

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 03/06/2026
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)		
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an effective grievance process for three of 33 sampled Residents (Residents 122, 66, and 120), when: 1. Resident 122 was not aware of the facility's response to her grievance related to visiting her friend in the facility and expressed she continued to have issues visiting her friend. 2. Resident 66 reported missing clothes to Social Services Assistant (SSA) six months ago and no action was taken. 3. Resident 120 requested assistance from SSA regarding scheduling surgery since admission. These failures had the potential to result in violation of resident's right to voice grievances, feel unheard and/or feel unsupported, and the lack of a functional grievance process left residents' concerns unaddressed. Findings: 1. Resident 122 was admitted on [DATE], with diagnoses which included weakness and unsteadiness on feet. During an interview with Resident 122 on 3/5/26 at 8:14 AM, Resident 122 stated she had an issue with staff and filed a grievance. Resident 122 stated she wanted to visit her friend who lived at the facility and a staff member would not allow her to visit her friend's room. Resident 122 was asked if they have heard anything back about her issue and stated, I never heard anything else about it. Resident 122 further stated, They are keeping me from [friend]. I have to visit her when I see her in the dining room. Resident stated she is still not able to visit her friend in her friend's room. During an interview with the Social Services Assistant (SSA) on 3/5/26 at 4 PM, SSA stated Resident 122 reported a staff member would not allow her to enter her friend's room. SSA stated, We spoke with the staff and then informed the resident, she was ok with the outcome. During an interview with Social Services Director (SSD) on 3/5/26 at 4 PM, SSD stated We did not give Resident 122 anything in writing. SSD further stated she was unaware a written response was required. During a record review of grievances log on 3/4/26 at 12 PM, the log indicated Resident 122 reported a grievance on 1/12/26. There was no documentation which indicated Resident 122 received a written response to her grievance including what the grievance was about, the actions taken by the facility, a conclusion, the remedies the facility took to resolve, or the date a written response was sent to resident or responsible party. During a review of the facility policy titled, Grievances/Complaints, Filing revised April 2017, the policy indicated, The resident, or the person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. A written summary of the investigation will also be provided to the resident, and a copy will be filed in the business office. 2. During a review of Resident 66's admission Record (AR) from 5/2/25 shows that Resident 66 was first admitted to the facility on [DATE] and then re-admitted on [DATE]. During a review of Resident 66's Quarterly MDS/CAA (Minimum Data Set/Care Area Assessment: a comprehensive and mandatory nursing home assessment process utilized to evaluate a resident's functional, medical, and psychosocial status) dated 1/22/26, indicated that the Brief Interview for Mental Status (BIMS: a standardized 15-point screening tool primarily used to assess cognitive function) for Resident 66 was scored at 15. During an interview on 3/5/26 at 2:58 PM with Resident 66, Resident 66 stated he spoke to Social Services Assistant (SSA) half a dozen times regarding missing clothes for six months. (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 66 also stated he spoke with SSA last week and asked to get his belonging inventory list, but request was not fulfilled. During an interview on 3/5/26 at 3:04 PM with Housekeeping Director (HD), HD stated when a resident complains of missing clothes, she asks social services or nurses for the copy of the belongings inventory or description of the clothes so she can start looking. HD also stated she recalled Resident 66 reporting multiple times about missing clothes within the last four months. During a review of Resident Grievance/Complaint Log, dated March 2025 to March 2026, the grievance log did not indicate Resident 66's complaint about missing clothes. During an interview on 3/5/26 at 4:09 PM with SSA, SSA stated Resident 66 informed her about six weeks ago regarding missing clothes. SSA stated she provided the belongings inventory to HD and they found the clothes. SSA stated she should have written down the complaints about Resident 66's missing clothes in the Grievance Log even though the clothes were found. SSA also stated residents do not receive a written record of the result of the investigation of the grievances. During an interview on 3/5/26 at 4:01 PM with Social Services Director (SSD), SSD stated staff usually notify Social Services Department if there were any grievance reported to them by the residents. SSD reported receiving only three grievances from March 2025 to March 2026. They log complaints as grievances only when residents label them as such; other complaints are addressed immediately but not recorded in the grievance log. During a review of the facility policy and procedure (P&P) titled, Grievances/Complaints, Filing dated April 2017, the P&P indicated, Residents . have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident. 1. Any resident . may file a grievance or complaint concerning care, treatment . staff members, theft of property, or any other concerns regarding his or her stay at the facility. 2. Residents . have the right to voice or file grievances. 3. All grievances, complaints or recommendations stemming from resident . concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. 7. The administrator has delegated the responsibility of grievance and/or complaint investigation to the grievance officer who is Social Services Department. 8. Upon receipt of a grievance and/or complaint, the grievance officer will review and investigate the allegations and submit a written report of such findings to the administrator withing five (5) working days of receiving the grievance and/or complaint. 3. During a review of Resident 120's admission Record, from 10/22/24 shows that Resident 120 was first admitted to the facility on [DATE] and then re-admitted on [DATE] with diagnosis including spinal stenosis (narrowing of the spinal canal) of the neck and upper back area. During a review of Resident 120's Quarterly MDS/CAA: (a comprehensive and mandatory nursing home assessment process utilized to evaluate a resident's functional, medical, and psychosocial status) dated 2/12/26, indicated that the Brief Interview for Mental Status (BIMS: a standardized 15-point screening tool primarily used to assess cognitive function) for Resident 120 was scored at 15. During an interview on 3/5/26 at 3:38 PM with Resident 120, Resident 120 stated she spoke with Social Services Assistant (SSA) about getting assistance with scheduling neck surgery since she was admitted on [DATE]. Resident 120 also stated the surgery was not something she could schedule herself and asked the assistance from Social Services Department multiple times but gave up asking because social services did not follow through.		

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on interview and record review, the facility failed to ensure the Social Services Director and Social Services Assistant met the qualification requirements as stipulated by the regulation. This failure had the potential to result in misidentification or mishandling of residents' cases which can lead to poor interventions and lack of support for all residents. Findings: During an interview on 3/4/26 at 2:37 PM with Social Services Director (SSD), SSD stated she had 15 years of social service experience but no degree, just high school diploma. SSD stated she worked full time and oversees the facility's social services department. During a concurrent interview and record review on 3/5/26 at 11:09 AM with the Director of Staff Development (DSD), SSD's Employee File was reviewed. The file indicated SSD has a high school diploma. DSD stated SSD had a performance evaluation completed by the Facility Administrator on 6/2/25. During a concurrent interview and record review on 3/5/26 at 11:03 AM with the Human Resources Director (HRD), SSD's Position History was reviewed. The history indicated SSD started the social services director role on 6/6/11. HRD stated that SSD had not held any other positions since then. During a review of Job Description: Social Services Director, dated February 2024, the job description indicated, Qualification Education and/or Experience Bachelor's Degree in Social Work or in Human Services and 2 years of supervised social work experience. MSW's (Master's of Social Work) preferred. During an interview on 3/4/26 at 2:39 PM with Social Services Assistant (SSA), SSA stated she had no degree, just a high school diploma. SSA stated she started as full-time SSA around 2023. During a concurrent interview and record review on 3/5/26 at 10:56 AM with the DSD, SSA's Employee File was reviewed. The file indicated SSA had a high school diploma. DSD stated SSA was originally hired at the facility on 3/8/17 for a different position. During a concurrent interview and record review on 3/5/26 at 11:03 AM with the HRD, SSA's Position History was reviewed. The history indicated SSA started the social services assistant role on 10/15/23. During a review of Job Description: Social Services Assistant, dated November 2016, the job description indicated, Qualification Education and/or Experience Bachelor's Degree in Social Work or related major and 1 year of supervised social work experience. During an interview on 3/4/26 at 2:49 PM with the Facility Administrator, the administrator stated she was aware of the requirements of social services to have a minimum of bachelor's degree in social services or related field. The administrator stated that neither the SSD nor the SSA had a bachelor's degree. During a review of Facility Assessment Tool, dated June 2025 through December 2025, the tool indicated, Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Social Services Department - Social Services Director and Assistant (Discharge Planning, Grievances, and Psychosocial needs). Education Required for the position. Social Services Director: The individual must have a bachelor's degree in social work or other related field from an accredited school with experience in SNF's.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program (the facility's program for identifying problems and improving resident care) addressed concerns related to social services staffing qualifications, including the lack of a qualified Social Services Director (SSD) and Social Services Assistant (SSA), as part of the facility's ongoing assessment and performance improvement activities. The QAPI program failed to identify and address this concern. This failure had the potential to limit the facility's ability to identify and address systemic issues (problems that affect more than one resident or area of the facility) related to psychosocial services (services that support residents' emotional and social needs), discharge planning, and resident support services, potentially impacting the quality of care and services provided to residents. During an interview on 3/4/26 at 2:39 PM with Social Services Assistant (SSA), SSA stated she had no degree, just a high school diploma. SSA stated she started as full-time SSA around 2023. During a concurrent interview and record review on 3/5/26 at 10:56 AM with the DSD, SSA's Employee File was reviewed. The file indicated SSA had a high school diploma. DSD stated SSA was originally hired at the facility on 3/8/17 for a different position. During a concurrent interview and record review on 3/5/26 at 11:03 AM with the Human Resources Director (HRD), SSA's Position History was reviewed. The history indicated SSA started the social services assistant role on 10/15/23. During an interview on 3/4/26 at 2:49 PM with the Facility Administrator (Adm), the Adm stated she was aware of the requirements of social services to have a minimum of bachelor's degree in social services or related field. During a review of Job Description: Social Services Assistant, dated November 2016, the job description indicated, Qualification Education and/or Experience bachelor's degree in social work or related major and 1 year of supervised social work experience. During a record review of the facility document titled Quality Assurance Performance Improvement Plan the plan indicated, .QAPI is integrated into the responsibilities and accountability of all facility leadership. However, the issue of the SSD and SSA not meeting the regulatory required qualifications had not been identified or addressed through the facility's QAPI program. During an interview on 03/06/26 at 9:15 AM with the Adm, the Adm was asked whether the issue of the Social Services Director and the Social Services Assistant qualifications had been addressed through the facility's QAPI program. The Adm confirmed the issue had not previously been addressed.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to implement and maintain an effective Quality Assurance and Performance Improvement (QAPI) program (the facility's program for identifying problems and improving resident care) to ensure resident and family complaints were consistently identified, documented, tracked, and analyzed through the QAPI process. This failure had the potential to prevent the facility from identifying systemic issues (problems that affect more than one resident or area of the facility), implementing corrective actions, and improving the quality of care and services provided to residents. On 03/04/2026 at 12:00 PM during a reviewed Facility Grievance Log there were only three grievances listed since March 2025. The log did not indicate what the grievance was about, the actions taken by the facility to investigate, a conclusion, the remedies the facility took to resolve the grievance, nor the date a written response was sent to the resident or representative. On 03/05/26 at 4:00 PM, during an interview with the Grievance Committee consisting of the Administrator (Adm), Social Service Director (SSD) and the Social Services Assistant (SSA), the SSD stated complaints were not the same as grievances and stated, I don't put all complaints on the grievance log. The SSD stated the facility maintained a theft and loss log to track missing items, but those complaints are not considered grievances. The SSD further stated complaints, theft, or lost property complaints were not processed as grievances. It's always been like that since I've been here. On 03/06/26 at 9:15 AM, during an interview with the Administrator (Adm), the Adm confirmed that not all complaints were documented on the grievance log. The Adm acknowledged that complaints and grievances are the same. The Adm stated, To be quite honest, if they state that they want to file a formal grievance, that's when we actually put it on the grievance log and complete the paperwork for a formal grievance. The Adm further acknowledged that other complaints may or may not be documented. The Administrator stated, When a resident or family member has a complaint, they don't all get documented. Some of it gets documented in the resident's chart in the progress notes, but some of it doesn't. The Adm also indicated there was not a consistent process guiding documentation of complaints. The Adm stated, There's no real guideline as to what gets documented and what doesn't. It kind of depends on how quickly we're able to resolve it. A review of the facility's QAPI Plan dated June 2, 2025, IV. Feedback, Data System and Monitoring section b, indicated, The following data is monitored through QAPI.v. Complaints/Grievances.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that allegations of abuse and injuries of unknown origin were reported to the State Agency for three of 33 sampled residents (Resident 49, 22, and 153). This failure resulted in delay in initiation of an external investigation and ensure residents' safety and resident-to-resident abuse to go uninvestigated and leave vulnerable residents unprotected from further abuse. Findings: 1. During an observation on 3/2/26 at 4:20 PM in the Memory Care Unit, Resident 49 was observed with red and purple bruising on her right upper and lower eyelids and bridge of nose. When resident was asked how she obtained the injury to her face, the resident appeared confused and unable to respond to the question. During an interview on 3/2/26 at 4:25 PM with Licensed Vocational Nurse (LVN) 6. LVN 6 stated that she did not know how Resident 49's injury happened. She stated the injury was first noted on 2/27/26. During an interview on 3/3/26 at 10:50 AM with the Administrator, the Administrator stated she was aware of Resident 49's bruising in her face. She stated it was an unwitnessed injury. The Administrator stated she was not sure if the injury was reported to the state agency district office. During a review of Resident 49's Progress Notes dated 2/27/26, the Progress Notes indicated, At approx. (approximately) 0730 CNA reported that resident has a new skin issue. Writer came inside her room, and found resident resting in her bed, writer observed discoloration to the right eye. When asked what happened, resident is unable to recall. During a review of Resident 49's Progress Notes dated 3/2/26, the Progress Notes indicated, Discoloration is now above her upper eyelid and below lower eyelid, color red/purple. During an interview on 3/4/26 at 10:05 AM with LVN 7, LVN 7 stated she was the nurse that conducted the assessment for Resident 49 on 2/27/26. LVN 7 stated during her assessment, she noted the discoloration on resident's right lower eyelid. She stated the resident could not recall how the injury to her face occurred. During an interview on 3/4/26 at 10:46 AM with the Administrator, the Administrator confirmed the injury of unknown origin to Resident 49's face was not reported to the state agency district office. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation & Reporting and Investigating, with a revision date of September 2022, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations). 2. Review of the admission Record indicated Resident 153 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's Disease (a brain disorder that slowly destroys a person's (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	memory and thinking skills). During an interview with Certified Nursing Assistant (CNA) 4 on 3/2/2026 at 3:20PM, CNA stated that Resident 153 reached out and yanked Resident 22's hair around lunch time. During an interview with Licensed Vocational Nurse (LVN) 10 on 3/2/2026 at 3:22PM, LVN 10 stated around lunch time, Resident 153 walked into the dining area, reached out and yanked Resident 22's hair. During an interview with Administrator and Assistant Director of Nursing (ADON) 2 on 3/4/2026 at 4:00PM, Administrator stated that she was the Abuse Coordinator. The Administrator stated resident to resident physical abuse was reported immediately to Ombudsman and the Law Enforcement, but not to the California Department of Public Health (CDPH). Administrator was unaware of the requirement to report all resident-to-resident abuse to CDPH and confirmed CDPH was not notified of the incident between Resident 153 and Resident 22. During a record review of Incident: Physical Aggression report, dated 3/2/2026, with Assistant Director of Nursing (ADON) 2, on 3/5/2026 at 9:56AM, the report indicated that Resident 153 had an altercation with another resident. Resident 153 tugged at Resident 22's hair. The report did not indicate that CDPH was notified of the incident. During a record review of the facility's policy and procedures titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating revised September 2022, the policy indicated, All reports of resident abuse (including injuries if unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection control program for 6 of 33 residents when:1.Certified Nursing Assistant (CNA) 2 obtained vital signs (pulse rate, temperature, respiration rate, and blood pressure) without disinfecting the equipment between use for Resident 100 and 93.2. CNA 1 did not wear a gown while providing toileting assistance to Resident 11 who was on Enhanced Barrier Precautions (EBP-gown and glove use to reduce spread of infection).3. Oxygen concentrator filters for Residents 6, 69 and 83 were observed covered with lint.These failures had the potential to increase the risk of cross-contamination and the spread of infection within the facility.1.During an observation on 3/2/26 at 2:33 PM in Resident 100's room, CNA 2 was observed obtaining Resident 100's vital signs. After completion, CNA 2 did not disinfect the blood pressure cuff or pulse oximeter and proceeded to obtain vital sign for Resident 93 using the same equipment. During an interview on 3/2/26 at 2:38 PM with CNA 2, CNA 2 acknowledged she did not disinfect the equipment between residents use. CNA 2 stated the equipment should have been disinfected to prevent cross-contamination. CNA 2 further stated she usually obtains disinfectant wipes from the room counter; however, none were available at that time. During a concurrent interview and record review on 3/4/26 at 2:55 PM with the Infection Preventionist (IP), the facility policy and procedure titled Cleaning and Disinfecting Non-Critical Resident-Care Items dated 06/2011 was reviewed. The policy indicated durable medical equipment are cleaned and disinfected or sterilized between residents. The IP stated vital sign equipment must be disinfected between residents to prevent the transmission of bacteria or infections. 2. During a review of Resident 11's physician orders dated 2/25/26 indicated Resident 11 required EBP during high contact activities due to chronic wound.During an observation on 3/2/26 at 3:19 PM in Resident 11's room, CNA 1 was observed assisting Resident 11 with toileting without wearing a gown. During a concurrent observation and interview on 3/2/26 at 3:32 PM with CNA 1, in front of Resident 11's room, a sign posted outside Resident 11's room indicated staff must wear a gown and gloves when changing briefs or assisting with toileting. CNA 1 acknowledged she should have worn a gown while providing toileting assistance to prevent cross-contamination. During a concurrent interview and record review on 3/4/26 at 2:55 PM with the IP, the facility policy and procedure titled Enhanced Barrier Precautions dated 2/2025 was reviewed. The policy indicated high-contact resident care activities requiring the use of gowns and gloves for EBPs include changing briefs or assisting with toileting. The IP stated, to prevent cross contamination gown and gloves should be worn when assisting with toileting. 3. During a review of Resident 83's admission Record (AR) undated, the AR indicated Resident 83 was admitted to the facility on [DATE] with a diagnosis of shortness of breath.During a concurrent observation and interview on 3/4/26 at 9:59 AM with LVN 3 in Resident 83's room, Resident 83 was receiving oxygen via a nasal canula (flexible plastic tube). LVN 3 removed the oxygen concentrator filter and stated the filter was covered with lint. LVN 3 stated the filter should be clean to allow proper functioning of the machine. During a review of Resident 69's AR undated, the AR indicated Resident 69 was admitted to the facility on [DATE] with Chronic Obstructive Pulmonary Disease (COPD-lung disease).During a concurrent observation and interview on 3/4/26 at 10:05 a.m. with LVN 3 in Resident 69's room, LVN 3 removed the oxygen concentrator filter and stated the filter was covered with lint. During a review of Resident 6's AR undated, the AR indicated Resident 6 was admitted to the facility on [DATE] with a diagnosis of COPD.During a concurrent observation and interview on 3/4/26 at 10:07 AM with LVN 3 in Resident 6's room, LVN 3 removed the oxygen filter and stated the filter was covered with lint.During a concurrent interview and records review on 3/4/26 at 2:55 PM with the IP, the facility policy and procedure titled Oxygen Concentrator and Oxygen Storage dated 12/1/23 was reviewed. The policy indicated, to administer oxygen in a safe manner using oxygen concentrator. Wash filters weekly and as needed, document in medical record. (continued on next page)		

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an interview, and record review, the facility failed to coordinate discharge planning with the receiving facility and communicate with the resident and resident's responsible party (RP) for one of 33 sampled residents (Resident 122). In addition, the facility failed to ensure the discharge care plan reflected the residents' goals and resident specific interventions. This failure resulted in facility staff, Resident 122, and the resident's responsible party not being aware of the resident's discharge plan. Findings: Resident 122 was admitted on [DATE], with diagnoses which included weakness and unsteadiness on feet. During an interview with Resident 122, on 3/5/26 at 8:37 AM, Resident 122 stated she was doing much better and wanted to move to an assisted living facility (ALF- residential housing for seniors or individuals with disabilities who need help with daily care). Resident 122 stated she has been waiting for a very long time and has no idea what was going on with her move. During an interview with Resident 122's family member (RP), on 3/5/26 at 9 AM, RP stated she has been trying to get Resident 122 into an ALF and a bed was available, but the resident could not transfer. RP stated she understood there was an insurance issue, but she was unsure what else needed to be done. RP stated she had no idea why it was taking so long to get resident moved as the ALF has been holding a bed for months for Resident 122. RP further stated she had not received any help from the facility's social services department and had not received any updates from them as to the discharge plan and when Resident 122 could move to ALF. During an interview with Social Services Director (SSD) on 3/5/26 at 10:24 AM, SSD stated the facility was currently waiting for [transition services management organization] to approve Resident 122's placement for ALF. SSD stated We have never worked with them [Transition Service Management Company] before. [RP] is getting her placed at ALF. SSD stated RP would let facility know when Resident 122 can move to the ALF. SSD stated, I have not spoken to [RP] in a while. SSD stated, in September 2025, SSD spoke with the ALF and has not followed up with the ALF or [transition services management company] since. SSD confirmed Resident 122 has been ready to move to a lower level of care since October 2025. During an interview with Licensed Vocational Nuse (LVN) 1, on 3/5/26 at 9:30 AM, LVN 1 stated she was unaware of Resident 122's discharge plan. During an interview with Registered Nurse Supervisor (RNS) on 3/5/26 at 2:04 PM, RNS stated she was not aware of any discharge plan for Resident 122. During a concurrent interview and review of Resident 122's Discharge Care Plan dated 9/9/25, with Minimum Data Set (assessment tool) Nurse (MDS) the Care Plan indicated, Resident preference to discharge to Assisted Living. The Care Plan further indicated a goal of Current level of care is appropriate considering current physical/social/emotional status. Interventions included: Review plan of care initial/quarterly or as needed, social services to document changes to goal, and social services to schedule IDT care plan meetings upon admission, quarterly, and as needed. MDS confirmed the care plan did not include a resident specific goal with measurable outcomes and did not include interventions which should be implemented to assist the resident in achieving those goals. MDS stated she was unaware of Resident 122's discharge plan. During a review of the Social [NAME] Progress Note dated 9/18/25, the note indicated SSD met with RP and [representative from ALF] on 9/18/25 to discuss possible placement when Resident 122 was ready for discharge. During a review of the Social History Review notes dated 12/4/25, the notes indicated Discharge Plan: Goal is for resident to go to [ALF] when there is a spot for resident, per RP. During a review of the Social History Review notes dated 2/27/26, Discharge Plan: Goal is for resident to go to [ALF] when there is a spot for resident, per RP. There was no documentation in the Social Service notes that the ALF or [transition management services organization] had been contacted to coordinate Resident 122's discharge since 9/23/25. During a review of the facility policy titled, Discharge Summary and Plan revised March 2025, the policy indicated, Every resident has an individualized discharge plan, which (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	begins at admission and is part of the comprehensive care plan. develop interventions to meet the resident's discharge goals and needs that must be addressed before the resident can be safely discharged .		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer insulin (medication used to lower blood sugar) within professional standards, when Lispro Insulin (fast acting insulin) was administered to one of 33 sampled residents (Resident 111) one hour prior to a meal. This failure had the potential to cause adverse outcome from hypoglycemia (a condition in which blood glucose concentration is below 70 mg/dl (unit of measurement) or harm to the resident. Findings: Review of the admission Record indicated Resident 111 was admitted to the facility on [DATE], with diagnoses which includes Type 2 Diabetes Mellitus with Ketoacidosis (a serious health condition when the body can't make enough insulin). During an interview with Licensed Vocational Nurse (LVN) 1 on 3/4/2026 at 12 PM, LVN 1 was asked if she would be checking Resident 111's blood sugar prior to lunch. LVN 1 stated that she had already checked Resident 111's blood sugar at 11:00AM and administered Lispro Insulin to the resident. During a concurrent observation and interview with the Speech Therapist (ST) in Unit 3 dining room on 3/4/26 at 12:10 PM, Resident 111 was observed beginning to eat his lunch meal with staff assistance. ST stated Resident 111 received his lunch tray and began eating his lunch at 12:05 PM. During an interview with LVN 1 on 3/4/2026 at 4:30 PM., LVN 1 stated Resident 111's blood sugar was checked at 11 AM and she administered Lispro Insulin at that time. LVN 1 stated the resident's meal tray was served at 12:05 PM LVN 1 stated Lispro Insulin was fast acting, probably 30 minutes after given, and it lowers the blood sugar. LVN 1 stated that she should have waited a little longer to check Resident 111's blood sugar and administer insulin. During a concurrent interview and record review on 3/5/2026 at 9:37 AM with Assistant Director of Nursing (ADON) 2, Medication Administration Record (MAR) for Insulin Lispro Injection solution was reviewed. Resident's 111 blood sugar was checked on 3/4/2026 at 11:00 AM by LVN 1, 4 units of insulin Lispro was administered. ADON 2 stated that Insulin Lispro was fast acting, and Resident 111's blood sugar could drop to low levels after administration. ADON 2 stated that nurse expectations are to give medications in the appropriate time. ADON 2 stated that if meal tray comes late, the doctor should be notified. During a record review of the Provider Order Summary, dated 12/4/2025, the order summary indicated, Insulin Lispro Injection Solution, inject subcutaneously [under the skin] before meals. During a review of the Insulin Lispro Manufacturer's Instructions, revised 9/23, the instructions indicated, Administer within 15 minutes before a meal or immediately after a meal. During a review of the facility's policy and procedure titled, Administering Medications revised date April 2019, indicated medications were administered in accordance with prescriber orders, including any required time frame.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure effective pain management was implemented for Resident 151 when: 1. The as needed pain medication (Tylenol) for Resident 151 was not administered according to the physician's order. 2. Resident 151's pain level was not assessed timely post-administration of the as needed pain medication. These failures had the potential to result in Resident 151's suffering and decreased mobility due to unresolved pain. Findings: 1. During a review of Resident 151's admission Record, from 1/15/26 showed that Resident 151 was first admitted to the facility on [DATE] and then re-admitted on [DATE] with diagnoses including right knee pain. During a review of Resident 151's Quarterly MDS/CAA (Minimum Data Set/Care Area Assessment: a comprehensive and mandatory nursing home assessment process utilized to evaluate a resident's functional, medical, and psychosocial status) dated 12/4/24, indicated that the Brief Interview for Mental Status (BIMS: a standardized 15-point screening tool primarily used to assess cognitive function) for Resident 151 was scored at 12. During a review of Resident 151's Physician Progress Note, dated 2/23/26, the progress note indicated Resident 151 had osteoarthritis (breakdown of joint tissues) contributing to joint pain, stiffness, and reduced functional mobility. During a concurrent observation and interview on 3/4/26 at 6:07 PM with Resident 151, Resident 151 was observed sitting at the edge of her bed with a walker next to her. Resident 151 stated she told a female staff about her right knee pain in the morning and did not receive the as needed pain medication until five (5 PM) in the afternoon. During a review of Resident 151 Physician Order (PO), dated 1/15/26, the PO indicated, Tylenol Tablet 325 mg (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain mild (1-3) . During a concurrent interview and record review on 3/4/26 at 6:16 PM with Licensed Vocational Nurse (LVN) 5, Resident 151's Medication Administration Record (MAR), dated February 2026 was reviewed. The MAR indicated Resident 151 received the as needed pain medication on six (6) occasions. Two (2) of which, dated 2/9/26 and 2/25/26, Resident 151 reported a pain level of five (5) out of 10. LVN 5 stated he should have called the physician for a stronger pain medication appropriate for the reported pain level because the as needed pain medication that was administered to Resident 151 on 2/9/26 and 2/25/26 was for mild pain only (for pain level 1-3). During a review of the facility's undated policy and procedure (P&P) titled, Physician Orders, Accepting, Transcribing and Implementing (Noting), the P&P indicated, Licensed nursing personnel will ensure that telephone and verbal orders will be recorded and implemented . 2a. Licensed nursing shall verify each order for completeness, clarity and appropriateness of doses . b. Institute monitoring criteria for the medications . 2. During a review of Resident 151's admission Record, from 1/15/26 showed Resident 151 was first admitted to the facility on [DATE] and then re-admitted on [DATE] with diagnoses including right knee pain. During a review of Resident 151's Quarterly MDS/CAA (Minimum Data Set/Care Area Assessment: a comprehensive and mandatory nursing home assessment process utilized to evaluate a resident's functional, medical, and psychosocial status) dated 12/4/24, indicated that the Brief Interview for Mental Status (BIMS: a standardized 15-point screening tool primarily used to assess cognitive function) for Resident 151 was scored at 12. During a review of Resident 151's Physician Progress Note, dated 2/23/26, the progress note indicated Resident 151 had osteoarthritis (breakdown of joint tissues) contributing to joint pain, stiffness, and reduced functional mobility. During a concurrent observation and interview on 3/4/26 at 6:07 PM with Resident 151, Resident 151 was observed sitting at the edge of her bed with a walker next to her. Resident 151 stated she told a female staff about her right knee pain in the morning and did not receive the as needed pain medication until five (5 PM) in the afternoon. During a review of Resident 151's Medication Administration Record (MAR), dated February 2026, the MAR indicated Resident 151 received the as needed pain medication on 2/9/26 at 9:26 PM and on 2/25/26 at 7:04 PM, for Resident 151's reported pain level of five (5) out of 10. During a concurrent interview and record (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review on 3/4/26 at 6:03 PM with Licensed Vocational Nurse (LVN) 4, Resident 151's Weights and Vitals Summary, dated 2/9/26 and 2/25/26 were reviewed. The vitals summary indicated Resident 151 reported a pain level of five (5) out of 10 on 2/9/26 at 9:26 PM, also the time Resident 151 received the pain medication. Resident 151's pain level was not re-assessed until 2/10/26 at 12:42 AM (more than two (2) hours has passed since pharmacological intervention was provided). In addition, on 2/25/26 Resident 151 reported a pain level of five (5) out of 10 at 7:04 PM, also the time Resident 151 received the pain medication. Resident 151's pain level was not re-assessed until 9:25 PM (more than two (2) hours had passed since pharmacological intervention was provided). LVN 4 stated the pain level should have been re-assessed after 30 minutes to one (1) hour of administration of pain medication to assess for effectiveness. During a review of facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated October 2022, the P&P indicated, Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after onset and reassessed as indicated until relief is obtained.		

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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 safely store, and label drugs and supplies in accordance with acceptable standards of practice when: One of two treatment carts was left unlocked and unattended on station 3. Personal food items were stored in one vaccine refrigerator. This failure had the potential to allow unauthorized access to treatment supplies by residents, staff, or visitors and maintain a controlled and sanitary environment for the storage of vaccines. 1. During an observation on 3/3/26 at 8:35 AM, Station 3's treatment cart was observed across the nurses' station. The treatment cart was unlocked and unattended. During a concurrent observation and interview on 3/3/26 at 8:46 AM, with Licensed Vocational Nurse (LVN) 2, the treatment cart remained located across from the nurses' station against the wall and was still unlocked and unattended. LVN 2 acknowledged the treatment cart had been left unlocked and stated the cart should be locked when unattended to prevent unauthorized access. During a concurrent interview and record review on 3/4/26 at 3:42 PM with the Assistant Director of Nurses (ADON), the facility policy and procedure titled Storage of Medications dated 11/2020 was reviewed. The policy indicated, the facility stores all drugs and biologicals in a safe, secure, and orderly manner and that compartments, including drawers and carts containing biologicals, must be locked when not in use. The ADON stated the treatment cart should be locked when unattended to prevent unauthorized access to treatment supplies. 2. During an observation on 3/2/26 at 5:50 PM of the infection prevention vaccine refrigerator, there was one personal food container, one box of soft cheese, and one container of dip stored directly alongside boxes of vaccines. During an interview with Infection Preventionist (IP) on 3/4/26 at 3:12 PM, IP stated Food should not be stored with vaccines, due to cross contamination. During a review of the facility policy titled, Medication Storage dated 2019, the policy indicated, Other foods such as employee lunches and activity department refreshments are not stored in this refrigerator. During a review of the facility policy titled, Storage of Medications revised November 2020, the policy indicated, Medications are stored separately from food and are labeled accordingly.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food safety standards were met when: 1.A linear black substance was found inside the ice machine in the kitchen.2. Two open bags of pasta and one open cornstarch were found in the kitchen unlabeled and undated and were not stored in an airtight container.3. One unlabeled and undated partially consumed bottled drink was found inside the resident's nutrition refrigerator at Station 2.4. One unlabeled and undated partially consumed frozen yogurt was not found inside the resident's nutrition freezer at Station 2.5. [NAME] 1 covered his mustache while preparing food in the kitchen.These failures had the potential to result in foodborne illnesses to all residents.Findings: During a review of the facility's policy and procedure (P&P) titled, Preventing Foodborne Illness - Food Handling, dated July 2014, the P&P indicated, Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized . 1. This facility recognizes that the critical factors implicated in foodborne illness are: a. poor personal hygiene of food service employees . 1.During a concurrent observation and interview on 3/2/26 at 2:52 PM with the Certified Dietary Manager (CDM) in the main kitchen, a black linear substance was found inside the ice machine when the cover was lifted and easily came off when wiped with a paper towel. CDM stated the black linear substance should not be there. During a review of undated facility document titled, YR Series Icemaker End-User Manual, the manual indicated, Cleaning/Sanitizing Procedure: This procedure must be performed a minimum of once every three months . Removes mineral deposits from areas or surfaces that are in direct contact with water . Clean the area around the ice machine as often as necessary to maintain cleanliness and efficient operation. During a review of the facility's policy and procedure (P&P) titled, Ice Machines and Ice Storage Chests, dated January 2012, the P&P indicated, Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. 2. During a concurrent observation and interview on 3/2/26 at 2:30 PM with the Certified Dietary Manager (CDM) in the main kitchen's dry goods storage area, two open bags of pasta noodles without an open date were found not tightly sealed. CDM stated once the item was opened, it should be dated and placed in a sealed bag. During a concurrent observation and interview on 3/2/26 at 2:26 PM with the Certified Dietary Manager (CDM) in the main kitchen's dry goods storage area, an open box of cornstarch without an open date was found not tightly sealed. CDM stated the cornstarch should have been labeled with an open date and tightly sealed. During a review of the facility's policy and procedure (P&P) titled, Storage of Food and Supplies, dated 2023, the P&P indicated, Food and supplies will be stored properly and in a safe manner . Dry food items which have been opened . will be tightly closed, labeled, and dated . 3. During a concurrent observation and interview on 3/4/26 at 10:05 AM with Registered Nurse (RN) 1 at Station 2 medication room, one (1) opened partially consumed bottled drink was found stored in the residents' nutrition refrigerator unlabeled and undated. RN 1 stated the unlabeled and undated partially consumed bottled drink was not supposed to be stored in the residents' nutrition refrigerator. During a review of the facility's policy and procedure (P&P) titled, Refrigerator, Storage of Food from Outside Sources, dated May 2024, the P&P indicated, The facility will ensure that food brought into the facility . is safely stored, handled, and monitored in facility-designated refrigerators . to reduce the risk of foodborne illness . All outside food must be identified with discard date . Any unlabeled or undated food will be discarded. 4. During a concurrent observation and interview on 3/4/26 at 10:08 AM with Registered Nurse (RN) 1 at Station 2 medication room, a bowl of partially consumed frozen yogurt without label and date was found stored in the residents' nutrition freezer. RN 1 stated the yogurt bowl was not supposed to be stored in the residents' nutrition freezer unlabeled and undated. During a review of the facility's policy and procedure (P&P) titled, Refrigerator, Storage of Food from Outside Sources, dated May 2024, the P&P indicated, The facility will ensure that food brought into the facility . is safely stored, handled, and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored in facility-designated refrigerators . to reduce the risk of foodborne illness . All outside food must be identified with discard date . Any unlabeled or undated food will be discarded. 5. During a concurrent observation and interview on 3/5/26 at 2:14 PM with [NAME] 1 in the main kitchen, [NAME] 1 was observed preparing food with the beard net but not covering his mustache. [NAME] 1 stated he was preparing gravy. During an interview on 3/5/26 at 2:22 PM with the Certified Dietary Manager (CDM), CDM stated [NAME] 1 should have worn the beard net all the way to cover the mustache not just the beard while preparing food. During a review of the facility's policy and procedure (P&P) titled, Dress Code, dated 2023, the P&P indicated, Personal hygiene and appropriate dress are a very important part of the total appearance of the Food & Nutrition Services Department . Proper Dress . beards and mustaches (any facial hair) must wear beard restraint.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident call system was operational and accessible when;1. The call light system in Resident room [ROOM NUMBER] bathroom was observed with missing required pull cord, preventing the residents from summoning staff assistance when needed.2. The call light system in Resident room [ROOM NUMBER] bathroom had missing call button preventing the residents from summoning staff assistance when needed.This failure had the potential to prevent residents from summoning staff assistance in a timely manner, placing residents at risk for unmet needs, accidents, or injuries.Findings:1. During an observation on 3/2/26 at 2:45 PM in room [ROOM NUMBER] bathroom, the call light system was observed with missing pull cord.During an interview on 3/3/26 at 2:50 PM with Certified Nursing Assistant (CNA) 3, CNA 3 confirmed the call light pull cord was missing.2. During an observation on 3/2/26 at 3 PM in room [ROOM NUMBER] bathroom, the call light system was observed to be broken with missing call light button. During an interview on 3/2/26 at 3:05 PM with CNA 4, CNA 4 confirmed the call light was not working and had a missing button.During an interview on 3/3/26 at 10:30 AM with the Maintenance Director, the Maintenance Director stated he was not notified of the call light issues. He stated staff were supposed to report any maintenance issues by documenting on the maintenance logbook in the nurse's station. The Maintenance Director confirmed the broken call lights had not been reported on the maintenance logbook. During a review of the facility's policy and procedure (P&P) titled, Environmental Services Inspection with a revision date of February 2023, the P&P indicated, It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. Policy Explanation and Compliance Guidelines:The Director of Environmental Services will perform random and/or routine inspections.All opportunities will be corrected immediately by environmental services personnel.Each environmental service personnel will be informed of their performance and re-trained on any opportunities as needed.Follow up inspections or spot checks will be conducted as needed to ensure that corrections have been made.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the physical environment was maintained in safe, clean and well maintained when;1. room [ROOM NUMBER] walls had large scuff marks present on the room walls and bathroom walls.2. room [ROOM NUMBER] bathroom vinyl flooring was lifted at the bathroom entrance.The facility's failure to maintain resident living areas in good repair had the potential to create an unsafe environment and increase the risk of trips, falls, or other injuries for residents, staff and visitors.Findings:1. During an observation on 3/2/26 at 2:20 PM in room [ROOM NUMBER], multiple large scuff marks and visible damage on the walls were observed. The wall surfaces appeared worn and need of repair.2. During observation on 3/2/26 at 2:45 PM in room [ROOM NUMBER], the vinyl flooring in the resident bathroom was lifted and separating from the floor surface near the bathroom entryway. The raised vinyl flooring created an uneven surface.During a concurrent observation and interview on 3/3/26 at 10:30 AM with the Maintenance Director, the Maintenance Director confirmed the condition of the walls and vinyl flooring. Stated staff were supposed to report any maintenance issues by logging in the maintenance log in the nursing station. The Maintenance Director confirmed the issues had not been reported for repairs.During a review of the facility's policy and procedure (P&P) titled, Environmental Services Inspection with a revision date of February 2023, the P&P indicated, It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. Policy Explanation and Compliance Guidelines:The Director of Environmental Services will perform random and/or routine inspections.All opportunities will be corrected immediately by environmental services personnel.Each environmental service personnel will be informed of their performance and re-trained on any opportunities as needed.Follow up inspections or spot checks will be conducted as needed to ensure that corrections have been made.		

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Form Approved OMB
No. 0938-0391

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 03/06/2026
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)		
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide the minimum square footage required by regulation for 11 of 50 resident rooms. During an observation on 3/3/26 at 10:01 AM, resident rooms 41-51 did not meet the required minimum square footage of 80 square feet per resident. room [ROOM NUMBER]: 227.2 sq. ft. (3 residents) room [ROOM NUMBER]: 219.2 sq. ft. (3 residents) Rooms 43-51: 234.5 sq. ft. (3 residents) During an interview on 3/6/26 at 9:15 AM with the Administrator (Adm), the resident room size waiver was discussed. The Adm acknowledged that rooms 41-51 did not meet regulatory requirements.		