encephalopathy (brain dysfunction due to metabolic [chemical changes that take place in a cell or an organism] disorder).dementia (impairment of at least two brain functions, such as memory loss and judgement).hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (blood flow to the brain is blocked, causing brain tissue to die) affecting right dominant side. During a review of Resident 1's Cognitive Patterns (CP) dated 3/24/25, the CP indicated, Brief Interview for Mental Status (BIMS assesses cognitive status with scores ranging from 0 - 15, with the higher the score the more intact the resident's cognitive status is).08 (indicating moderate cognitive [mental process involved in knowing, learning, and understanding things] impairment) . During a review of Resident 1's Progress Notes (PN-written by Director of Staff Development [DSD]) dated 5/21/25 at 9:50 a.m., the PN indicated, Writer received complaint from staff member in regards to a possible altercation between CNA (Certified Nursing Assistant) and resident [1]. Resident [1] was interviewed by ADON (Assistant Director of Nursing) and DSD in regards [sic] the altercation. Resident stated it was just a playful banter (playful and friendly exchange of teasing remarks) and she is happy with the CNA and would still like the CNA to assist her. During an interview on 6/11/25 at 12:24 p.m. with Resident 1, Resident 1 stated approximately two to three weeks ago, CNA 1 was assigned to her. Resident 1 stated when she was on the phone with Family Member (FM) 1, CNA 1 was in the room and CNA 1 said something (unable to recall what was said) to her, and she (Resident 1) said something back and stuck her tongue out at CNA 1. CNA 1 then popped her with the back of her hand in the head and her head hit the side rail of the bed. (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 1:15 p.m. with DSD, DSD stated on 5/21/25 the IP (Infection Preventionist) reported that FM 1 had made an allegation of abuse towards CNA 1 saying she had bopped Resident 1 over the head while she was on the phone with her. DSD stated CNA 1 was suspended and the allegation was reported to the Administrator, Human Resources (HR) and Director of Nursing (DON). DSD stated an investigation was initiated by the ADON and HR. DSD stated she did not report the allegation to any outside entity (Ombudsman, law enforcement, state licensing agency). During an interview on 6/11/25 at 1:28 p.m. with IP, IP stated on 5/21/25 FM 1 reported that when she was on the phone with Resident 1, CNA 1 went into Resident 1's room and Resident 1 offered her some food. CNA 1 declined the food and Resident 1 said oh you are going to be a diabetic today and CNA 1 said yes, she did not want her sugar to go up. CNA 1 then walked over to do something, and Resident 1 said 'ow' and when FM 1 asked what happened Resident 1 said CNA 1 bopped her over the head. IP stated she reported the incident to the Administrator who immediately removed CNA 1 from resident care. IP stated the allegation was not reported to any outside agencies and the alleged incident should have been reported within two hours. During an interview on 6/11/25 at 1:54 p.m. with DON, DON stated on 5/21/25 it was reported to her that Resident 1 had stated CNA 1 had bopped her in the head. DON stated the allegation was not reported to any outside agencies and it should have been. During an interview on 6/11/25 at 4:08 p.m. with Family Member (FM) 1, FM 1 stated during a phone call with Resident 1 on approximately 5/17/25 or 5/18/25 she heard Resident 1 offer CNA 1 some cinnamon balls from Taco Bell and then say your going to be diabetic and then Resident 1 said 'ow'. FM 1 asked Resident 1 what happened, and Resident 1 said CNA 1 bopped her over the head with her hand. FM 1 stated she reported the allegation to the IP. FM 1 stated she had a meeting with the Administrator, DSD and another staff on 6/5/25 regarding the incident. FM 1 stated I think it could be abuse, think she was very unprofessional and crossed the line. During an interview on 6/19/25 at 11:43 a.m. with Administrator, Administrator stated on 5/21/25 the IP informed him that FM 1 reported that CNA 1 had bopped Resident 1 on her head. Administrator stated CNA 1 was removed from resident care and an investigation was completed. Administrator stated he was aware of the allegation, and the allegation was not reported to any outside agencies. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 2021, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies. the state licensing/certification agency responsible for surveying/licensing the facility.the local/state ombudsman.law enforcement officials.Immediately is defined as.within two hours of an allegation involving abuse or result in serious bodily injury or.within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the care plan for one of five sampled residents (Resident 4) when staff witnessed Resident 4 invading Resident 5's personal space looking angry and aggressive and did not intervene. This failure resulted in Resident 4 cussing at and hitting Resident 5 on the left leg. Findings: During a review of Resident 4's Care Plan (CP) dated 11/26/24, the CP indicated, Has episodes of being verbally abusive behaviors r/t (related to) poor impulse control.Interventions/Tasks.gentle redirection when applicable. During a review of Resident 4's Minimum Data Set (MDS - a standardized, comprehensive assessment tool to evaluate the status of residents) dated 4/8/25, the MDS indicated, BIMS (Brief Interview for Mental Status - used to assess knowledge, manipulation of information, and reasoning with score ranging from 0 - 15. The higher the score the more intact the resident's cognition is) Summary Score.09 (moderately impaired cognitive status) .Behavior Symptom - Presence & Frequency.Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others).1 (behavior of this type occurred 1 to 3 days).Impact on others.Significantly intrude on the privacy or activity of others.1.Significantly disrupt care of living environment.1. During a review of Resident 4's S (Situation) B (Background) A (Appearance) R (Review and Notify) dated 6/10/25 at 2 p.m., the SBAR indicated, Writer made aware by CNA's (Certified Nursing Assistant) that resident was being verbally & physically abusive towards roommate [Resident 5]. Writer made aware that resident was cussing, slapping her roommate's legs and throwing her belongings on the floor. During a review of Resident 5's Progress Notes (PN) dated 6/10/25 at 6:21 p.m., the PN indicated, Writer made aware by CNA's that resident's roommate [Resident 4] was being verbally & physically abusive towards them. Writer made aware that roommate was cussing, slapping the resident's legs, and throwing the resident's belongings on the floor. During a review of Resident 5's MDS assessment dated [DATE], the MDS indicated, BIMS (Brief Interview for Mental Status-used to assess knowledge, manipulation of information, and reasoning) Summary Score. 99 (resident was unable to complete the interview) . During an interview on 6/11/25 at 11:12 a.m. with CNA 1, CNA 1 stated on 6/10/25 she was providing care to a resident when CNA 2 came into the room and said Resident 4 was getting close to Resident 5 and something was going on in the room. CNA 1 stated when she arrived in Resident 4 and Resident 5's room, Resident 5 was laying in bed and Resident 5's blankets were on the floor and her flowers had been put in the trash can. Resident 4 was cussing at Resident 5 and hit her leg. CNA 4 stated Resident 5 was sleeping and hugging her baby doll. CNA 1 stated Resident 4 had acted like this before and she doesn't like Resident 5 laying in bed. CNA 1 stated Resident 4 is always yelling at Resident 5 to get out of the room and gets really upset. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 11:12 p.m. with CNA 2, CNA 2 stated on 6/10/25 as she was passing by Resident 4 and Resident 5's room, she witnessed Resident 4 in Resident 5's space looking aggressive and angry. CNA 2 stated she did not go near Resident 4 or Resident 5 but went to the next room and told CNA 1. During an interview on 6/11/25 at 2:08 p.m. with Director of Nursing (DON), DON stated when CNA 2 was walking by the room and seen Resident 4 in Resident 5's space she should have intervened right away and removed Resident 5 from a stressful situation. During a review of the facility's policy and procedure (P&P) titled, Behavior Management dated 12/31/15, the P&P indicated, It is the policy of this Center to make reasonable efforts to ensure when a resident displays mental or psychosocial adjustment difficulties, that he/she receives appropriate treatment and services to address the identified problem(s).Behavioral interventions are individualized non-pharmacological approaches (including direct care or activities) that are provided as part of a supportive physical or psychosocial environment directed toward preventing, modifying, and/or relieving a resident's distressed behavior.