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	01/29/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 1) was provided dignified care when Resident 1's urine collection bag was not covered and was visible to other residents, staff, and visitors. This failure had the potential to result in emotional distress for Resident 1. Findings: During an observation on 1/26/26 at 12:33 p.m. in Resident 1's room, Resident 1 was sitting in his wheelchair. A urine collection bag containing yellow liquid was hanging from the right side of Resident 1's wheelchair. The urine collection bag was uncovered and contents were visible. During a concurrent observation and interview on 1/26/26 at 12:48 p.m. with Licensed Vocational Nurse (LVN) 8, in Resident 1's room. Resident 1 had an uncovered urine collection bag hanging from the right side of his wheelchair. LVN 8 stated he did not put the urine bag in a dignity bag because they did not have any in the facility. LVN 8 stated The Foley [urine collection bag] should be covered. During a current interview and record review with Director of Staff Development (DSD), the facility's orientation book titled, Non-Licensed LTC [long term care] Orientation, (NLO) undated was reviewed. DSD stated the NLO indicated the patient's privacy and dignity is always a priority and the indwelling catheters (IUC) bag must remain in a discreet cover. DSD stated IUCs should be covered with a dignity bag for privacy. During a review of the facility's NLO undated, the NLO indicated, Remember the patient's privacy and dignity is always a priority - the IUC bag must remain in a discreet cover when patient is out of their room-this bag cover must be changed as needed but at least every 30 days. During a review of the facility's policy and procedure (P&P) titled Resident Right and Responsibilities, dated 2025, the P&P indicated, It is the belief of this facility that each resident has a right to a dignified existence, self-determination.

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 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. Based on interview and record review, the facility failed to ensure two of 17 sampled residents (Resident 19 and Resident 23) were provided an opportunity to formulate an Advance Directive (legal document that specifies a person's medical care and end of life wishes, should the person become unable to communicate those wishes). This failure had the potential for residents' rights to formulate an advance directive, and medical care wishes and/or end of life issues to not be honored.Findings: During a concurrent interview and record review on 1/28/26 at 3:14 p.m. with Social Worker (SW), Resident 23's Social Services Evaluation (SSE), dated 4/12/24 was reviewed. SW stated there was no documentation Resident 23 had an Advanced Directive completed or if an Advanced Directive was offered. During a concurrent interview and record review on 1/28/26 at 8:18 a.m. with Director of Nursing (DON), Resident 19's medical record was reviewed. DON stated she was unable to find documentation of an Advanced Directive being offered or discussed with Resident 19 or his representative. During a review of the facility's policy and procedure (P&P) titled, Advance Directives dated 10/26/22, the P&P indicated, [The corporation] honors the patient's advance health care directives in inpatient and outpatient areas as they are made known to the organization. Patients admitted to the. skilled nursing units.will be asked if they have executed an Advance Directive designating their health care wishes and/or health care decision maker. Any patients desiring to formulate an Advance Directive with the capacity to do so will be assisted by being given a choice of an approved Advance Directive form. [The corporation] provides education to the Community about Advanced Directives. Under [state] law patients can designate a decision-maker to speak for them even when they are still able to speak for themselves. Procedure: I. Upon admission to. [the] skilled nursing units. all patients will be asked if they have an Advanced Directive or desire more information about Advance Directives.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interview and record review, the facility failed to ensure hygiene Activities of Daily Living (ADL- fundamental care tasks such as bathing, dressing, eating, toileting, moving in and out of bed or chair) were provided timely to one of three sampled dependent residents (Resident 7). This failure had the potential for skin breakdown and to negatively impact Resident 7's dignity.Findings:During an interview on 1/27/26 at 10:03 a.m. with Family Member (FM) 1, FM 1 stated her father does not always receive good care. FM 1 stated she came into the facility to visit him on a Saturday, and he had dried phlegm on his face and his brief was soiled with bowel movement (BM).During an interview on 1/27/26 at 10:22 a.m. with FM 2, FM 2 stated she had concerns with Resident 7's daily needs not being met. FM 2 stated she came to visit Resident 7 and there were a few times when his brief was soiled with BM.During an interview on 1/27/26 at 12 p.m. with Charge Nurse (CN), CN stated Resident 7 received his nutrition via feeding tube (essential nutrition, fluids, and medication are delivered directly into the stomach or small intestine for individuals unable to take in adequate nourishment by mouth).During an interview on 1/28/26 at 9:51 a.m. with CN, CN stated registered nurses (RN) round (checking on the resident's status) on their residents at the odd hours and certified nursing assistants (CNA) round at the even hours. CN stated if the resident had soiled briefs the CNA would be notified to change the resident's briefs. CN stated tube feeding is typically continuous over a 24 hour period and there is not a time when soiled briefs can be expected. CN stated all staff are responsible for ensuring dependent residents are clean, including washing their faces as needed.During an interview on 1/28/26 at 10:22 a.m. with CN, CN stated Resident 7 was dependent on staff for all his ADL needs.During a concurrent interview and record review on 1/28/26 at 11:05 a.m. with CN, Resident 7's ADLs for brief changes were reviewed. The following was noted:1/21/26 brief changed at 5 p.m.1/22/26 brief changed at 3 a.m. and 7 a.m.1/23/26 brief changed 7 a.m.1/24/26 brief changed 8 a.m.1/25/26 no brief change documented.1/26/26 brief changed 10 a.m., 3 p.m. and 5 p.m.1/27/26 brief changed 10 a.m., 1 p.m., 5 p.m. and 6 p.m.1/28/26 brief changed 3 a.m. and 5 a.m.CN stated the expectation was for all brief changes to be documented and when brief changes are not done frequently the resident's skin can begin to break down and result in wounds.A policy and procedure for ADL care for dependent residents was requested, none was provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Pressure Ulcer Prevention and Treatment for one of three sampled residents (Resident 7). This failure had the potential to cause pressure injuries (damaged skin and underlying tissue from prolonged pressure) and had the potential to increase Resident 7's susceptibility to pneumonia.Findings:During an interview on 1/27/26 at 10:03 a.m. with Family Member (FM) 1, FM 1 stated Resident 7 had to go to the hospital every few months for pneumonia.During a concurrent interview and record review on 1/28/26 at 11:22 a.m. with Minimum Data Set (resident assessment tool) Coordinator (MDSC), Resident 7's MDS was reviewed. MDS Section I indicated, Resident 7 had a diagnosis of Chronic Respiratory Failure. MDS Section O indicated, Resident 7 had a tracheostomy (surgical opening in neck to assist in breathing) and was on a ventilator (mechanical method to provide breathing).During a concurrent interview and record review on 1/28/26 at 3:11 p.m. with Charge Nurse (CN), Resident 7's MDS Self-Care Performance indicated, he was dependent on staff for all his Activities of Daily Living (ADL- fundamental care tasks such as bathing, dressing, eating, toileting, moving in and out of bed or chair) needs. CN stated Resident 7 relies on staff for all his care needs.During a concurrent interview and record review on 1/28/26 at 3:33 p.m. with CN, Resident 7's medical record was reviewed. The Care Plan for pressure injury prevention, dated 11/7/25, indicated Resident 7 was to be turned and repositioned every two hours. Resident 7's Turn documentation was reviewed, the following was noted:1/20/26 turned at 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., 7 p.m., and 9 p.m.1/21/26 turned at 6 a.m., 8 a.m., 10 a.m., 12 p.m., 2 p.m., and 4 p.m.1/22/26 turned at 7 a.m. and 7 p.m. 1/23/26 turned at 6 a.m., 7 a.m., 11 a.m., 1 p.m., and 9 p.m. 1/24/26 turned at 8 a.m. and 11 a.m. 1/25/26 turned at 6 a.m., 7 a.m., and 7 p.m.1/26/26 turned at 8 a.m., 10 a.m., and 11 a.m. 1/27/26 turned at 6 a.m., 7 a.m., 9 a.m., 10 a.m., 12 p.m., 2 p.m., 4 p.m., and 6 p.m. 1/28/26 turned at 6 a.m. and 8 a.m. During a concurrent interview and record review on 1/29/26 at 10:13 a.m. with Director of Nursing (DON), DON stated Resident 7 was transferred and admitted to the hospital on [DATE]. The hospital History and Physical (H&P), dated 10/25/25, indicated Resident 7's admission diagnosis was, Health Care Associated Pneumonia. DON stated Resident 7 was discharged from the hospital and returned to the facility on [DATE].During an interview on 1/29/26 at 10:38 a.m. with DON, DON stated that expectation for repositioning dependent residents every two hours is important for skin health and prevention of pneumonia.During a review of the facility's P&P titled, Pressure Ulcer Prevention and Treatment dated 9/20/24, the P&P indicated, B. Patient's position should be changed at least every two hours especially when patient is bedbound.

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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. Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P), titled SNF Storage of Leftover Patient Food. when a refrigerator was not provided for resident's food brought in by family. This failure had the potential to place residents at risk of foodborne illness due to unmonitored food brought in by the family and could limit food choices and options for residents. Findings: During a concurrent interview and record review on 1/27/26 at 2:50 p.m. in a room next to the nurse's station, with Licensed Vocational Nurse (LVN) 9. The refrigerator in the room had a posted sign on the outside of the refrigerator door. The sign indicated No patient food from home allowed in fridge per policy number: FNS. 615. LVN 9 stated resident's food could not be placed that refrigerator. LVN 9 stated she was unaware of a refrigerator at the facility that was used to store residents' food from home. LVN 9 stated she was not aware family could bring in food for the residents to be stored at the facility. During a concurrent interview and record review on 1/27/26 at 2:57 p.m. with LVN 9, the P&P titled, SNF [skilled nursing facility] Storage of Leftover Patient Food was reviewed, LVN 9 stated she was not aware of the SNF Storage of Leftover Patient Food P&P. During a concurrent interview and record review on 1/28/26 at 9:46 a.m. with Director of Rehabilitation (DOR), the P&P titled, SNF Storage of Leftover Patient Food was reviewed. DOR stated the refrigerator that was used for residents to store their food was not working. DOR stated they had not been able to store food brought in for residents and stated the P&P should have been followed. During a review of the facility's P&P titled, SNF Storage of Leftover Patient Food, dated 2025, the P&P indicated, 1. Any food item that is brought from the outside for a resident that is left over and requires cold storage will be labeled by nursing with patient name, room number and date the food was brought in. II. Food items requiring cold storage will be stored in a clearly labeled patient food refrigerator on the unit.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and record review the facility failed to ensure the facility Medical Director had oversight over medical services and resident care when the medical director did not attend three quarterly Quality Assurance and Performance Improvement (QAPI- data-driven, comprehensive, and proactive approach to improving safety and quality in healthcare, particularly nursing homes) committee meetings. This failure had the potential to compromise patient safety. Findings:During a concurrent interview and record review on 1/29/26 at 2:47 p.m. with Director of Nursing (DON), the Quarterly Performance Improvement (QPI), committee attendance sign in records dated 6/27/25, 9/19/25, and 1/8/26 were reviewed. The QPI committee attendance sign in records indicated the Medical Director's signature was not documented for the QPI quarterly meetings on 6/27/25, 9/19/25, and 1/8/26. The DON stated the medical director had not attended the last three QPI committee meetings.During a review of the facility's P&P titled, Quality Improvement, dated 3/17/25, the P&P indicated, Membership includes the following personnel: Medical directors.

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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. Based on observation, interview, and record review the facility failed to follow infection control standards when a germicidal (substance that destroys germs) wipe container was left open exposing the germicidal wipes. This failure had the potential for the germicidal solution to be ineffective against germs which could lead to the spread of illness and diseases to residents, staff, and visitors.Findings:During a concurrent observation and interview on 1/29/26 8:05 a.m. with Registered Nurse (RN) 1, at the nurses station, a Germicidal wipes container with wipes sticking out through the open top was on a wall near the nurses station. RN 1 stated the Germicidal container needed to be closed. During a concurrent interview and record review on 1/29/26 at 9:20 a.m. with Infection Prevention Manager (IPM) and Infection Preventionist (IP) the facility's training manual, titled, Infection Prevention (undated) was reviewed. The training manual indicated, Germicidal wipes closed lid=[equals] wet wipes=working disinfectant! Germicidal wipe container lids must be kept closed. Germicidal wipe containers left open dry out. Dried wipes do not disinfect. The IP stated the container needs to be kept closed so it does not create a wick (process of absorbing or drawing away fluid) effect and dries out the germicidal wipes.