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Form Approved OMB
No. 0938-0391

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	02/17/2026

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 0917 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. Based on interview and record review, the facility failed to provide a clean mattress for one of six sampled residents (Resident 1). This resulted in Resident 1 sleeping on a stained mattress and potential for skin irritation and respiratory issues.Findings:During an interview on 2/17/26 at 10:39 a.m. with Licensed Vocational Nurse (LVN), LVN stated on 2/8/26 Resident 1's Low Air Flow mattress (a therapeutic medical device) had a dark, brown circle stain. LVN stated the mattress stain did not look appealing. it should have been changed.During an interview on 2/17/26 at 11 a.m. with Director of Nurses (DON) and Director of Housekeeping (DOH), DON and DOH reviewed a photo of Resident 1's mattress taken on 2/8/26. DON and DOH confirmed Resident 1's mattress had a dark brown stain. DON and DOH stated the mattress should have been removed and replaced.During a review of the facility's policy and procedure (P&P) titled, Homelike Environment dated 2001, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

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