

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 05/08/2024
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 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>38993</p> <p>Based on interview and record review, the facility failed to notify the physician in a timely manner when one of three sampled resident's (Resident 1) continued to experience a change in condition. This failure resulted in a delay of care.</p> <p>Findings:</p> <p>During a review of Resident 1's ED [Emergency Department] Note Physician (EDNP), dated 2/2/24 at 4:02 p.m. the EDNP indicated, Chief Complaint.Abdominal pain.Final Diagnosis.Abdominal Pain.Nausea.Hx (history) of gastric bypass (weight loss surgery).small bowel obstruction (digested material is prevented from passing normally through the bowel).</p> <p>During a review of Resident 1's Progress Notes (PN), dated 1/31/24 at 3 p.m. the PN indicated, Resident had 2 episodes of emesis (vomiting) and meal refusal for breakfast and lunch. Resident complained of abd (abdominal) pain to left upper quadrant and mid abdomen. Placed call to [Physician 1] and gave new orders: Stat (immediately) CBC (complete blood count-measures many different parts and features of the blood) & CMP (comprehensive metabolic panel-provides important information about balance of chemicals in the body) & ammonia (produced in the body by the bacteria in the intestines, ammonia levels rise when the liver is not functioning properly). Also a stat (immediately or without delay) abdominal xray.Resident will be on monitor for emesis and abd (abdominal) pain.</p> <p>During a review of the Patient Report (PR), reported 1/31/24 at 6:03 p.m. the PR indicated, Impressions. There is an.air-filled and slightly dilated loop of large bowel which appears to represent the ascending (first section of colon) colon and hepatic (relating to the liver) flexure (bent or curved part) of undetermined significance. This may represent an adynamic ileus (functional motor paralysis of the digestive tract secondary to neuromuscular failure).</p> <p>During a review of Resident 1's PN, dated 1/31/24 at 11:55 p.m. the PN indicated, Text [Physician 1] abd. Xray report. Messaged [Physician 1] to call facility with any new orders.</p> <p>During a review of Resident 1's PN, dated 2/1/24 at 12:17 a.m. the PN indicated, Resident has had no episodes of vomiting tonight, was nauseated earlier and refused 2000 (8 p.m.) meds (medications). Taking fluids well. Pending abdominal xray. Labs in A.M. will f/u (follow up) with M.D. (Physician) when results available.</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 0580</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 PN, dated 2/2/24 at 1:35 a.m. (approximately 34 hours after onset of symptoms), the PN indicated, Resident has had 2 episodes of N/V (nausea and vomiting) tonight given Zofran (medication used to treat nausea and vomiting) and is effective for a short time and then res (resident) gets nausea again. Vomiting clear liquid, approx. (approximately) 1/2 cup. To have AM nurse f/u with [Physician 1] as this cont (continues).</p> <p>During a review of Resident 1's Weekly Summary (WS), dated 2/2/24 at 1:51 a.m. the WS indicated, Resident has had multiple episodes of N/V (nausea and vomiting). Has had abd (abdominal) xray. [Physician 1] received results on 2/1/24 waiting on any new orders. To have AM nurse f/u (follow up) today as N/V continues.</p> <p>During a review of Resident 1's PN, dated 2/2/24 at 3:10 p.m. (approximately 48 hours after onset of symptoms), the PN indicated, Resident continues to have episodes of N/V x3 today. [Physician 1] has been informed and awaiting for further orders.</p> <p>During a review of Resident 1's PN, dated 2/2/24 at 4:02 p.m. the PN indicated, Received new order from [Physician 1] to send resident out to rule out small obstruction.</p> <p>During a review of Resident 1's PN dated 2/2/24 at 11:45 pm. the PN indicated, Per RN (registered nurse), resident was still being evaluated but was most likely going to be admitted to hospital for bowel obstruction.</p> <p>During a concurrent interview and record review, on 5/7/24 at 3:39 p.m. with Director of Nursing (DON), DON reviewed Resident 1's PN's. DON stated when Resident 1 continued to have nausea on 2/2 at 1:35 a.m. and the medication was not working, the physician should have been notified.</p> <p>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, The nurse will notify the resident's attending physician when there has been a(an).need to alter the resident's medical treatment significantly. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>38993</p> <p>Based on interview and record review, the facility failed to ensure wound treatments were provided for one of three sampled residents (Resident 1). This failure had the potential for Resident 1's wounds to worsen.</p> <p>Findings:</p> <p>During a review of Resident 1's Treatment Administration Record (TAR), dated January 2024, the TAR indicated, Monitor right heel diabetic ulcer (serious complication caused by a combination of poor circulation, susceptibility to infection and nerve damage from high blood sugar levels) daily for 1. Pain/discomfort, 2. s/s (signs and symptoms) of infection. Every day shift.start date 1/12/24.Monitor right lower back stage 3 (full thickness tissue loss wound caused by pressure) daily for 1. Pain/discomfort, 2. s/s of infection. Every day shift.start date 1/12/24.Monitor sacrococcygeal (base of the spine near the tailbone) DTI (deep tissue injury) daily for 1. Pain/discomfort, 2. s/s of infection. Every day shift.start date 1/12/24.Right heel diabetic ulcer treatment: wipe with betadine swab. Every day.start date 1/11/24.Right lower back stage 3 treatment: Cleanse with N/S (normal saline), pat dry apply Collagen (structural protein found in skin and other connective tissues) fiber & medihoney manuka (medication used to treat wounds) pad and cover with dry dressing. Every day shift.start date 1/12/24.Sacrococcygeal DTI (deep tissue injury) treatment: Cleanse with N/S, pat dry, apply skin prep and cover with foam dressing, every day shift every Mon, Wed, Sat for DTI.start date 1.13/24.Apply heel/foot protectors to bilateral feet while in bed every shift for monitor placement.start date 1/23/24.Dycem in which to prevent resident from sliding off. Monitor placement. Every shift for prevent sliding.start date 1/13/24.LAL (low air loss) mattress. Set to resident's weight. Check to ensure proper placement and function. To promote skin integrity. Every shift for mattress check.start date 1/11/24. The TAR was blank (indicating the treatment was not done) on 1/13/24, 1/14/24, 1/15/24, 1/19/24, 1/22/24, 1/23/24, 1/24/24, 1/27/27.</p> <p>During a concurrent interview and record review on 5/29/24 at 3:59 p.m. with Assistant Director of Nursing (ADON), ADON reviewed the TAR dated 1/24. ADON stated confirmed the findings and stated when the treatment was completed, the nurse should have documented it on the TAR.</p> <p>During a review of the facility's policy and procedure (P&P) titled Wound care dated 10/10, the P&P indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record.The type of wound care given. the date and time the wound care was given.the name and title of the individual performing the wound care. the signature and title of the person recording the data.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38993</p> <p>Based on interview and record review, the facility failed to ensure bowel movement (BM) documentations were completed for one of three sampled residents (Resident 1). This failure resulted in incomplete documentation.</p> <p>Findings:</p> <p>During a concurrent interview and record review with Director of Nursing (DON), on 5/30/24 at 12 p.m. Resident 1's BM Report (BMR), undated, was reviewed. The BMR indicated, Resident 1 had no BM documentation on 1/15 and was incontinent of BM on 1/10, 1/11, 1/13, and 1/16. There was no consistency or size of BM documented on 1/10, 1/11, 1/13 and 1/16. DON stated the BM documentations were incomplete. DON stated the size and consistency of the BM should have been documented.</p> <p>During an interview on 5/7/24 at 12:30 p.m. with Director of Staff Development (DSD), DSD stated she was responsible for training the staff on how to document BM's. DSD stated the staff should have documented whether the resident was continent or incontinent, the consistency of the BM and the size.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Bowel Management Protocol dated 2/15/15, the P&P indicated, CNA's (Certified Nursing Assistant) to document the number of bowel movements and size of bowel movements on the resident flow record.</p>		