

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 08/05/2025
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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interview and record review, the facility failed to notify the Attending Physician (AP) for one of three sampled residents (Resident 1) when Resident 1's scheduled dialysis (a medical procedure that filters the blood of a person whose kidneys are not functioning properly) treatment was missed. This failure had the potential for fluid retention and adverse outcome. Findings:During a review of Resident 1's admission Record (AR), dated 7/2025, the AR indicated Resident 1 had a diagnosis of End Stage Renal Disease (irreversible kidney failure) . Resident 1's Order Summary Report (OSR), dated 7/2025 indicated, Hemo Dialysis thru LUE (Left Upper Extremity) at (dialysis center name) on T (Tuesday), TH (Thursday), SAT (Saturday) at 0400 AM till 0700 AM.During a review of Resident 1's Progress Notes (PN), dated 7/26/25 at 9:56 a.m., the PN indicated, . Dialysis. Resident (Resident 1) did note [sic] attend r/t (related to) transport did not come pick up resident.During a concurrent interview and record review on 8/5/25 at 1:34 pm. with Director of Nurses (DON), DON reviewed Resident 1's clinical records and confirmed Resident 1 did not go to his scheduled dialysis treatment on Saturday 7/26/25. DON stated, He (Resident 1) didn't attend that day.During an interview on 8/5/25 at 3:17 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 did not go to his scheduled dialysis treatment on Saturday 7/26/25. LVN 1 stated it was the facility practice to notify the AP of any missed dialysis treatment. LVN 1 stated she had reviewed Resident 1's clinical records and found no evidence of his AP being notified of the missed dialysis treatment on 7/26/25.During an interview on 8/5/25 at 3:47 p.m. with LVN 2, LVN 2 stated she did not notify Resident 1's AP of his missed scheduled dialysis treatment on Saturday 7/26/25. LVN 2 stated, I didn't know he (Resident 1) didn't get picked up at all. During an interview on 8/5/25 at 4 p.m. with Registered Nurse (RN), RN stated it was the facility practice to notify the residents AP of any missed dialysis treatment.During an interview on 8/7/25 at 9:08 a.m. with Director of Nurses (DON), DON stated the expectation was for the nurses to notify the AP for missed dialysis treatment. DON confirmed Resident 1's AP was not notified of the missed dialysis treatment.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/21, the P&P indicated, 1. The nurse will notify the resident's attending physician or physician on call when there has been a(an): a. accident or incident involving the resident; . A significant change of condition is a major decline or improvement in the resident's that: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self limiting); a. impacts more than one area of the resident's health status:</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.

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)		
<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>Based on interview and record review, the facility failed to ensure transportation was provided for one of three sampled residents (Resident 1). This failure resulted in Resident 1 missing hemodialysis treatment (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and potential for serious health risks and even death. Findings: During a review of Resident 1's admission Record (AR), dated 7/2025, the AR indicated Resident 1 had a diagnosis of End Stage Renal Disease (irreversible kidney failure). Resident 1's Order Summary Report (OSR), dated 7/2025 indicated, Hemo Dialysis thru LUE (Left Upper Extremity) at [dialysis center name] on T (Tuesday), TH (Thursday), SAT (Saturday) at 0400 AM till 0700 (AM). During a review of Resident 1's Progress Notes (PN), dated 7/26/25 at 9:56 a.m., the PN indicated, . Dialysis. Resident (Resident 1) did not [sic] attend r/t (related to) transport did not come pick up resident. During a concurrent interview and record review on 8/5/25 at 1:34 pm. with Director of Nurses (DON), DON reviewed Resident 1's clinical records and confirmed Resident 1 did not go to his scheduled dialysis treatment on Saturday 7/26/25. DON stated, He (Resident 1) didn't attend that day. During an interview on 8/5/25 at 3:17 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 was scheduled for dialysis every Tuesday, Thursday, and Saturday. LVN 1 stated transportation company was not notified when Resident 1 was not picked up for his scheduled dialysis treatment on Saturday 7/26/25. LVN 1 stated it was the facility practice to notify transportation to find out what happened. LVN 1 stated Resident 1 missed his scheduled dialysis treatment on Saturday 7/26/25. During an interview on 8/5/25 at 3:47 p.m. with LVN 2, LVN 2 stated she did not notify the transportation company when Resident 1 was not picked up for his scheduled dialysis treatment on Saturday 7/26/25. LVN 2 stated Resident 1 had missed his scheduled dialysis treatment on Saturday 7/26/25. LVN 2 stated, I didn't know he (Resident 1) didn't get picked up at all. During an interview on 8/7/25 at 9:08 a.m. with Director of Nurses (DON), DON stated the expectation was for the nurses to notify transportation company why they didn't pick up Resident 1 for his scheduled dialysis treatment. DON confirmed transportation company was not notified. During a review of the facility's policy and procedure (P&P) titled, Transportation, Social Services, dated 12/08, the P&P indicated, Our facility shall help arrange transportation for residents as needed.</p>		