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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555208 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/01/2025 |
| NAME OF PROVIDER OR SUPPLIER Westgate Gardens Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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) |
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| <p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>Based on interview and record review, the facility failed to follow their own policy and procedure for one of three sampled residents (Resident 1) when a gait belt was not used for a transfer. This failure resulted in Resident landing on her bed face down. Findings: During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 6/20/25, the MDS indicated, Functional Abilities.chair/bed-to-chair transfer. 03 (Partial/moderate assistance-helper does less than half the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. During a review of the Facility Reported Event (FRE) dated 6/24/25, the FRE indicated, Describe incident: During a transfer the resident expressed that the CNA (Certified Nursing Assistant) and LVN (Licensed Vocational Nurse) had a rough transfer. Full investigation was completed and CAN (sic) and LVN did not transfer the resident appropriately. During a review of Resident 1's Progress Notes (PN) dated 6/24/25 at 9:32 a.m., the PN indicated, Resi (Resident) told LN (Licensed Nurse) that around 03:30 AM today a LN (Licensed Vocational Nurse) & CNA were rude with her. Did not transfer her correctly due to which she landed from w/c (wheelchair) into her bed face down. During an interview on 7/1/25 at 3:22 p.m. with Social Services Director (SSD), SSD stated Resident 1 reported that during a transfer from her wheelchair to the bed she stumbled and fell on the bed. During an interview on 7/1/25 at 3:46 p.m. with Director of Staff Development (DSD), DSD stated when she interviewed CNA 1 regarding the transfer, CNA 1 reported she had transferred Resident 1 from her wheelchair to the bed and during the transfer Resident 1 was wobbly and had to be assisted to turn her hips and sit on the bed. DSD stated CNA 1 was not using a gait belt to transfer Resident 1 and performed an inappropriate transfer. During an interview on 7/1/25 at 4:04 p.m. with Director of Nursing (DON), DON stated when Resident 1 was being transferred a gait belt was not used and Resident 1 flopped on the bed. DON stated a gait belt should have been used per policy when transferring Resident 1. During a review of the facility's policy and procedure (P&P) titled Transfer Assistance undated, the P&P indicated, Transfer from wheelchair to the bed. Place the gait belt snugly around the resident's waist to allow for both of your hands to fit beneath the belt. Assist to raise the resident, slightly, then to a standing position. If you are unable to raise the resident to a standing position, call for a second person to assist. The second person may assist from the back, or with one person assisting on each side of the resident. Assist the resident first to a sitting position on the side of the bed then to a comfortable lying position and remove the gait belt. During a review of the facility's policy and procedure (P&P) titled Gait Belt Policy and Procedure undated, the P&P indicated, It is the policy to always use a gait belt with any resident that is not completely independent. If the resident is unsteady with their gait or unable to transfer them, a gait belt should always be used. There is no exception to this rule.</p> |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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