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	05/21/2026

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 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 observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) had a physician's order for the use of side rails (a safety device or structural support installed on beds, to prevent fall, assist with repositioning, and provide stability when getting in and out of bed). This failure had the potential for inappropriate use of side rails and potential for injury.Findings:During an observation on 5/4/26 at 9:58 a.m. in Resident 1's room, Resident 1 was lying in bed with side rails positioned up on both sides at the head of the bed.During a concurrent interview and record review on 5/4/26 at 11:57 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's Order Summary Report (OSR), dated 5/4/26 was reviewed. LVN 1 was not able to find a physician order for Resident 1's side rails. LVN 1 stated Resident 1's side rails should have a physician's order. During an interview on 5/4/26 at 12:05 p.m. with Director of Nursing (DON), DON stated side rails need a physician's order.During a review with of the facility's policy and procedure (P&P) titled, Bed Safety and bed Rails dated August 20, 2022, the P&P indicated, 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of be rails. The interdisciplinary evaluation includes d. consultation with the attending physician.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its own policy and procedure (P&P) titled, Safety and Supervision of Residents for one of two sampled residents (Resident 1) when Resident 1 was outside the patio area without supervision. This failure resulted in Resident 1 having unwitnessed fall, sustaining a fracture (broken bone) to the right humerus (long bone of the upper arm).FindingsDuring a review of Resident 1's admission Record (AR), dated [DATE], the AR indicated, Resident 1 is [AGE] years old, was admitted on [DATE] with diagnoses of muscle weakness, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), unsteadiness on feet, difficulty in walking, dizziness, and history of falling.During a review of Resident 1's quarterly Minimum Data Set (MDS-a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 1 had a BIMS (Brief Interview for Metal Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 (0-7 severely impaired [decline in one or more mental abilities that affects a person's daily functioning]). During a review of Resident 1's Fall Risk Observation/Assessment (FROA-an assessment tool used to identify the likelihood of falling) dated [DATE], the FROA indicated, Score 18 [score of 16-42 means high risk for falls].During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated, Resident 1 was at risk for falls.During a review of Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated [DATE], the SBAR indicated, resident (Resident 1) found laying [sic] face down on pavement, responsive, noted to scattered abrasion underneath chin with controlled bleeding, c/o (complaint of) loss of sensation to RUE (right upper extremity) note to arm in free hanging motion unable to lift extremity.During a review of Resident 1's hospital right shoulder x-ray (medical imaging technique that uses radiation to create a picture of the inside of the body) report dated [DATE], the x-ray result indicated Resident 1 had a comminuted (bone is broken or shattered into three or more pieces) displaced (moved out of its normal alignment) proximal (close to) humeral (long bone in the upper arm) fracture (broken bone).During a review of the facility Follow Up Report dated [DATE], the report indicated, Resident 1 had an unwitnessed fall on the outside patio area.later received from (hospital name) who reported imaging (x-ray) of the right upper extremity showed. fracture to the upper humerus.During an observation on [DATE] at 10:13 a.m. in Resident 1's room, Resident 1 was sitting on the side of the bed. Resident 1's right arm was swollen and purple, wrapped in a sling (medical device to protect and keep arm from moving). During an interview on [DATE] at 10:22 a.m. with Patio Aide (PA) 1, PA 1 stated, it was his responsibility to keep an eye and supervise all residents while outside in the patio area. PA 1 stated, on [DATE] his shift ended at 7 p.m. and left the patio area at 6:48 p.m. PA 1 stated he was not aware Resident 1 was still outside the patio area unsupervised. During an interview on [DATE] at 10:36 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated all residents require supervision when outside the patio area. LVN 1 stated no residents, including Resident 1, were allowed to go outside the patio area when there was no patio aide present. During an interview on [DATE] at 10:55 a.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 was not ok to be outside the patio area without supervision. During an interview on [DATE] at 1:24 p.m. with Director of Nursing (DON), DON stated Resident 1 had an unwitnessed fall outside the patio area on [DATE]. DON stated there were no staff present outside the patio area when Resident 1 fell on [DATE] at 6:48 p.m. During an interview on [DATE] at 1:47 p.m. with Administrator, Administrator stated, patio aide's shift was over at 7:00 p.m. and should remain in the patio area until end of shift. Administrator stated residents, including Resident 1, should not be outside the patio area (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	unsupervised. During an interview on [DATE] at 2:01 p.m. with Activities Director (AD), AD stated, PA's responsibilities are to keep residents safe and prevent falls. AD stated, patio area is open until 7:00 p.m. and PA's end of shift is 7:00 p.m. AD stated, I know they (PA) leave early sometimes and they're not supposed to. During a review of the facility's patio aide job description titled, Patio Aide-Memory Lane (PAML) undated, the PAML indicated, Monitor/Assist residents in patio area.During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents dated 7/2017, the P&P indicated, Individualized, Resident-Centered Approach to Safety 3. The care team shall target interventions to reduce individual risk related to hazards in the environment, including adequate supervision. Systems Approach to Safety 2. Resident supervision is a core component of the systems approach to safety.