STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555396	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaweah Health Skilled Nursing Center	1633 South Court Street Visalia, CA 93277

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 45654 Based on interview and record review, the facility failed to follow it's policy and procedure on Advance Directive (AD - a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them) for one of 36 sampled resident's (Resident 28). This failure had the potential to result in staff not providing to Resident 28 the appropriate treatment in the event of emergency. Findings: During a review of Resident 28's clinical record it was noted there was no documented advance directive. During an interview on 3/18/24 at 2:47 p.m. with Director of Nursing (DON), DON stated the licensed nurses on the floor go over the admission and ask the patients if they want an AD. DON stated if they mark a yes, the information goes over to the social worker. During a concurrent interview and record review on 3/19/24 at 8:44 a.m. with Registered Nurse (RN) 3, Resident 28's, Electronic Health Record (EHR- an electronic patient chart) was reviewed. Resident 28's EHR indicated, no documented AD. RN 3 stated if the AD is checked yes, then it would go to patient family services. RN 3 stated patient family services would complete the AD. RN 3 stated she is unable to locate AD. During an interview on 3/19/24 at 10:30 a.m. with Resident 28, Resident 28 stated when he was admitted into the facility, he informed staff that he had an AD. During an interview on 3/19/24 at 10:40 a.m. with Social Services (SS), SS stated when the nurses mark the box yes or no on the admission assessment, it generates a clinical order for the AD. SS stated the AD was not followed and the order was not generated. During a review of the facility's policy and procedure (P&P) titled, Advanced Directives (AD), dated 10/16/2022, the P&P indicated, I. Upon admission to (facilty) inpatient units, skilled nursing units . all will be asked if they have an Advanced Directive or desire more information about Advance Directives. B. If a patient at Admission states Yes they have an Advance Directive, but a copy is not readily available, then the following will be done: 1. The Patient Access Registrar will enter Yes in the hospital information system.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 27157 Based on interview and record review, the facility failed to ensure one of 36 sampled residents (Resident 23) significant change in status MDS (Minimum Data Set; Resident Assessment and Care Screening) was accurately completed for section K (Nutritional Status) when Resident 23 received nutrition care for a planned weight gain. This failure had the potential to result in an inaccurate MDS that could impede care planning to meet resident's needs. Findings: During a concurrent interview and record review on 03/20/24 at 09:57 a.m., with the Registered Dietitian (RD), Resident 23's Nutrition Note (NN), completed by RD on 9/2/22 was reviewed. Resident 23's NN, dated 9/2/22, indicated, Weight .: 79.7 kg [175 pounds] . Ideal Body Weight Calculated: 105.2 kg [231 pounds]. RD stated the NN, dated 9/2/22, was Resident 23's admission comprehensive nutrition assessment. RD stated, Resident 23's daily nutritional needs were assessed at 2,700 calories (a unit of energy) a day based on 35 kcal[calories]/kg [per kilogram, a unit of mass, of body weight] of his admission weight of 79.7 kg to promote weight gain. RD stated the goal was for Resident 23 to gain weight due to his underweight status as evidenced by a BMI [body mass index; used as an indicator of obesity and underweight] of 17.5, and he was 75.76% [percent] of his ideal body weight of 105.2 kg. During a concurrent interview and record review on 03/20/24 at 02:25 p.m., with RD in the presence of MDS Coordinator (MDSC), Director of Nursing (DON) and Assistant Director of Nursing (ADON), Resident 23's MDS titled Significant change in status assessment (SCS), dated as complete on 8/31/23 by the MDSC was reviewed. The SCS indicated, K0200. Height and Weight: 75 inches, 211 pounds. RD stated she completed section K (Nutritional Status) of the MDS on 8/31/2023. RD stated for the previous 30 days and six months of the 8/31/23 MDS, Resident 23 was on a planned weight gain tube feeding regimen. RD reviewed K0310. Weight Gain, and RD stated it was coded as 2 meaning Yes [had significant weight gain], not on physician-prescribed weight-gain regimen. RD stated the facility was actively trying to achieve weight gain for Resident 23, and RD stated the tube feeding orders were assessed to provide a planned weight gain. RD stated she was not sure who was responsible for contacting the doctor to get a specific physician order for weight gain to reflect the care and services provided to Resident 23, which was a planned weight gain regimen. RD stated I guess it was me who should have done that. During a concurrent interview and record review on 03/20/24 at 02:35 p.m. with MDSC, MDSC reviewed Resident 23's MDS titled Significant change in status assessment (SCS), dated as complete on 8/31/23. MDSC stated section K0310. Weight Gain was not completed accurately when a 2 was coded that meant Yes, not on physician-prescribed weight-gain regimen. MDSC stated, section K0310. Weight Gain should have been coded as a 1 which meant Yes [had weight gain], on physician-prescribed weight-gain regimen. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, RAI Process: Skilled Nursing Care, dated 9/14/23, the P&P indicated, Policy: All disciplines participating in the Resident Assessment Instrument (RAI) process will accurately complete their assessments. Sections to be completed. K . Responsible Discipline: Registered Dietician. After completing a section, the discipline will sign their name, electronically attesting to its accuracy. Then, the RN [Registered Nurse] assessment coordinator signs the assessment (Z0500) verifying assessment completion.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44134 Based on observation, interview, and record review, the facility failed to ensure the head of bed (HOB) of one of 10 sampled residents (Resident 8) was elevated at least 30 degrees while receiving enteral tube (delivery of nutrition via a tube or catheter inserted directly into the stomach through the abdominal wall) feedings. This failure had the potential to result in aspiration (inhaling foreign substance such as food or liquid into the airway and lungs) and lung problems to Resident 8. Findings: During a review of Resident 8's Order Sheet (OS), dated10/10/23, the OS indicated, Tube Feeding Continuous.GTUBE [enteral tube], Jevity 1.5 [formula].55 [milliliters per hour], 24 hours [per day]. During an observation on 3/18/24 at 10:24 a.m. in Resident 8's room, Resident 8 was laying on his left side with the HOB elevated to 15 degrees as indicated by the measuring guide on the side of Resident 8's bed. Resident 8's enteral tube feeding was running at 55 milliliters (ml) per hour. During an interview on 3/18/24 at 10:29 a.m. with Registered Nurse (RN) 1, RN 1 stated according to policy Resident 8's HOB should be elevated at 30 degrees while receiving enteral feeding. During a concurrent observation and interview on 3/18/24 at 10:30 a.m. with Assistant Director of Nursing (ADON) in Resident 8's room, ADON stated Resident 8's HOB was elevated at 15 degrees. ADON stated Resident 8's HOB should have been elevated to a minimum of 30 degrees while receiving enteral feeding. During a review of Resident 8's At Risk for Aspiration IPOC (IPOC-Individual Plan of Care), dated 3/29/19, the IPOC indicated, Elevate Head of Bed during and after Meals.Position Head of Bed to Prevent Aspiration. During a review of the facility's policy and procedure (P&P) titled, Nutrition: Enteral Nutrition, dated 10/30/23, the P&P indicated, To provide best practice guidelines in order to prevent complications and guide the safe management of enteral nutrition in adult inpatients.III.B. Aspiration precautions.HOB elevated to 30-45 degrees.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45654 Based on observation, interview, and record review, the facility failed to ensure: 1. One of 36 sampled residents (Resident 190) expired medication was disposed. 2. One of 36 sampled residents (Resident 138) medication was properly labeled with an expiration date. These failures had the potential for residents to receive expired medications which can adversely affect residents health condition. Findings: 1. During a concurrent observation and interview on 3/20/24 at 9:59 a.m. with LVN 2, in medication storeroom one, Resident 190's [NAME] mouth wash (oral medication containing various liquid medications) 120 milliliter (ml)/10 ml had expired on 3/11/24. LVN 2 stated Resident 190 had been discharged from the facility and this medication should have been discarded. During a review of the facility's policy and procedure (P&P) titled Disposal of Unusable Medications, dated 8/24/22, the P&P indicated, Procedure: I. Initial handling of pharmaceutical waste. A. Unused or outdated medications returned to pharmacy shall be evaluated for disposition (disposal, return to stock, or sent to a pharmaceutical waste management company). During a review of the facility's P&P titled Medication: Administration, dated 3/7/24, the P&P indicated, . C. Discharges. 3. All medications specific to a particular patient, which are not being sent home, will be promptly returned to pharmacy for proper disposal. 2. During a concurrent observation and interview on 3/20/24 at 8:19 a.m. with LVN 2, LVN 2 administered Eye relief/refresh eye drops to Resident 138 right and left eye. LVN 2 reviewed the bottle of eye drops and stated there should be an opened date and expiration date on the bottle and there was not. During a concurrent observation and interview on 3/20/24 at 10:22 a.m. with Pharmacist (Pharm), in the medication storeroom, Resident 138 Eye relief/refresh artificial drops were reviewed. Pharm stated Resident 138 eye drops were not properly labeled with an open or expiration date. During a review of the facility P&P titled, Labeling Standards, dated 9/22/23, the P&P indicated, All medications sent to the nursing unit for inpatient use and not available in pyxis will be labeled . and include the following information: Beyond use or expiration date, and lot number when not noted on the original package.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48756 Based on observation, interview, and record review the facility failed to follow individualized meal tray ticket directions for one of 36 sampled residents (Resident 189) vegetables were not chopped. This failure had the potential to result in meal preferences not being honored. Findings: During an observation on 3/18/24 at 11:54 a.m. in Kitchen 2, Resident 189's lunch plate was prepared by Cook II (CK) 1 and placed in the meal delivery cart by Diet Clerk (DC) 1. Resident 189's lunch plate included mixed vegetables (Cauliflower florets, Broccoli florets, and Carrot rounds) that were not served in a chopped texture. During a concurrent interview and record review on 3/18/24 at 11:54 a.m. with Certified Dietary Manager (CDM) 1, Resident 189's Lunch Meal Tray Ticket (MT), dated 3/18/24 was reviewed. The MT indicated Resident 189's texture request: chopped meats and chopped vegetables. CDM 1 stated the vegetables were not chopped and should have been in accordance with Resident 189's individualized menu directions located on the lunch meal tray ticket. During a review of Resident 189's Physician Orders (PO), dated 3/6/24, the PO indicated, Resident 189 was on a cardiac diet, diabetic, send chopped meats with gravy due to chewing issues per patient request. During a review of the facility's diet manual for chopped diet, (undated), the diet manual indicated, The Chopped/Dysphagia [difficulty swallowing] Level 3 diet is mechanically altered to meet the needs of patients with chewing or swallowing difficulties. Foods served require limited chewing. This diet is designed to maintain or improve the nutritional status of the patient. Food are moist and in bite-size pieces no larger than 1/2 inch. During a review of the facility's policy and procedure (P&P) titled, Tray Assembly Distribution and Cart Delivery, dated 10/14/2021, the P&P indicated, The following steps are used to ensure the accurate and timely distribution and retrieval of trays to patients with prescribed diets: .3. Food service staff member places food items on patient tray during tray line process according to the items listed on the patient tray ticket.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48756 Based on observation, interview, and record review the facility failed to ensure: 1. Potentially hazardous food (food capable of supporting microbial growth) was documented on the cool down log. 2. Expired food was removed from the freezer in kitchen 2. 3. Frozen food storage was dated in kitchen 2. 4. The ice machine in kitchen was sanitized in accordance with manufacturer's guidelines. These failures had the potential to result in the spread of foodborne illnesses. Findings: 1. During a concurrent observation and interview on [DATE] at 9:54 a.m. with Certified Dietary Manager (CDM) 1, in Kitchen 2, a large container of cooked pasta was located in the walk-in refrigerator. CDM 1 stated the cooked pasta was for the resident's lunch today. During a concurrent interview and record review on [DATE] at 9:58 a.m. with Cook II (CK) 1, the facility's food cooling log (CL), (undated) was reviewed. CK 1 stated he was the one who cooked the pasta yesterday ([DATE]). CK 1 stated, I hope I documented it. CK 1 reviewed the CL and the pasta noodles were not noted on the log. CK 1 stated he forgot to log his cool down process for the noodles. During an interview on [DATE] at 10:37 a.m. with CDM 1, CDM 1 stated the pasta should have been on the cool down log and was not. During a review of the facility's policy and procedure (P&P) titled, Food Safety HACCP [Hazard Analysis and Critical Control Points], dated [DATE], the P&P indicated, The Food and Nutrition Services Department has a comprehensive food safety and self-inspection system that includes equipment monitoring to ensure the effectiveness and quality of the food safety program for all of our food service customers. 5. Cooling of foods: Internal product temperatures must be recorded of the Food Cool-down log and kept on file for one year for health department inspections and audit purposes. 2. During a concurrent observation and interview on [DATE] at 10:05 a.m. with CDM 1 and Diet Clerk (DC) 3 in Kitchen 2 walk in freezer, a unopened package of Salisbury steak with a used by date of [DATE]. CDM 1 and DC 3 stated that was the correct label. DC 3 stated that it's a use by date and it was expired and should have been tossed out. During a review of the facility's Frozen Storage Life of Foods guidelines, (undated), the guidelines indicated, Discard all items on the expiration date and time. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Food Labeling, dated [DATE], the P&P indicated, It is the policy of the Food and Nutrition Services Department to develop a mechanism to ensure the safe and accurate storage of food and nonfood products. Food storage methods are strictly defined. Food Labeling: Once any food product is opened and not used in its entirety, a Use By sticker shall be placed on the container of the unused portion/product. Product will be discarded at the end of the day from the Use by date placed on the product. 3. During a concurrent observation and interview on [DATE] at 10:05 a.m. with CDM 1 and DC 3 in Kitchen 2 walk in freezer there was a large container of unopened, frozen raw chicken in a large bin that was undated. DC 3 checked for a date and stated there was no date on the container and that it should be dated. During a review of the facility's policy and procedure (P&P) titled, Food Labeling, dated [DATE], the P&P indicated, It is the policy of the Food and Nutrition Services Department to develop a mechanism to ensure the safe and accurate storage of food and nonfood products. Food storage methods are strictly defined. Food labeling: All food products will be labeled with a Received Date. Items once removed from the main box/case will also be manually identified with a Received Date. 4. During a concurrent interview and record review on [DATE] at 2:44 p.m. with Maintenance Employee (MT) 1, the Scotsman Clear 1- Scale remover for Ice Machines bottle was reviewed. MT 1 stated he cleans the ice machine using a cleaner (Scotsman Clear-1) that both descales and sanitizes. MT 1 stated this is the only product that was circulated through the top part of the ice machine. MT 1 stated the product he is using is both a cleaner and a sanitizer. MT 1 stated, I know I saw that somewhere, maybe its on the manufacturers guidelines. MT 1 was unable to find where the ice machine cleaner (Scotsman Clear 1) also indicated the same product was a sanitizer. MT 1 confrmed the findings. During a concurrent interview and record review on [DATE] with MT 1 and CDM 1, Kitchen 2 ice machine Manufacturer's Guidelines (MG) was reviewed. The MG indicated, .7. Allow the ice machine scale remover to circulate in the water system for 10 minutes . 21. Circulate the sanitizer solution for 5 minutes. MT 1 stated the sanitizing step was not being done. CDM 1 stated the ice machine was not sanitized in accordance with ice machine manufacturers guidelines or the dietary policy and procedure on ice machine as is indicates to follow the manufacturers guidelines. During a review of the facility's policy and procedure (P&P) titled, Dispensing Ice, dated [DATE], the P&P indicated, The Food and Nutrition Services Department prepares and dispenses ice in a safe manner to ensure clean machines and handling and prevent cross contamination. Cleaning ice machines: Internal cleaning of the ice producing machinery per manufacturer recommendations are performed by the Plant Operations department.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 48756 Based on observation, interview, and record review the facility policy failed to address residents right to store outside food. This failure had the potential to not honor a resident and/ or families request to store food from the outside for later consumption. Findings: During an interview on 3/18/24 at 3:00 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated outside food has to be approved by the nurse and then the patient can have it, but the facility cannot store outside food due to potential cross contamination. During an interview on 3/18/24 at 3:02 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated our process for outside food brought in by family is to check with the nurse, family can bring in food to the resident's room. The facility cannot store patient food because the facility does not have a refrigerator for that. During an interview on 3/18/24 at 3:10 p.m. with Certified Dietary Manager (CDM) 1, CDM 1 stated the facility does not store outside food for patients. CDM 1 stated family can bring food in, but it has to be eaten or tossed, we do not store outside food for patients. During an interview on 3/18/24 at 3:44 p.m. with Director of Nursing (DON), DON stated the facility does not store outside food in the nourishment refrigerator or any refrigerator. DON stated if resident's family wanted to bring food from outside of the facility, the facility staff are trained to offer a bucket with ice but that would be for short term storage. During an observation on 3/18/24 at 3:47 p.m. the nourishment refrigerator in the nourishment floor had a sign that indicated, No patient food from home allowed in fridge per policy number: FNS.615. During an interview on 3/19/24 at 11:28 a.m. with Registered Nurse (RN) 2, RN 2 stated we don't store or reheat outside food. If it's something like candy it can be kept at the bedside, that's ok. It really isn't requested that often. During a review of the facility's policy and procedure (P&P) titled, Storage of Leftover Patient Food [FNS. 615], dated 10/7/2021, the P&P indicated, Temperature Controlled for Safety food [TCS] [also known as potentially hazardous food] that is not consumed by a patient will be discarded within four hours of delivery and will not be stored in patient floor stock refrigerators. Procedure: . 3. In order to prevent risk of cross-contamination, uneaten patient food is not to be stored in patient floor stock refrigerators. During a review of the facility's policy and procedure (P&P) titled, Nutrition: Cafeteria and outside food, dated 2/2/2024, the P&P indicated, The Food and Nutrition Services department does not provide any oversight over any outside food for patient use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44134 Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures when two of two sampled Environmental Service Aides (EVS 1 and EVS 2) failed to ensure high touch surface areas (handrails, call lights, doorknobs, pull cords etc.) were properly disinfected daily. This failure had the potential to place residents, staff, and visitors at risk for the spread of infectious diseases. Findings: During a concurrent observation and interview on 3/20/24 at 8:29 a.m. with EVS 1 in the housekeeping closet, the facility's cleaning detergents and disinfectants were on a wall mounted dispenser. EVS 1 stated, Vindicator [disinfectant used to kill bacteria, fungus and viruses] is used for surfaces in resident's rooms, Top Clean [cleaner that removes soil and leaves a shine] is for the floor and Multi-Purpose [cleaner that aids in brightening grout and enhancing the appearance of tiled surfaces] is for the handrails in hallways. EVS 1 stated the dwell time (amount of time a disinfectant needs to sit on a surface, without being wiped away or disturbed, to effectively kill germs) for Vindicator is one minute. EVS 1 stated she sprays the Vindicator onto surfaces, waits, and then wipes the surfaces down. During an interview on 3/20/24 at 8:41 a.m. with EVS 2, EVS 2 stated handrails in the resident hallways are disinfected with Vindicator once per week. During an interview on 3/20/24 at 9:55 a.m. with Laundry Manager (LM), LM stated Vindicator used in patient care areas and on high touch surfaces. LM stated Vindicator wet the entire 10 minutes. LM stated, We do not dry Vindicator. LM stated Housekeeping should not wipe surfaces after using Vindicator. LM stated hallway handrails are considered high touch areas and should be cleaned by housekeeping daily with Vindicator. During an interview on 3/21/24 at 2:11 p.m. with Infection Preventionist (IP), IP stated housekeeping had an approved disinfectant that they use on high touch surfaces. IP stated high touch surfaces should be disinfected daily and as needed. IP stated it was her expectation for housekeeping to follow what they had been trained to do based on facility policy. During a review of the facility's policy and procedure (P&P) titled, Cleaning Disinfectant(s)/Chemical(s), dated 9/2/19, the P&P indicated, Environmental Services staff shall use proper methods of disinfecting and cleaning as trained, using hospital approved cleaning disinfectant(s)/Chemical(s) that are deemed safe and effective.Environmental staff will disinfect/clean all surfaces in patient care and none [sic] patient care areas as defined by scope of work, using approved cleaning disinfectant(s)/chemical(s). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Equipment Cleaning and Low/Intermediate Level Disinfection, dated 4/20/23, the P&P indicated, All common areas and common equipment will be cleaned appropriately according to standards provided by accrediting bodies, relevant associations, and the manufactures' manuals/ recommendations.The dwell times for cleaning solutions used at [facility] are listed in Table 1. Multiple cloths may be needed to ensure the minimum wet time is met. Surfaces must be allowed to air dry. Do not attempt to dry surfaces with a dry cloth, fan, by blowing on them or waving them through the air. General Areas: restrooms, countertops, elevators, furniture, televisions, telephones, office equipment, surfaces.Cleaning Product.Hospital Approved Disinfectant or Germicidal wipe.Frequency.Daily and as needed. During a review of the Manufacturer's Guidelines (MG) titled, Vindicator + Disinfectant Cleaner, (undated), the MG indicated, DISINFECTION.Apply solution with a mop, cloth, sponge, hand pump trigger sprayer or low-pressure coarse sprayer so as to wet all surfaces thoroughly. Allow to remain visibly wet for 10 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555396	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaweah Health Skilled Nursing Center	1633 South Court Street Visalia, CA 93277

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48756 Based on observation, interview, and record review the facility failed to ensure the walk-in freezer in Kitchen 1 was maintained in good repair. This failure had the potential to result in compromised food quality and safety. Findings: During an observation on 3/19/24 at 8:45 a.m. the walk-in freezer in Kitchen 1 had ice buildup on the plastic strip curtain entering the freezer, on tubing (pipe) on the door and ice buildup on a cardboard box. During a concurrent observation and interview on 3/19/24 at 8:46 a.m. with Certified Dietary Manager (CDM) 2 in Kitchen 1 walk in freezer, CDM 2 stated the ice buildup was addressed with a recent work order completed on 2/28/24, to repair the seals on the door. Per CDM 2 this work order was initiated on 2/27/24 due to ice buildup. CDM 2 stated he had not yet reported back to maintenance about the continued ice buildup and that he was observing it (ice buildup). CDM 2 stated the ice buildup is about the same as it was before the repair. CDM 2 stated there was no pending work orders for maintenance to the walk-in freezer. During a concurrent observation and interview on 3/19/24 at 9:34 a.m. with Maintenance Staff (MS) 2 in Kitchen 1 walk in freezer, MS 2 stated he thought the ice buildup was normal due to door being opened and hot air going in. MS 2 stated the extensive ice buildup was a sign of a properly working freezer because its less than zero degrees Fahrenheit (measurement of temperature). MS 2 stated there were no further repairs pending since the freezer is working properly. During a review of the [NAME] Refrigerated Boxes, Inc. walk in freezer manufacturers guidelines (MG), dated 2013, the MG indicated, Routine Maintenance.C. Note: Condensation or ice buildup around doors may indicate leakage or heater failure. Contact a serviceman immediately.F. Drain pan or drain line heater failure will result in ice buildup and Evaporator damage. During a review of the Food and Drug Administration (FDA) Food Code Annex (FDAFCA), dated 2022, the FDAFCA indicated, Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. During a review of the facility's policy and procedure (P&P) titled, Preventative Maintenance, dated 09/01/2021, the P&P indicated, Department Managers and Facility Maintenance department participate in and administer a preventative maintenance program in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555396	A. Building B. Wing	03/21/2024

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Kaweah Health Skilled Nursing Center	1633 South Court Street Visalia, CA 93277

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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 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. 45654 Based on observation, interview, and record review, the facility failed to ensure 2 of 36 sampled residents (Resident 135 and Resident 140) empty vials of Heparin (a medicine used to decrease blood clots) were discarded in a designated waste bin. This failure had the potential to compromise the safety of residents, staff and visitors. Findings: During an observation on 3/19/24 at 8:32 a.m. at medication cart one, medication cart one was unattended with a vial of Heparin (a medicine used to decrease blood clots) 5,000 units (unit of measure) sitting on top of the cart. Several staff were noted walking past the unattended medication cart. During a concurrent observation and interview on 3/19/24 at 8:34 a.m. with Licensed Vocational Nurse (LVN)1, at medication cart one, LVN 1 stated the vial of Heparin was empty and left unattended on top of the cart. During a concurrent interview and record review on 3/19/24 at 11:09 a.m. with LVN 1, Resident 135 and Resident 140's Medication Administration Record (MAR), dated 3/2024 were reviewed. LVN 1 stated Resident 135 and Resident 140 were the only residents he had administered Heparin during his morning medication pass. LVN 1 stated the empty Heparin medication vial could have belonged to Resident 135 or Resident 140, which was administered between 6:59 a.m. and 7:40 a.m. LVN 1 stated he knows he should have disposed of the empty vial into the receptacle immediately after medication administration. During a review of the facility's P&P titled Medication: Administration, dated 3/7/24, the P&P indicated, . Used, discontinued medications originally dispensed from the pharmacy.should be promptly placed in a pharmaceutical waste bin.