

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  05/16/2024
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>38993</p> <p>Based on observation, interview, and record review, the facility failed to provide a homelike environment for one of three sampled residents (Resident 1) when the bed linen was not in good repair. This failure resulted in Resident 1's bed sheet having a hole and two areas where the sheet was discolored due to the thinning of the sheet.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 5/16/24 at 12:15 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 1's room, Resident 1 had a hole at the bottom of her bed sheet and an area of discoloration caused by thin and tattered threads on the side of the bed sheet. CNA 1 stated the sheet was thinning and identified the hole at the bottom of the sheet.</p> <p>During a concurrent observation and interview on 5/16/24 at 1 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, Resident 1 had two areas on her bottom bed sheet that were thinning and discolored. LVN 1 stated the sheets were thin, and it was causing the discolored areas.</p> <p>During an interview on 5/29/24 at 12:29 p.m. with Director of Nursing (DON), DON stated when the bed sheets contained holes and were discolored, they should have not been used.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Bed, making an unoccupied dated 2/18, the P&amp;P indicated, The purpose of this procedure is to provide the resident who is able to get out of bed with a clean, comfortable bed. Protecting the resident's skin. Do not use torn linen.</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>38993</p> <p>Based on interview and record review, the facility failed to report an allegation of abuse for one of three sampled residents (Resident 1) when a Family Member (FM) 1 made Licensed Vocational Nurse (LVN) 1 aware of the allegation of abuse. This failure had the potential for delayed investigation and place other residents at risk for abuse.</p> <p>Findings:</p> <p>During an interview on 5/16/24 at 8:40 a.m. with FM 1, FM 1 stated over the weekend (approximately 4-5 days earlier), she reported to Licensed Vocational Nurse (LVN) 1 every time a male staff (unidentified) walked by Resident 1 would say he hits me.</p> <p>During an interview on 5/16/24 at 11:56 a.m. with LVN 1, LVN 1 stated When there is an allegation of abuse the allegation was to be reported (to the management) right away.</p> <p>During an interview on 5/16/24 at 1 p.m. with LVN 1, LVN 1 stated approximately two weeks ago, Resident 1's FM had reported to her Resident 1 seemed upset when a male staff would work with her. Resident 1 would say the male staff would hit her. LVN 1 stated she did not report the allegation.</p> <p>During an interview on 5/16/24 at 1:08 p.m. with LVN 2, LVN 2 stated when an allegation of abuse was reported, an SOC 341 (form used to report suspected dependent adult/elder abuse) was to be completed, social services, the police department, California Department of Public Health (CDPH) and the Ombudsman were to be notified immediately or as soon as possible.</p> <p>During an interview on 5/16/24 at 1:16 p.m. with Director of Nursing (DON), DON stated there was no allegations of abuse reported recently. DON stated when an allegation of abuse was made, the staff were expected to complete an SOC 341 right away and an abuse investigation was to be initiated.</p> <p>During an interview on 5/16/24 at 1:35 p.m. with Social Service Director (SSD), SSD stated she was not made aware of any allegation of abuse.</p> <p>During a concurrent interview and record review on 6/5/24 at 4:33 p.m. with DON, the facility's policy and procedure (P&amp;P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 9/22, the P&amp;P indicated, All reports of resident abuse are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. If resident abuse is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse. DON stated the staff member should have followed the facility policy and procedure and reported the allegation of abuse.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>38993</p> <p>Based on observation, interview, and record review, the facility failed to provide podiatry services for two of three sampled residents (Resident 1 and Resident 2). This failure resulted in Resident 1 and Resident 2 having long, jagged, discolored toenails.</p> <p>Findings:</p> <p>a. During an observation on 5/16/24 at 12:03 p.m. in the hallway, Resident 2 was walking in the hallway with opened toe sandals. Resident 2's toenails were long and discolored.</p> <p>During a review of Resident 2's Order Summary Report (OSR) dated 5/20/24, the OSR indicated, Consult - Podiatry as needed for Mycotic (disease caused by a fungus)/Hypertrophic (alteration of shape, partial loss, or absence of the nail) nails and/or keratotic (patches or lesions on the outer layer of the skin) lesions.order date 2/13/23.</p> <p>During a concurrent interview and record review on 5/16/24 at 2:21 p.m. with Director of Nursing (DON), DON reviewed Resident 2's clinical record and was unable to provide evidence Resident 2 had received podiatry care. DON stated the facility staff does not provide toenail care and relies on the podiatrist.</p> <p>b. During a review of Resident 1's Podiatry Progress Note (PN) dated 8/19/23 (approximately 9 months prior), the PN indicated, Follow up.2 months.</p> <p>During a review of Resident 1's Shower Sheets (SS) dated 4/5/24, 4/23/24, 4/30/24, 5/3/24, 5/10/24, the SS indicated, Toe Nails.Needs Clipping.Yes.</p> <p>During an observation and interview on 5/16/24 at 12:15 p.m. with Certified Nursing Assistant (CNA) 1 in Resident 1's room, Resident 1 was lying on the bed. Resident 1 had long toenails, some with jagged edges and there were debris under them. CNA 1 stated CNAs were not allowed to trim the resident's toenails.</p> <p>During an interview on 5/16/24 at 12:38 p.m. with LVN 1, LVN 1 stated podiatry services were responsible for resident toenails and Resident 1 needed to be seen by podiatry.</p> <p>During an interview on 5/16/24 at 1:35 p.m. with Social Service Director (SSD), SSD stated nursing staff was responsible to report to social services when residents needed podiatry services. SSD stated Resident 1 was last seen by podiatry in August 2023.</p> <p>During an interview on 5/21/24 at 9:39 a.m. with DON, DON stated when he observed Resident 1 and Resident 2's feet both residents had long toenails and they didn't look good. DON stated both residents needed podiatry services.</p> <p>(continued on next page)</p>		

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F 0687  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Foot Care dated 10/22, the P&P indicated, Residents are provided with foot care and treatment. overall foot care includes the care and treatment of medical conditions to prevent foot complications. Residents are assisted in making appointments and with transportation to and from specialists (podiatrist.) as needed.		