

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055551	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Sequoia Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the physician of a change of condition for one of three sampled residents (Resident 1) when there was significant weight loss. This failure resulted in the physician being unaware of significant weight loss and the potential for Resident 1 to have unmet nutritional needs. Findings: During a review of Resident 1's IDT (Interdisciplinary Team-group of medical professionals from diverse specialties who work together to address a patient's complex needs) - Weight Variance Assessment (WVA) dated 2/16/26, the WVA indicated, Problem weight (lb-pound) -18 lbs. weight loss/gain (%) -9.6 % in (x) number of weeks. 2. During a review of Resident 1's WVA dated 2/23/26, the WVA indicated, Root cause analysis. 26 lb/13% wt. (weight) loss x 3 weeks since admit. During a review of Resident 1's WVA dated 3/2/26, the WVA indicated, Root cause analysis. 29 lb/15 % wt loss x 4 weeks since admit. During a review of Resident 1's WVA dated 3/9/26, the WVA indicated, Root cause analysis. 36 lb/19% wt loss x 5 weeks since admit. During a review of Resident 1's WVA dated 3/16/26, the WVA indicated, Root cause analysis. 37 lb/20% wt loss x 6 weeks since admit. During a review of Resident 1's WVA dated 3/30/26, the WVA indicated, Root cause analysis. 38 lb/20% wt loss x 2 months [sic] since admit. During a concurrent interview and record review on 6/3/26 at 2:40 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed the weight committee binder notes. LVN 1 stated she was responsible for notifying the physician with a change of condition when there was a significant weight change. LVN 1 stated a significant weight loss was a loss or gain of 5% in 30 days, 7.5 % in 90 days and 10 % in 6 months. LVN 1 stated Resident 1 had experienced a significant weight loss from admit (1/31/26) up to 4/8/26 when her weight stabilized. LVN 1 stated at the time she was informing the physician of the weights weekly via a faxed list, but it was being sent to the wrong physician. LVN 1 stated when Resident 1 had a significant weight loss she did not complete a change of condition and she should have. During a concurrent interview and record review on 6/15/26 at 2:28 p.m. with Director of Nursing (DON), DON reviewed Resident 1's clinical record. DON was unable to provide evidence that a change of condition was completed to notify the physician of Resident 1's significant weight losses. DON stated that when Resident 1 had significant weight changes a change of condition should have been completed. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status undated, the P&P indicated, The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-call Physician when there has been a significant change in the resident's physical/emotional/mental condition. A significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Impacts more than one area of the resident's health status. Requires interdisciplinary review and/or revision to the care plan. During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention undated, the P&P indicated, any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. The threshold for significant unplanned and undesired weight loss will be based on the following criteria. 1 month - 5% weight loss is significant; greater than 5 % is severe. 3 months - 7.5% weight loss is significant; greater than 7.58 % is severe. 6 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055551 If continuation sheet Page 1 of 6

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	months - 10% weight loss is significant; greater than 10% is severe. The physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss or increasing the risk of weight loss.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to:1. Develop a care plan when one of three sampled residents (Resident 1) experienced significant weight loss;2. Implement interventions when significant weight loss was identified for one of three sampled residents (Resident 1).These failures resulted in the potential for Resident 1 to have continued weight loss and unmet nutritional needs.Findings:1. During a review of Resident 1's IDT (Interdisciplinary Team-group of medical professionals from diverse specialties who work together to address a patient's complex needs) - Weight Variance Assessment (WVA) dated 2/16/26, the WVA indicated, Problem weight (lb-pound) -18 lbs.weight loss/gain (%) -9.6 %.in (x) number of weeks.2.Interventions/Implementations.Diet is liberalized for max (maximum) diet variety.(2/4) SLP (speech language pathologist) following for safest, least restrictive diet. Clear protein drink BID (twice a day).Appetite stimulant in place. Continue weekly NAR (nutritional at risk) monitoring.During a review of Resident 1's WVA dated 2/23/26, the WVA indicated, Root cause analysis.26 lb/13% wt. (weight) loss x 3 weeks since admit.Interventions/Implementations.Add magic cup (high-calorie, high-protein nutritional supplement) QD (every day) at lunch. Continue weekly NAR monitoring.During a review of Resident 1's WVA dated 3/2/26, the WVA indicated, Root cause analysis.29 lb/15 % wt loss x4 weeks since admit.Interventions/Implementations.Magic cup QD trialed but poorly accepted. Will d/c (discontinue) IV (intravenous administered through a vein) provided. Banatrol (medical food and dietary supplement used to naturally manage and thicken loose stools) in place for loose stools. Continue weekly NAR monitoring.During a review of Resident 1's WVA dated 3/9/26, the WVA indicated, Root cause analysis.36 lb/19% wt loss x 5 weeks since admit.interventions/Implementations.Care conference to discuss POC (plan of care) w/ (with) RP (responsible party). Continue weekly NAR monitoring.During a review of Resident 1's WVA dated 3/16/26, the WVA indicated, Root cause analysis.37 lb/20% wt loss x 6 weeks since admit.Interventions/Implementations.Continue weekly NAR monitoring.During a concurrent interview and record review on 6/16/26 at 9:24 a.m. with Assistant Director of Nursing (ADON), ADON reviewed Resident 1's clinical record. ADON was unable to provide evidence that a care plan was developed when Resident 1 experienced significant weight loss. ADON stated it was the responsibility of the weight committee to develop the care plan.2. During a review of Resident 1's WVA dated 3/9/26, the WVA indicated, Root cause analysis.36 lb/19% wt loss x 5 weeks since admit.interventions/Implementations.Care conference to discuss POC (plan of care) w/ (with) RP (responsible party).During an interview on 6/3/26 at 2:40 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there was a care plan conference recommended to discuss Resident 1's weight loss with the responsible party on 3/9/26 but she did not know if the care plan conference was held.During an interview on 6/15/26 at 1:57 p.m., with Registered Dietitian (RD), RD stated it was his responsibility to complete the weight changes and report them at the weight committee meeting. RD stated it was the responsibility of LVN 1 to reach out to Social Services (SS) to coordinate the care plan conference with the responsible party and he would attend if he was available. RD stated he did not recall participating in a meeting or know if a care plan conference was held.During a concurrent interview and review of the clinical record for Resident 1on 6/15/26 at 2:28 p.m. with Director of Nursing (DON), DON reviewed Resident 1's clinical record. DON was unable to provide documentation for the care plan conference.During an interview on 6/15/26 at 2:49 p.m. with Social Service Assistant (SSA), SSA stated she was unaware of a care plan conference regarding Resident 1's significant weight loss needing to be scheduled with Resident 1's responsible party.During a review of the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention undated, the P&P indicated, Care planning for weight loss or impaired nutrition will be a multidisciplinary effort and will include the Physician, nursing staff, the Dietitian, the Consultant Pharmacist, and the resident or resident's legal surrogate.Individualized care plans shall address, to the extent possible.the identified (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	causes of weight loss; goals and benchmarks for improvement; and time frames and parameters for monitoring and reassessment.		

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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. Based on interview and record review, the facility failed to ensure physicians orders were followed when labs were not completed for one of three sampled residents (Resident 1). This failure resulted in a delay of care and Resident 1 experiencing lower abdomen (part of the body between the chest and pelvis) pain, requiring transfer to the hospital and being diagnosed with a urinary tract infection (UTI-infection in any part of your urinary system).Findings:During a review of Resident 1's Care Plan Report (CP) dated 2/2/26, the CP indicated, Bladder incontinence: (Resident name) has mixed bladder incontinence and is reflatd to recent hospitalization, weakness.date initiated 2/2/26.interventions/tasks.labs per order. Notify physician of results.date initiated.2/2/26.During a review of the General Surgery Clinic Office Note (CSCON) dated 3/23/26, the CSCON indicated, Orders.Urinalysis (used to diagnose urinary tract infection), C/S (culture and sensitivity) if indicated.Iron Panel (group of blood tests that evaluate how much iron is circulating, moving, and stored in your body).H pylori (common bacteria that infects the lining of your stomach and the upper part of your small intestine) stool ag (antigen) (stool sample that checks for specific proteins released by H pylori bacteria).During a review of Resident 1's Progress Notes (PN) dated 3/23/26 at 3:30 p.m., the PN indicated, Resident came back from her app (appointment) with new orders for labs in 2 weeks.UA with C&S, H Pylory [sic].iron studies. Orders in place.During a review of Resident 1's Order Summary Report (OSR) dated 6/3/26, the OSR indicated, .UA with C&S/H pylory [sic].iron studies.Start date 4/2/26.During a review of Resident 1's PN dated 4/18/26 (16 days after the labs were ordered to be collected) at 4:30 a.m., the PN indicated, Resident had a large amount of dark red urine and had discomfort from spasms in her rectum. Resident says her lower abdomen comes and goes with pain.Recommendations.Send to ED (emergency department) for further evaluation.During a review of Resident 1's Imaging Report (IR) dated 4/18/26, the IR indicated, CT (computed tomography- x-ray procedure that takes slices of the body to help diagnose diseases or injuries) abdomen with intravenous (administered through the vein) contrast (substance used during imaging tests to highlight specific organs, blood vessels, or tissues).CT pelvis with intravenous contrast.indications.hematuria (blood in urine) today.Impression.Minimal right hydronephrosis (the swelling of one or both kidneys that occurs when urine cannot drain properly and builds up) without ureteral (carry urine from kidneys to bladder) calculi (stone like deposits that form inside the body), consider urinary tract infection.During a review of Resident 1's emergency room Note dated 4/18/26 at 6:42 a.m. reevaluated patient noted that patients Foley catheter (a thin tube inserted into the bladder to drain urine) containing gross blood, patient feels she has had a UTI for a while has made her facility aware, patient feels nothing has been done to address the UIT [sic].7:57 a.m. after a brief course of continuous bladder rogation [sic], patient's urine cleared completely without any complications. Patient received antibiotics for urinary tract infection.During a review of Resident 1's PN dated 4/20/26 at 2:33 p.m., the PN indicated, IDT (Interdisciplinary Team-group of medical professionals from diverse specialties who work together to address a patient's complex needs).On 4/18/26 resident was noted to have hematuria with suprapubic (above the pubic bone) pain noted. MD (Doctor of Medicine) notified and received order to send to ER (Emergency room) for evaluation and treatment. Resident returned from (hospital name) on 4/18/26 with dx (diagnosis).UTI (urinary tract infection). Received order for ciprofloxacin (antibiotic used to treat infection) .During an interview on 6/3/26 at 11:55 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated a couple of months ago she provided care to Resident 1 and there was blood in her urine. CNA 1stated she reported it to the nurse and the nurse wanted to get a urine sample, but she didn't know if it was ever collected.During a concurrent interview and record review, on 6/15/26 at 2:28 p.m. with Director of Nursing (DON), DON reviewed Resident 1's clinical record. DON was unable to provide evidence of the labs being completed as ordered. DON stated the labs were not completed and they should have been. During a review of the facility's policy and procedure (P&P) titled, Physician orders, accepting, transcribing (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and implementing (noting) undated, the P&P indicated, Licensed nursing personnel will ensure that telephone and verbal orders will be recorded and implemented. During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol dated 11/18, the P&P indicated, The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. the staff will process test requisitions and arrange for tests.		