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	03/20/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 51320 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 342) were answered with a prolonged delay. This failure had the potential for Resident 342 to experience psychosocial harm when she stated the delay made her feel unimportant. Findings: During a review of Resident 342's History and Physical (H&P), dated 3/15/25, the H&P indicated, Resident 342 had a lumbar laminectomy (the removal of the back part of a lower back bone). and was alert and oriented. During an interview on 3/17/25 at 10:27 a.m. with Resident 342, Resident 342 stated she pressed her call light when she required assistance to the bathroom. Resident 342 stated when she activated her call light prior to shift change, she would wait 45 minutes to an hour for a response. Resident 342 stated the staff would come into her room, turn off the call light, then leave the room. Resident 342 stated the staff help her use the bathroom thirty minutes after shift change. Resident 342 stated she was afraid she might urinate on her self because of the staff's delay in answering her call light when she needed to use the bathroom. Resident 342 stated the staff would come in with sighing noises before assisting her to the bathroom. Resident 342 stated the staff actions made her feel unimportant. During an interview on 3/19/25 at 8:41 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated staff should address the concerns of the resident when turning off the call light. During a review of the facility's policy and procedure (P&P) titled, Nurse Call System, dated 2024, the P&P indicated, D. Staff will respond promptly to ensure resident safety and health needs are met in a reasonable amount of time. During a review of the facility's P&P titled, California Standard Admission Agreement For Skilled Nursing Facilities and Intermediate Care Facilities, undated, the P&P indicated, .(e) Accommodation of needs.(1). receive services in the facility with reasonable accommodation of individual needs and preferences.

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 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. 50939 Based on observation, interview, and record review, the facility failed to provide services that meet professional standards when: 1. One of five sampled residents (Resident 343) did not have a physician's order severe pain. This failure resulted in Resident 343's severe pain to not be managed. 2. Four of Four Licensed staff (Registered Nurse [RN] 2, Licensed Vocational Nurse [LVN] 4, and RN 1) were unaware of the process of checking for Gastrostomy Tube (GTube - a tube surgically inserted to the abdomen into the stomach)'s placement for three of three sampled residents (Resident 21, Resident 8, and Resident 15). This failure had the potential for Resident 21, Resident 8, and Resident 15 to aspirate (accidental inhalation of foreign substances into the lungs) and had the potential to cause harm or death. 3. LVN 1 failed to flush the GTube with water between medication administration for one of five sampled residents (Resident 8). This failure had the potential for medications to clog or block the GTube and not reach the stomach for proper absorption. Findings: 1. During a concurrent observation and interview on 3/19/25 at 8:52 a.m. with LVN 1, in Resident 343's room, LVN 1 administered Norco (pain reliever for moderate pain) to Resident 343 for a pain level of 7 of 10 on a pain scale (1. Mild=1-3, 2. Moderate=4-6, 3. Severe=7-10.). During a review of Resident 343's Order Sheet (OS), dated 3/12/25, the OS indicated, Norco 1 tab, by mouth, every 4 hours. PRN [as needed] for pain, moderate (scale 4-6). During a review of Resident 343's Flowsheet Print Request (FPR), dated 3/19/25, the FPR indicated, Norco was administered for Numeric Pain Score above 6 on the following dates and times: 3/13/25 at 10:07 p.m. Numeric Pain Score of 7 3/14/25 at 3:59 p.m. Numeric Pain Score of 7 3/14/25 at 9:49 p.m. Numeric Pain Score of 8 3/15/25 at 3:24 p.m. Numeric Pain Score of 7 3/17/25 at 9:25 a.m. Numeric Pain Score of 9 3/17/25 at 11:18 a.m. Numeric Pain Score of 8 3/17/25 at 7:21 p.m. Numeric Pain Score of 7 3/18/25 at 9:49 p.m. Numeric Pain Score of 7 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/19/25 at 8:52 a.m. Numeric Pain Score of 7 During an interview on 3/19/25 at 2:38 p.m. with LVN 1, LVN 1 stated she did not notify the doctor regarding Resident 343's severe pain level of 7 out of 10. During an interview on 3/19/25 at 2:49 p.m. with Director of Nursing (DON) 1, DON 1 stated there was no severe pain medication order for Resident 343. DON 1 stated the nurse should have contacted the doctor regarding Resident 343's severe pain that was greater than six on the pain scale. DON 1 stated there was no documentation the nurse contacted the doctor regarding Resident 343's pain score of seven. During a review of the facility's P&P titled, Pain Assessment and Reassessment, Standards for, dated 10/20/22, the P&P indicated, Policy: [facility name]recognized and upholds the rights of patients to have pain safely and effectively managed .The presence and intensity of pain will be based on the patient's self-report . indicators in order to balance the need for pain control with the risk of over sedation. Patients will receive the best level of pain control that can be safely provided. All patient care staff will demonstrate competency in the identification and intervention for pain management within the scope of his/her role. Staff will gather data on the patient's level of pain and sedation as the 5th Vital Sign and communicate unexpected findings as appropriate among the healthcare team .VII. PRIOR TO PHARMACOLOGICAL INTERVENTION FOR PAIN: .C. Severity (0-10/10). Numeric values for pain for verbal .are defined as: 1. Mild=1-3, 2. Moderate=4-6, 3. Severe=7-10. 2. During an observation on 3/18/25 at 12:15 p.m. in Resident 21's room, RN 2 placed syringe on Resident 21's GTube port and aspirated (pulled out) to check for residual formula (amount of liquid left in the stomach). During an interview on 3/18/25 at 12:26 p.m. with RN 2, RN 2 stated she aspirated for residual formula to check for correct placement of a GTube During an observation on 3/20/25 at 8:27 a.m. in Resident 8's room, LVN 4 used a syringe to aspirate formula residuals from Resident 8's GTube. During an observation on 3/20/25 at 9:06 a.m. in Resident 15's room, LVN 4 used a syringe to aspirate Resident 15's GTube for residuals. During an interview on 3/20/25 at 9:24 a.m. with RN 1, RN 1 stated nurses can either aspirate with syringe to check for formula residuals or use a stethoscope to check for GTube placement. During an interview on 3/20/25 at 9:31 a.m. with LVN 4, LVN 4 stated we can aspirate the GTube for residual to check for placement. During an interview on 3/20/25 at 11:38 a.m. with DON 2, DON 2 stated nurses should follow the policy for medication administration via GTube. DON 2 stated using a stethoscope to check for placement was not on the policy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Medication: Administration, dated 11/2024, the P&P indicated, K. Administration via tube .4. Assessment prior to medication administration, (1) Verify placement of the tube prior to medication administration by checking markings on the tube to make sure it has not migrated. 3. During an observation on 3/20/25 at 8:27 a.m. in Resident 8's room, LVN 4 administered Famotidine (treats excess stomach acid) and then administered Carvedilol (treats high blood pressure) without flushing with 5 ml (milliliters) of water between each medication. During a review of the facility's P&P titled, Medication Administration, dated 11/20/24, the P&P indicated, 5. When administering multiple medications each separate medication must be crushed and dissolved separately and administered separately using 5 ml of water to flush in between each medication.

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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. 50939 Based on observation, interview, and policy review, the facility failed to ensure one of one medication cart (Medication Cart 1) was kept locked or under direct observation by authorized staff. This failure had the potential for residents, unauthorized staff, and visitors to have access to medications. Findings: During an observation on 3/19/25 at 8:25 a.m. outside the medication room, there was an unlocked medication cart (Medication Cart 1). Medication Cart 1 contained insulin vials. During an interview on 3/19/25 at 8:26 a.m. with Director of Nursing (DON) 1, DON 1 stated the medication cart should have been locked. During an interview on 3/19/25 at 8:27 a.m. with Director of Rehabilitation (DOR), DOR stated the medication cart should be kept locked when not in use. During a review of the facility's policy and procedure (P&P) titled, Medication: Security in Patient Care Areas, dated 9/23/19, the P&P indicated, Policy: All medications are to be stored in a secure manner and accessible to authorized staff only.D. Medication Carts 1. Medication carts must be locked when not in use.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51320 Based on observation, interview and record review, the facility failed to ensure three of three nutritional products available for resident use were not expired. This failure had the potential for residents to develop food borne illness. Findings: During a concurrent observation and interview on [DATE] at 11 a.m. with Registered Nurse (RN) 3 in Wing A medication room, there were three unopened pro source protein nutrition product that had an expiration date of [DATE]. RN 3 stated the expired pro source products should not have been available for resident use. During a review of the facility's policy and procedure (P&P) titled, Recall & [and] Expired Products, dated 2024, the P&P indicated, Recall and expired food and other nutrition products will not be provided to patients and customers.

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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** 42148 Based on observation, interview, and record review, the facility failed to follow infection control standards of practice when: 1. The vinyl cover on two of four linen carts in the hallway were damaged exposing the clean linen. 2. The Infection Preventionist Nurse (IPN) did not ensure infection control surveillance was being done on a regular basis. 3. A Wound Treatment Nurse (WTN) did not change gloves or wear gown in good repair during a wound care treatment for one of one sampled resident (Resident 5). 4. An used urinal was on a bedside table for one of one sampled resident (Resident 291). 5. The glucometer machine (measures the amount of sugar in the blood) was disinfected with unapproved wipes for two of two sampled residents (Resident 20, Resident 343). These failures had the potential to cause infections and spread of bacteria to residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 3/18/25 at 4:27 p.m. with Registered Nurse (RN) 4 near room [ROOM NUMBER], one linen cart's vinyl drape was open exposing the clean linen. RN 4 stated the linen cart vinyl cover should have been closed. During a concurrent observation and interview on 3/19/25 at 9:33 a.m. with IPN in the subacute unit, two linen carts were observed in the hallway. Both carts damaged vinyl covers with multiple tears and large holes. IPN stated, I am aware of this, it is unacceptable, clean linen should be covered without exposure. During a review of the facility's policy and procedure (P&P) titled, Linen Carts, dated 9/29/15, the P&P indicated, Laundry staff will monitor the condition of linen carts and cart covers and report issues to the Supervisor for action .III. Cart covers will be checked daily by the linen attendant and replaced as they become soiled or damaged. Covers will be removed when needed and washed, dried and returned to carts . V. Laundry staff will check carts daily and report needed repairs to maintenance department. 2. During an interview on 3/19/25 at 9:45 a.m. with IPN, IPN was unable to provide evidence of infection control monitoring, infection control audits or data collection. IPN stated, I don't document anything about surveillance on paper. I don't have any type of tracking system. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/20/25 at 10:53 a.m. with IPN and Infection Prevention Manager (IPM), the facility's P&P titled, Healthcare Associated Infection Surveillance Plan, dated 8/19/22, the P&P indicated, VII. Surveillance data will be summarized into a report for review by the Infection Prevention Committee. VIII. Surveillance summaries are included in the IP dashboard. IPN was unable to provide infection control surveillance data. IPN stated the data she reported to Quality Assurance Program Improvement was In my head. 3. During a concurrent observation and interview on 3/17/25 at 11:12 a.m. with WTN in Resident 5's room, Resident 5's wound care was performed by WTN. WTN entered Resident 5's room wearing a cloth gown missing the ties in the back, top, and bottom used to tie the gown closer to the body. WTN put on glovers. WTN removed Resident 5's brief and three soiled dressings from Resident 5's lower back and buttocks. WTN sprayed the lower back and buttock wounds with wound cleaner and removed feces from around the wounds. WTN applied a barrier cream to the wounds and three clean dressings. WTN turned Resident 5 to her back and removed the feeding tube dressing. WTN cleansed the area and placed a new dressing around the feeding tube. WTN did not change her gloves or wash her hands at any time during the procedures. The WTN's gown was falling off her shoulders and fell to her elbows during the procedures. WTN stated she should have changed gloves after moving from dirty (i.e. removing soiled dressing) to clean (i.e. handling clean supplies, applying medication). During a review of Centers for Disease Control and Prevention (CDC) Organization, the CDC indicated, It's crucial to change gloves and perform hand hygiene when moving from a dirty to a clean task or area, and also when gloves become soiled or damaged. During an interview on 3/19/25 at 2:19 p.m. with IPN, IPN stated if a gown is not in good condition and missing the strings that tie in the back, it was no longer a barrier and should not be worn by staff. During an interview on 3/19/25 at 2:20 p.m. with Laundry Manager (LM), LM stated, each building has a reject container for linens and staff gowns that were not in good condition. She stated a gown that is torn or missing the ties should not be worn, it should be placed in the reject container. 50939 4. During a concurrent observation and interview on 3/17/25 at 10:17 a.m. with Resident 291 in Resident 291's room, there was a used urinal on the bedside table near a water pitcher, grapes in an open storage bag, and a denture container. During an interview on 3/17/25 at 10:25 a.m. with Certified Nurses Assistant (CNA) 1, CNA 1 stated Resident 291's urinal should not be placed on Resident 291's bedside table. CNA 1 stated she should have placed the urinal on the urinal holder. During an interview on 3/19/25 at 10:59 a.m. with Director of Nursing (DON) 1, DON 1 stated the facility had a urinal holder that was placed at side of the bed. DON 1 stated Resident 291's used urinal should not have been placed on the bedside table next to his personal belongings. 5. During an observation on 3/18/25 at 12 p.m. at the nurse's station, Registered Nurse (RN) 2 used CAVI wipes (cleaner and disinfectant) to clean the glucometer machine then placed the glucometer machine on the charging port. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/25 at 12:01 p.m. with RN 2, RN 2 stated she used the CAVI wipes to clean the glucometer machine after checking residents fingerstick blood sugar. During an interview on 3/18/25 at 12:03 p.m. with Assistant Director of Nursing (ADON), ADON stated the facility used CAVI wipes or alcohol wipes to clean the glucometer machine after each resident use. During an interview on 3/19/25 at 8:32 a.m. with DON 1, DON 1 stated the staff are to clean the glucometer machine after resident use using an alcohol pad or a CAVI wipe. During a concurrent interview and record review on 3/20/2025 at 11:03 a.m. with Infection Preventionist Nurse (IPN), the Nova Biomedical Stat Strip Glucose Hospital Meter System (glucometer) Instructions for Use Manual, (IFUM) dated 2024 was reviewed. The IFUM indicated, Acceptable Cleaning and Disinfecting Materials: Nova Biomedical recommends the use of Clorox Healthcare Bleach Germicidal Wipes. IPN stated the facility's Sani-Cloth and CAVI wipes do not contain bleach. IPN stated she was not aware the glucometer machine required the use of disinfecting wipes which contained bleach for cleaning. During an interview on 3/20/25 at 1:23 p.m. with DON 1, DON 1 stated she did not know that the glucometer manual requires bleach for disinfecting. During a review of the facility's P&P titled, Equipment Cleaning and Low/Intermediate Level Disinfection, dated 6/27/24, the P&P indicated, Policy: All common areas and common equipment will be cleaned appropriately according to standards provided by . the manufactures' manuals/recommendations.