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	05/04/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 2) needs were met when the bed was not long enough. This failure resulted in Resident 2 being uncomfortable due to not being able to extend his legs while in bed. Findings:During a concurrent observation and interview on 5/4/26 at 11:03 a.m. with Resident 2, in Resident 2's room, Resident 2 was lying on the bed. Resident 2's head of bed was elevated, his knees were bent and his feet were flat against the foot board of the bed. Resident 2 stated he slept squished up and with his knees bent because the bed was not long enough and he was uncomfortable. Resident 2 stated he had told several staff that the bed was too short but was told the facility did not have longer beds.During a concurrent observation and interview on 5/4/26 at 1:15 p.m. with Assistant Director of Nursing (ADON), in Resident 2's room, ADON stated she could see where the bed needed to be longer for Resident 2.During an interview on 5/4/26 at 1:38 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated when she cared for Resident 2, when he was first admitted (3/15/26), Resident 2 told her that his feet were always hitting the bottom of the bed. CNA 1 stated when Resident 2 told her that she should have put it in the maintenance log or told the nurse. CNA 1 stated she thought the issue would have been resolved by now.During a concurrent interview and record review, on 5/4/26 at 1:54 p.m. with Maintenance (MT), station 2's maintenance logs dated March and April 2026 were reviewed. There was no documentation of Resident 2's bed being too short on the log. MT stated he was unaware of Resident 1's bed being too short.During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs dated 3/21, the P&P indicated, The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis.In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility.providing a variety of types.sizes (height and depth), and firmness of furniture in rooms and common areas.

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

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	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Visalia Post Acute	1925 E. Houston Ave Visalia, CA 93292

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure their policy and procedure was followed when medications were left at the bedside for one of three sampled residents (Resident 1). This failure had the potential for the staff to be unaware if the medication was taken by Resident 1and put other residents at risk for ingesting the medication and experiencing an adverse reaction.Findings:During a concurrent observation and interview on 5/4/26 at 10:12 a.m. with Resident 1, in Resident 1's room, Resident 1 was sitting at the end of her bed in her wheelchair with the over bed table next to her. There was a medicine cup on the over bed table that contained six pills. Resident 1 stated the nurse left the medications on her table so she could take them after she ate her breakfast. During a concurrent observation and interview on 5/4/26 at 10:36 a.m. with Registered Nurse (RN) 1, in Resident 1's room, RN 1 confirmed she was the nurse for Resident 1. RN 1 stated she left the medications on the table for Resident 1 because Resident 1 wanted to take her medications after she ate her breakfast. RN 1 stated the medicine cup contained atenolol (medications used to treat high blood pressure), cranberry capsule (supplement used to promote urinary health), iron tablet (supplement used to treat low blood count), stool softener (used to make stool easier to pass), Vitamin C (supplement), and magnesium (supplement). RN 1 stated the medications should not have been left on the table.During an interview on 5/4/26 at 12:33 p.m. with Assistant Director of Nursing (ADON), ADON stated Resident 1 did not have an assessment for self-administration of medications and the medications should not have been left on Resident 1's table.During a review of the facility's policy and procedure (P&P) titled, Administering Oral Medications dated 10/10, the P&P indicated, Remain with the resident until all medications have been taken.