STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055604	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Visalia Post Acute	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to assess, notify the physician and treat a change of condition for one of three sampled residents (Resident 1) when Resident 1's left foot 2nd toe was swollen, had drainage coming from it and dry crusty debris covering the top of the toe and the nail bed. These failures resulted in a delay of care and the potential for Resident 1's foot to worsen. Findings:During a concurrent observation and interview on 8/14/25 at 10:49 a.m. with Resident 1 in Resident 1's room, Resident 1 was lying on bed with her feet exposed. Resident 1's left foot appeared swollen, there were debris between the toes, a circular dried scab/skin on the inside of the foot, and the second toenail bed and top of the toe was covered with a lumpy and bumpy debris (cauliflower in appearance) that was dry, yellow, and crusty in appearance.During a review of Resident 1's Shower/Bed Bath Sheet (SBBS) dated 8/7/25 (7 days prior to the observation), the SBBS indicated, CNA: identify any skin issues.healing scab on left foot (top).Licensed Nurse: Review information and take follow-up action as indicated.Is this a new skin issue or change.Yes.No.(there was no documented response by the licensed nurse) .Follow-up action: (no documented response by licensed nurse) .(signed by LVN 2).During a concurrent observation and interview on 8/14/25 at 11:20 a.m. with Licensed Vocational Nurse (LVN) 1 and Resident 1, in Resident 1's room, LVN 1 donned gloves and began evaluating Resident 1's left foot. LVN 1 stated Resident 1's 2nd toe was swollen, dry, had drainage coming from it and looked infected. LVN 1 began cleaning and removing the debris from Resident 1's left toes. While cleaning the debris from the toes the base of the wound opened at the bottom of the 2nd and 3rd toes and LVN 1 was able to remove the debris that were covering the nail bed and top of the 2nd toe. When the debris were removed from the 2nd toe, the nail bed area was white and soft. The 2nd toe had no nail. LVN 1 stated there were no current treatments being administered to the left foot.During an interview on 8/14/25 at 11:53 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 1 had a history of injuring her left foot during a transfer. CNA 1 stated initially the injury was red and the skin was torn back. CNA 1 stated the 2nd toe had looked like a cauliflower since the initial injury. During a concurrent interview and record review, on 9/3/25 at 12:14 p.m. with LVN 2, LVN 2 stated when there was a skin issue identified on a SBBS and there was no ongoing treatment to the area a change of condition should have been done. LVN 2 stated there was no change of condition done on 8/7/25 when the healing scab on the left foot was identified because there was ongoing treatment to the area. LVN 2 reviewed the clinical record and was unable to provide evidence of any ongoing treatment or monitoring to the left foot on 8/7/25.During an interview on 9/3/25 at 10:44 a.m. with Director of Nursing (DON), DON stated when staff were aware of Resident 1's left foot skin issues there should have been a change of condition completed, the physician should have been notified, and any new orders should have been implemented.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status dated 2/2021, the P&P indicated, The nurse will notify the resident's attending physician or physician on call when there has been a(an): significant change in the resident's physical/emotional/mental condition.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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, the facility failed to reevaluate wounds when the treatment orders were ending for one of three sampled residents (Resident 1). This failure had the potential to result in worsening of Resident 1's wounds and going untreated.Findings:During a review of Resident 1's Progress Notes (PN) dated 6/25/25 at 4 p.m. the PN indicated, Resident is sitting up in w/c (wheelchair) just arrived from (hospital name) appointment.skin assessment done, noted to have dry blood on the left foot sock, removed sock to left foot 2nd toe left toe noted nail is not intact and 2nd toe is bleeding, left 2nd toe nail was smashed, and nail is off from nail bed, notify MD (doctor of medicine).cleanse with NS (normal saline), pat dry apply bacitracin (antibiotic ointment) very (sic) shift, leave open to air. Cleanse skin tr=ear (sic) to left lateral (side of the body part) foot, pat dry, apply bacitracin every shift, monitor for infection and worsening shift x14 days, follow up with wound Dr.During a review of Resident 1's Treatment Administration Record (TAR) dated 7/2025, the TAR indicated the last day of treatment and monitoring to the left foot 2nd toe and left lateral foot was 7/6/25 on day shift.During an interview on 8/14/25 at 1:14 p.m. with Treatment Nurse (TN) 1, TN 1 stated when the treatment order ended on 7/6/25, the wounds should have been reevaluated to see if treatment should continue or be discontinued. TN 1 stated there should be progress notes documented when the reevaluation was completed. TN 1 was unable to provide documentation of the wounds being re-evaluated. During a concurrent interview and record review, on 9/3/25 at 10:44 a.m. with Director of Nursing (DON), DON stated when treatment orders were ending the wounds being treated were to be reevaluated and a progress note was to be completed indicating whether the wound treatment needed to be continued or if the wound had resolved. DON was unable to provide documentation of the wound being reevaluated. Policy requested and none provided.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on interview and record review, the facility failed to follow physician orders when there was no referral to the wound care doctor and treatment was not provided to one of three sampled residents (Resident 1) when it was ordered by the podiatrist. This failure resulted in Resident 1's wound going untreated and had the potential for Resident 1's wound to worsen. Findings:During a review of Resident 1's Podiatry Evaluation (PE) dated 6/2/25, the PE indicated, Wound of foot.The patient presently has a wound of the lower extremities. A dressing was applied today. Nursing was notified of the presence of the wound. Will defer wound management to the wound care MD (Doctor of Medicine). If recommendations for wound care are requested from a podiatry standpoint please reconsult specifically for that reason.wound x1 noted to left dorsal (back part of the body part) forefoot measuring 3x3 cm (centimeters-a unit of measurement).During a concurrent interview and record review, on 9/3/25 at 11:11 a.m. with Treatment Nurse (TN) 1, Resident 1's clinical record was reviewed. TN 1 was unable to provide documentation of Resident 1 being referred to the wound doctor. TN 1 stated when the nurse was made aware of the wound, the nurse should have completed a change of condition and notified the MD. TN 1 stated Resident 1 should have been referred to the wound doctor when the podiatrist ordered it.During a concurrent interview and record review, on 9/3/25 at 10:44 a. m. with Director of Nursing (DON), Resident 1's clinical record was reviewed. DON stated he was unable to provide evidence of Resident 1 being referred to the wound doctor as ordered by the podiatrist. 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 in accordance with professional standards of practice. Overall foot care includes the care and treatment of medical conditions to prevent foot complications from these conditions.