

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055604	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/03/2024
NAME OF PROVIDER OR SUPPLIER  Visalia Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1925 E. Houston Ave Visalia, CA 93292	

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38993</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was provided supervision when staff failed to respond to a security door alarm going off in the dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking) unit. This resulted in Resident 1 exiting the open security gate that provided access off of the facility grounds and being found approximately a quarter of a mile away from the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Plan of Care (POC), dated 8/22/22, the POC indicated, Elopement Care Plan. [Resident 1] is at risk for elopement/exiting seeking due to: altered cognitive status (dementia).date initiated: 8/22/22.interventions.monitor resident's whereabouts frequently.provide redirection to resident as needed.</p> <p>During a review of Resident 1's Admission Record (AR), dated 2/14/24, the AR indicated, admitted [DATE]. Diagnosis Information.Unspecified dementia, unspecified severity, without behavioral disturbance, psychotic (loss of reality) disturbance, mood disturbance, and anxiety (nervousness or unease).Altered mental status, unspecified, Bipolar Disorder (episodes of mood swings ranging from depressive lows to manic highs), unspecified.Schizophrenia (a serious mental condition of a type involving a breakdown in the relation between thought, emotion and behavior, leading to faulty perception, inappropriate actions and feelings, withdrawal from reality and personal relationships into fantasy and delusion, and a sense of metal fragmentation), unspecified.Nicotine Dependence, cigarettes, uncomplicated.wandering in diseases classified elsewhere.</p> <p>During a review of Resident 1's Elopement Risk Observation/Assessment (EROA), dated 1/10/24, the EROA indicated, Category: At risk for Elopement.Score: 10.The resident.is fully ambulatory.</p> <p>During a review of Resident 1's Cognitive Patterns (CP), dated 1/11/24, the CP indicated, BIMS (Brief Interview for Mental Status) Summary Score.02 (indicating severe cognitive impairment)</p> <p>During a review of Resident 1's Change in condition (COC), dated 2/13/24, the COC indicated, list the other change: Elopement.This started on: 2/13/24.resident has history of exit seeking.Primary Diagnosis. unspecified dementia).</p> <p>(continued on next page)</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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Notes (PN), dated 2/14/24, the PN indicated, Per nurses noted date 2/13/24 @ (at) 1950 (7:50 p.m.); writer starting med(medication)-pass when alarm starts to go off, CNA (Certified Nursing Assistant) goes to turn it off when they notice that the resident was nowhere to be seen. Last seen in hallway a [sic] approximately at 1920 (7:20 p.m.) after code [NAME] was called on the overhead, staff searching the facility grounds, administrator DON was notified of missing resident including responsible party and the local police department.received call from DON approximately at 1950 (7:50 p.m.) that resident was found and retrieved by administrator.Upon return tothe [sic] facility [Resident 1] stated he was going to the store to buy some cigarettes and weed.</p> <p>During an interview on 2/27/24 at 10:14 a.m., with Patio Aide (PA) 1, PA 1 stated, Resident 1 will try and leave the facility if he does not get to smoke when he wants to smoke. PA 1 stated cigarettes are left during the night with the nurse so Resident 1 can smoke during the night. PA 1 stated there is no patio aide available after 7 p.m. PA 1 stated there were two security door alarms on the dementia unit and both provide access to the parking lot. PA 1 stated when the security doors are pushed, the alarm will sound and then the doors open in about 12-15 seconds.</p> <p>During an interview on 2/27/24 at 10:28 a.m., with CNA 1, CNA 1 stated when Resident 1 does not get his way he will start exit seeking. CNA 1 stated the security gate alarms can be heard inside the unit and it was the responsibility of all staff to respond to the alarm when it is going off.</p> <p>During an interview on 2/27/24 at 10:32 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when Resident 1 did not get to smoke when he requested it, he gets mad and looks for ways out of the dementia unit. LVN 1 stated Resident 1 was fast and would open the security doors to go to the front of the facility when he was upset. LVN 1 stated Resident 1 was constantly pushing on the doors to go out. LVN 1 stated when the security door alarms go off, it was everyone's responsibility to respond. LVN 1 stated Resident 1 was not to be outside without supervision.</p> <p>During an interview on 3/12/24 at 2:34 p.m., with Administrator, Administrator stated on 2/13/24, she was notified by staff Resident 1 could not be located on facility grounds. As she was driving to the facility, she saw Resident 1 on the left side of the road approximately a quarter of a mile away from the facility. Administrator stated she approached Resident 1 and was able to get him in the car and return him to the facility. Administrator stated when she returned Resident 1 to the facility, the service gate entrance was open and that is where Resident 1 had left the facility. Administrator stated the service gate was not working at the time Resident 1 eloped. Administrator stated the service gate had a sensor that would open/close the gate, the sensor was not functioning due to a past accident. Administrator stated the service gate leads to a busy street in front of the facility, and it was normally kept closed for safety.</p> <p>During an interview on 3/12/24 at 3:13 p.m., with Maintenance Director (MD), MD stated at the time Resident 1 eloped from the facility, the service gate was not functioning, and it was unable to close. MD stated the service gate was normally closed for resident safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/12/24 at 9:19 p.m., with LVN 2, LVN 2 stated she was assigned to Resident 1 on the night he eloped. LVN 2 stated the security door alarm was ringing and ringing (unsure of length of time) and by the time someone went to go check on it, they (staff) realized Resident 1 had gotten further than the security doors. LVN 2 stated the back yard, and the parking lot were searched, a code [NAME] (alerts staff there is a missing resident) was called, police and administration were notified. LVN 2 stated during the search for Resident 1, it was noted the service gate had not been repaired and was left open. LVN 2 stated Resident 1 walked fast and was able to leave facility grounds through the service gate entrance. LVN 2 stated when Resident 1 requested a cigarette, prior to the security door alarm sounding, she was unable to give him the cigarette at that time and that is when he got upset and left the facility. LVN 2 stated when the security door alarms are sounding, the staff are expected to stop what they are doing and check to see why they are going off. LVN 2 stated when the alarm was sounding, she could not leave her medication cart unattended because at the time the medication cart could not be secured.</p> <p>During an interview on 3/12/24 at 9:36 p.m., with CNA 2, CNA 2 stated she was assigned to Resident 1 the night he eloped. CNA 2 stated she was providing care to another resident when the security alarms were sounding. CNA 2 stated it took her approximately two to three minutes to respond to the alarm because she was busy providing care to another resident. CNA 2 stated Resident 1 was already outside going to the back when she finished providing care to another resident. CNA 2 stated she looked everywhere for Resident 1 and was told the back gate (service gate) was open in the front of the facility. CNA 2 stated she came back into the facility to get a sweater and continued to search. CNA 2 stated Resident 1 only gets up out of bed when he wants a cigarette. CNA 2 stated Resident 1 walked fast and always tried to leave the facility when he did not get a cigarette. CNA 2 stated it was all the staff's responsibility to respond to the alarm.</p> <p>During an interview on 3/13/24 at 11:04 a.m., with Director of Nursing (DON), DON stated it was the expectation of the staff to respond to the security door alarms right away.</p> <p>During an interview on 3/16/24 at 9:57 p.m., with CNA 3, CNA 3 stated she was working on the night Resident 1 eloped. CNA 3 stated she was aware of the security alarm going off but was providing resident care. CNA 3 stated she thought someone else had gone after Resident 1. CNA 3 stated when the alarm goes off it means the resident was at the door and the door will open in a few seconds allowing the resident off the unit. CNA 3 stated when the security alarms go off staff are supposed to run to the door. CNA 3 stated Resident 1 would wake up in the middle of the night to smoke and when he did not get a cigarette, he would try to leave the facility. CNA 3 stated Resident 1 was not safe to leave the facility and Resident 1 was found outside the facility walking down the street, it was bad.</p> <p>During an interview on 3/16/24 at 10:07 p.m., with CNA 4, CNA 4 stated on the night of the elopement he was doing rounds and suddenly heard the security alarm going off. He then was told Resident 1 was missing. CNA 4 stated when he heard the alarm sounding he was far from the side of the unit where the alarm was sounding and he did not respond. CNA 4 stated when Resident 1 wanted a cigarette, he would attempt to leave the facility if he did not get it. CNA 4 stated the security alarm was going off for approximately a minute to a minute and a half. Resident 1 was too quick, and when looking for him they could no longer find him, because he had gone too far. CNA 4 stated when the security alarms go off everyone should respond.</p> <p>During an interview on 3/16/24 at 10:15 p.m., with CNA 5, CNA 5 stated when the security alarms go off staff are supposed to respond right away.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&amp;P) titled, Safety and Supervision of Residents dated 7/17, the P&amp;P indicated, Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision an assistive devices. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. The type and frequency of resident supervision may vary among residents and over time for the same resident. For example, resident supervision may need to be increased when there are temporary hazards in the environment (such as construction) or if there is a change in the resident's condition.</p>		