

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  10/02/2024
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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>34401</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1) call light was within Resident 1's easy reach. This failure had the potential for Resident 1 to not received assistance when needed.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 10/2/24, at 12:10 p.m. in Resident 1's room, Resident 1's call light (a communication device used to alert staff for assistance) was noted on the floor not within Resident 1's reach. Resident 1 stated he uses the call light to call for staff assistance. Resident 1 started looking for his call light, using his hands to feel under his back, bottom area, above head, and on the bed side rails. Resident 1 was unable to locate his call light. Resident 1 stated, Oh well, it's not here.</p> <p>During a concurrent observation and interview on 10/2/24, at 12:17 p.m. with Certified Nursing Assistant (CNA 1), in Resident 1's room, CNA 1 confirmed Resident 1's call light was on the floor not within Resident 1's reach. CNA 1 stated Resident 1's call light should always be within reach.</p> <p>During an interview with on 10/2/24, at 12:36 p.m. with Licensed Vocational Nurse (LVN), LVN stated Resident 1 were able to use the call light for assistance if the call light was within his reach. LVN stated Resident 1's call light should always be near him and within reach.</p> <p>During an interview on 10/2/24, at 1:16 p.m. with CNA 2, CNA 2 stated she had laid Resident 2 back to bed after being up in his wheelchair. CNA 2 stated she had forgot to ensure Resident 1's call light was near him and within reach. CNA 2 stated the call light should always be within reach.</p> <p>During an interview on 10/2/24, at 1:22 p.m. with Director of Nurses (DON), DON stated call light should be placed within reach.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Call System, Residents, dated 9/22, the P&amp;P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation.</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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