STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055551	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoia Transitional Care	350 North Villa Street Porterville, CA 93257

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 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38993 Based on observation, interview, and record review, the facility failed to provide care and services for one of three sampled residents (Resident 1) who was high risk for falls, had history of falls, and had a diagnosis of Dementia (decline in memory and thinking, severe enough to interfere with daily life) when Resident 1 was left waiting in the room to be toileted for approximately 30 minutes. This failure resulted in Resident 1 falling, sustaining laceration (cut) to the top of the head requiring three staples (little wire), and compression fracture (a type of broken bone that can cause the spine to collapse) of T (thoracic- middle section of spine) 5 (T5- is the fifth bone of the thoracic spine located in the middle of the back). Findings: During a review of Resident 1 ' s Admission Record (AR), dated 4/8/25, the AR indicated, Resident 1 was initially admitted on [DATE]. The AR indicated, Diagnosis. Repeated Falls.Muscle Weakness.Dementia. During a review of Resident 1 ' s annual Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 2/17/25, the MDS indicated Resident 1 had a BIMS (Brief Interview for Metal Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 6 (0-7 severely impaired [decline in one or more mental abilities that affects a person ' s daily functioning]). The MDS section GG-Functional Abilities (a person ' s capacity to perform everyday activities) F. Toilet transfer: The ability to get on and off a toilet or commode (furniture shaped like a chair). indicated Resident 1 was 01. Dependent-Helper does ALL the effort, Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. During a review of Residents 1 ' s Post Fall Review (PFR-assessment after a fall to identify factors contributing to the fall to determine the necessary course of care), dated 6/15/24, 7/5/24, 7/26/24, 2/24/25, 3/1/25 and 3/30/25, the PFR ' s indicated Resident 1 was High Risk for falls. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan ([current] CP) titled, Falls date initiated 5/24/24, the CP indicated, Resident 1 had 6/15/24 un-witness fall, 7/5/24 un-witness fall, 7/25/24 un-witness fall, 7/26/24 un-witness fall, 2/24/25 un-witness fall, 3/1/25 un-witness fall, 3/30/25 un-witness fall. Resident 1 ' s CP titled, ADL (Activities of Daily Living)/Mobility dated 2/18/25 indicated, Resident 1 has actual at risk for ADL/mobility decline and requires assistance related to cognitive impairment, fluctuating (constant changing) ADLs, medical conditions, weakness. Goal included Will have needs anticipated and met by staff. Intervention included, Toileting: Assist of total dependence. During a review of Resident 1 ' s Change of Condition (COC) dated 3/30/25 at 6:24 p.m., the COC indicated, . resident (Resident 1) had fallen while she was attempting to use the bathroom.sent out (acute hospital) due to having neck and back pain along with the bleeding that was coming from her head. During a review of the facility investigative report titled, Facility Reported Event (FRE), undated, the FRE indicated, on 3/30/25 at 5:20 p.m. Resident 1 had an unwitnessed fall in her bathroom. The FRE indicated a full investigation was completed and indicated at approximately 4:40 p.m. Resident 1 had asked for help to be taken to the bathroom by Certified Nursing Assistant (CNA 3). At approximately 5:10 p.m. (30 minutes later) CNAs nearby heard a noise and found Resident 1 on the bathroom floor. During a concurrent observation and interview on 4/8/25 at 1:47 p.m. with Resident 1, Resident 1 was noted lying in bed. Resident 1 stated on 3/30/25 I had to pee, but nobody came.I told a couple of people I had to pee, and they walked in and left.I took myself to the bathroom because no one came when I scream and holler. I fell out. I have three staples on my head. It feels like I broke everything. During an interview on 4/8/25 at 1:57 p.m. with Licensed Vocational Nurse (LVN), LVN 1 stated Resident 1 was admitted to the acute hospital (3/30/25) for observation and readmitted to the facility on [DATE] with three staples on top of the head, with T5 compression fracture (broken bone) and a back brace (a device fitted to something, in particular a weak or injured part of the body, to give support). During an interview on 4/8/25 at 2:05 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated Resident 1 was alert with confusion (lack of understanding). CNA 1 stated Resident 1 had a history of falling and required assistance (total) in toileting. During an interview on 4/8/25 at 2:09 p.m. with LVN 2, LVN 2 stated on 3/30/25 at approximately 5:30 p.m., Resident 1 had slipped and fell while taking herself to the bathroom. LVN 2 stated Resident 1 was found lying on the bathroom floor up against the wall, bleeding from her head. LVN 2 stated Resident 1 was sent to the acute hospital (3/30/25) and stated the fall and fracture could have been prevented if Resident 1 was assisted right away to the toilet. LVN 2 stated right away is within two minutes. During an interview on 4/8/25 at 2:18 p.m. with CNA 2, CNA 2 stated on 3/30/25 during dinner time, she heard Resident 1 yelling. CNA 2 stated Resident 1 was found on the floor in the bathroom with her pants down. CNA 2 stated, It looked like she (Resident 1) tried to go use the bathroom. CNA 2 stated Resident 1 was a fall risk and required assistance for toileting. CNA 2 stated the fall could have been prevented if Resident 1 was taken to the bathroom. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/8/25 at 4 p.m. with Director of Nurses (DON), the FRE was reviewed. DON stated on 3/30/25 at 5:20 p.m. Resident 1 had an unwitnessed fall in the bathroom. DON confirmed Resident 1 was left waiting to be assisted to the bathroom for approximately 30 minutes. DON stated 30 minutes was a long time to wait for assistance. During an interview on 4/10/25 at 2:10 p.m. with CNA 3, CNA 3 stated on 3/30/25 at approximately 4:40 p.m. Resident 1 requested to be taken to the bathroom. CNA 3 stated he left Resident 1 in the room without assisting Resident 1 to the bathroom. CNA 3 stated at approximately 5:10 p.m. (30 minutes later) Resident 1 was heard yelling and was found on the bathroom floor. CNA 3 stated Resident 1 was a high fall risk for falls and cannot take herself to the bathroom. CNA 3 stated the fall could have been prevented if Resident 1 was taken to the bathroom right away. During a review of acute hospital Resident 1 ' s Emergency Department (ED) note, dated 3/30/25 at 7:22 p.m. , the ED note indicated, Chief Complaint.unwitnessed fall from (facility name) . staff heard fall and checked on her. Neck pain, back pain, left thumb swelling, lac (laceration) to head. Attempted to self-transfer to bathroom. During a review of Resident 1 ' s MRI (Magnetic resonance imaging-test that produces detailed images including bones), dated 3/31/25 at 11:12 a.m., the MRI result indicated, acute (recent) compression fracture of T5. During a review of the facility ' s policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, dated 3/18, the P&P indicated, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: .c. elimination (toileting).