

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 01/09/2025
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)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>40516</p> <p>Based on interview and record review, the facility failed to ensure the resident's representative and the state long term care ombudsman (representatives who assist residents in long-term care facilities with issues related to day-to day care, health, safety, and personal preferences) were notified, in writing, when two of seven sampled residents (Resident 52 and Resident 82) were transferred to the hospital. This failure resulted in the resident representative and the ombudsman to not be aware of resident's healthcare status and location.</p> <p>Findings:</p> <p>During an interview on 1/7/25 at 2:37 p.m. with Resident 52, Resident 52 stated he had been to the hospital several times because of his diabetes (disorder characterized by difficulty in blood sugar control and poor wound healing) and high blood pressure.</p> <p>During a concurrent interview and record review on 1/8/25 at 3:36 p.m. with Minimum Data Set (MDS - a federally mandated resident assessment tool) Consultant (MDSCL), Resident 52's medical record was reviewed. MDSCL stated Resident 52 was transferred to the hospital on 3/27/24 for GI [Gastro (stomach)-intestinal] bleeding and nausea and vomiting. Resident 52's History & Physical (H&P) dated 4/12/24 indicated, Resident 52 was discharged from the hospital and readmitted to the facility with a diagnosis of GI bleed. MDSCL stated Resident 52's family member was not notified because the nurse listed Resident 52 as his own representative. Resident 52's Admission Record was reviewed. MDSCL stated Resident 52's family member was listed as his Responsible Party (RP) and should have been notified. MDSCL stated Resident 52 was transferred to the hospital on 10/9/24 due to a fall but his family member was not notified because the Voicemail box was full. The facility H&P dated 10/11/24 indicated, Resident 52 was discharged from the hospital and readmitted to the facility with diagnoses of altered mental status, chronic kidney disease, high blood acid levels, high levels of potassium in his blood.</p> <p>During an interview on 1/8/25 at 4:01 p.m. with Social Services Designee (SSD), SSD stated she did not notify RPs in writing when residents were transferred to the hospital, and she did not send notification to the ombudsman when a resident was discharged /transferred to the hospital.</p> <p>46958</p> <p>(continued on next page)</p>

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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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 82's, Transfer Form (TF), dated 11/12/24, the TF indicated, Resident 82 was transferred to the hospital on 11/12/24.</p> <p>During an interview on 1/9/25 at 9 a.m. with SSD, SSD stated she did not notify the ombudsman about Resident 82's transfer to the hospital.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, Facility-Initiated, dated 10/2022, the P&P indicated, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy . 1. When a resident is transferred or discharged from the facility, the following information is documented . b. That an appropriate notice was provided to the resident and/or legal representative . 3. A copy of the notice is sent to the office of the State Long-Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40516</p> <p>Based on observation, interview and record review, the facility failed to ensure individualized, person-centered care plans were developed and implemented for three of six residents (Resident 46, Resident 52, and Resident 79). This failure had the potential for care needs to not be met.</p> <p>Findings:</p> <p>a. During an observation on 1/7/25 at 10:41 a.m. in Resident 46's room, Resident 46 was in her wheelchair, and she was speaking in short clips of gibberish with no discernable words.</p> <p>During an interview on 1/8/25 at 3:46 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she can understand Resident 46's needs from having cared for her for the past year.</p> <p>During a concurrent interview and record review on 1/8/25 3:36 p.m. with Minimum Data Set (MDS - a federally mandated resident assessment tool) Consultant (MDSCL), Resident 52's medical record was reviewed. MDSCL stated Resident 52 was transferred to the hospital on 3/27/24 for GI [gastro (stomach)-intestinal] bleeding and nausea and vomiting. Resident 52's History & Physical (H&P) dated 4/12/24 indicated Resident 52 was discharged from the hospital and readmitted to the facility with a diagnosis of GI bleed. MDSCL was not able to find a care plan for GI bleeding.</p> <p>b. During a concurrent interview and record review on 1/9/25 at 10:41 a.m. with MDSCL, Resident 79's medical record was reviewed. The Bowel and Bladder Observation/assessment dated [DATE] indicated, Incontinence [inability to control bladder and/or bowel] Assessment 1. Length of incontinence 1. Days and 3. Needs assistance getting to toilet. MDS Section H indicated, Urinary continence 3. Always incontinent and Bowel Continence 3. Always incontinent. MDSCL stated she was unable to find a care plan for incontinence.</p> <p>c. During a concurrent interview and record review on 1/9/25 at 2:11 p.m. with MDSCL, Resident 46's medical record was reviewed. The Minimum Data Set (MDS- Assessment tool) Section B indicated, Speech Clarity 1. Unclear speech. Makes Self Understood 3. Rarely/never understood. MDSCL stated she was unable to find a care plan for a speech deficit.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition, b. when the desired outcome is not met, c. when the resident has been readmitted to the facility from a hospital stay.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>40516</p> <p>Based on observation interview and record review, the facility failed to ensure a communication tool was used for one of one sampled resident (Resident 46) with a speech impairment. This failure had the potential for Resident 46's concerns and needs to be unmet and for her psychosocial health to be negatively impacted.</p> <p>Findings:</p> <p>During an observation on 1/7/25 at 10:41 a.m. in Resident 46's room, Resident 46 was in her wheelchair, and she was speaking in short clips of gibberish with no discernable words.</p> <p>During an interview on 1/8/25 at 3:46 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated she can understand Resident 46's needs from having cared for her for the past year.</p> <p>During a concurrent interview and record review on 1/9/25 at 2:11 p.m. with Minimum Data Set Consultant (MDSCL), Resident 46's medical record was reviewed. The Minimum Data Set (MDS- Assessment tool) Section B indicated, Speech Clarity 1. Unclear speech. Makes Self Understood 3. Rarely/never understood.</p> <p>During an interview on 1/9/25 at 2:26 p.m. with Minimum Data Set Coordinator (MDSC), MDSC stated not using a communication tool for Resident 46 would make it difficult for newer staff assigned to care for her, to understand her, and meet her needs.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Effective Communication, dated 2/2018, the P&P indicated, Staff will assist hearing impaired residents and residents with language barriers to maintain effective communication with clinicians, caregivers, other residents and visitors.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40516</p> <p>Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Repositioning, for three of three sampled residents (Resident 71, and Resident 52) who were dependent on staff to change position or transfer. This failure had the potential to result in further loss of mobility and skin breakdown.</p> <p>Findings:</p> <p>a. During an interview on 1/7/25 at 9:10 a.m. with Resident 71, Resident 71 stated she does not get out of bed or do any exercising because it might interfere with her brittle bones.</p> <p>During a concurrent interview and record review on 1/8/25 at 10:55 a.m. with Assistant Director of Nursing (ADON), Resident 71's medical record was reviewed. The Minimum Data Set (MDS- Assessment tool) Section GG Functional Abilities indicated, Resident 71 was Dependent on facility staff to A. Roll left and right: B. Sit to lying: C. Lying to sitting on side of bed: D. Sit to stand: E. Chair/bed-to-chair transfer . FF. Tub/shower transfer. The Task: Turn and Reposition (TTR) dated 12/26/24 to 1/8/25 was reviewed and the following was noted:</p> <p>12/26/24 Resident 71 was turned at 1:59 p.m., and 4:52 p.m.</p> <p>12/27/24 Resident 71 was turned at 1:59 a.m., 10:37 a.m., 5:33 p.m., and 11:03 p.m.</p> <p>12/28/24 Resident 71 was turned at 8:48 a.m., 2:50 p.m., and 11:42 p.m.</p> <p>12/29/24 Resident 71 was turned at 6:35 a.m., and 3:17 p.m.</p> <p>12/30/24 Resident 71 was turned at 1:38 a.m., 7:35 a.m., 3:24 p.m., and 10:47 p.m.</p> <p>12/31/24 Resident 71 was turned at 9:43 a.m. and 2:59 p.m.</p> <p>1/1/25 Resident 71 was turned at 5:49 a.m., 8:14 a.m., and 5:17 p.m.</p> <p>1/2/25 Resident 71 was turned at 1:42 a.m., 9:28 a.m., 4:04 p.m., and 11:55 p.m.</p> <p>1/3/25 Resident 71 was turned at 9:42 a.m., 3:10 p.m., and 4:52 p.m.</p> <p>1/4/25 Resident 71 was turned at 1:43 p.m., 2:14 p.m., and 11:07 p.m.</p> <p>1/5/25 Resident 71 was turned at 6:38 a.m., 2:32 p.m., and 10:44 p.m.</p> <p>1/6/25 Resident 71 was turned at 1:59 p.m., and 10:28 p.m.</p> <p>1/7/25 Resident 71 was turned at 3:45 a.m., 9:09 a.m., and 5:12 p.m.</p> <p>1/8/25 Resident 71 was turned at 1:31 a.m. and 9:49 a.m.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. During a concurrent observation and interview on 1/7/25 at 2:30 p.m. with Resident 52, in his room, Resident 52 was in a wheelchair. Resident 52 was unable to use his left arm. Resident 52 stated he relies on the nursing staff to turn him when he was in bed.</p> <p>During a review of Resident 52's, Admission Record (AR), the AR indicated, a diagnosis of Hemiplegia [inability to use one side of the body] and Hemiparesis [muscle weakness on one side of the body] following Cerebral Infarction [loss of blood flow to a part of the brain, causing brain tissue to die] affecting left non-dominant side.</p> <p>During a concurrent interview and record review on 1/9/25 at 11:47 a.m. with Minimum Data Set Consultant (MDSCL), Resident 52's medical record was reviewed. MDS Section GG Functional Abilities dated 12/3/24 indicated Resident 52 was dependent on staff for mobility. The Care Plan dated 11/23/24 indicated an ADL [activities of daily living] Self Care Deficit r/t [related to] Activity Intolerance, Confusion, Hemiplegia, Stroke [blood flow to brain is interrupted, causing damage to brain tissue]. MDSCL stated the care plan does not indicate Resident 52 is dependent on staff for mobility and that the MDS is more accurate. The TTR dated 12/27/24 to 1/9/25 was reviewed and the following was noted:</p> <p>12/27/24 Resident 52 was turned at 12:30 a.m., 8:51 a.m., 5:08 p.m., and 10:57 p.m.</p> <p>12/28/24 Resident 52 was turned at 8:53 a.m., 2:40 p.m., and 11:13 p.m.</p> <p>12/29/24 Resident 52 was turned at 6:29 a.m. and 3:12 p.m.</p> <p>12/30/24 Resident 52 was turned at 1:32 a.m., 1:43 p.m., 2:24 p.m., and 10:40 p.m.</p> <p>12/31/24 Resident 52 was turned at 9:49 a.m. and 2:46 p.m.</p> <p>1/1/25 Resident 52 was turned at 2:30 a.m., 8:08 a.m., and 2:23 p.m.</p> <p>1/2/25 Resident 52 was turned at 5:59 a.m., 9:18 a.m., and 3:59 p.m.</p> <p>1/3/25 Resident 52 was turned at 3:05 a.m., 9:32 a.m., and 2:54 p.m.</p> <p>1/4/25 Resident 52 was turned at 5:36 a.m., 11:14 a.m., and 2:08 p.m.</p> <p>1/5/25 Resident 52 was turned at 3:41 a.m., 6:35 a.m., and 2:30 p.m.</p> <p>1/6/25 Resident 52 was turned at 3:58 a.m., 1:59 p.m., and 8:23 p.m.</p> <p>1/7/25 Resident 52 was turned at 1:46 a.m., 9:48 a.m., and 5:07 p.m.</p> <p>1/8/25 Resident 52 was turned at 4:27 a.m., 9:48 a.m., and 3:21 p.m.</p> <p>1/9/25 Resident 52 was turned at 5:59 a.m.</p> <p>MDSCL stated the only information documented when a resident is turned, is the time.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/9/25 at 10:11 a.m. with Minimum Data Set Coordinator (MDSC), MDSC stated a lack of documentation makes it seem like the dependent residents are not being turned. MDSC stated a difference in the MDS assessment coding and a resident's individualized care plan could result in a resident injury, if the care plan does not accurately reflect the actual degree of resident needs.</p> <p>During a review of the facility P&P titled, Repositioning dated 5/2013, the P&P indicated, The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed-or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Interventions 3. Residents who are in bed should be on at least an every-two-hour. repositioning schedule. 5. Residents who are in a chair should be on a every one hour. repositioning schedule. Documentation The following information should be recorded in the resident's medical record: 1. The position in which the resident was placed. This may be on a flow sheet. 2. The name and title of the individual who gave the care. 3. Any changes in the resident's condition. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the care and the reason(s) why. 6. Observations of anything unusual exhibited by the resident. 7. The signature and title of the person recording the data.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>40516</p> <p>Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 79) was assessed for a Bowel and Bladder Training program (structured plan designed to help residents regain control over their bowel and bladder functions). This failure had the potential for Resident 79 to be unable to maintain toileting abilities.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 1/9/25 at 10:41 a.m. with Minimum Data Set (MDS - a federally mandated resident assessment tool) Consultant (MDSC), Resident 79's medical record was reviewed. Resident 79's Bowel and Bladder Observation/Assessment (BBOA) dated 12/12/24 indicated, Incontinence [inability to control bladder and/or bowel] Assessment 1. Length of incontinence 1. Days and 3. Needs assistance getting to toilet. MDS Section H indicated, Urinary continence 3. Always incontinent and Bowel Continence 3. Always incontinent. MDSC stated she was unable to find a care plan for incontinence and no documentation of Resident 79 being placed on a bowel and bladder training program.</p> <p>During an interview and record review on 1/9/25 at 10:48 a.m. with Minimum Data Set Coordinator (MDSC), MDSC stated the information on the BBOA might not be correct, but there was no other documentation to clarify Resident 79's continence status prior to admission to the facility. MDSC stated that if Resident 79 had only been incontinent for a matter of days she would have expected him to be placed on a bowel and bladder training program.</p> <p>A bowel and bladder training program policy was requested, none was provided.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>46958</p> <p>Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled and on duty eight hours a day, seven days a week. This failure had the potential for resident care to be negatively impacted.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 1/8/25 at 9:09 a.m. with Director of Staff Development (DSD), the Nursing Staff Assignment and Sign-in Sheet (NSASS) dated July 2024 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 7/1/24, 7/2/24, 7/3/24, 7/4/24, and 7/5/24. DSD stated there was not an RN on duty for 8 hours a day on those days.</p> <p>During a concurrent interview and record review on 1/8/25 at 11:07 a.m. with DSD, the NSASS dated August 2024 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 8/5/24, 8/6/24, 8/7/24, 8/8/24, and 8/9/24. DSD stated there was not an RN on duty for 8 hours a day on those days.</p> <p>During a concurrent interview and record review on 1/8/25 at 11:50 a.m. with DSD, the NSASS dated September 2024 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 9/2/24, 9/3/24, 9/4/24, 9/5/24, 9/6/24, and 9/30/24. DSD stated there was no RN on duty for 8 hours a day on those days.</p> <p>During a concurrent interview and record review on 1/8/25 at 11:55 a.m. with DSD, the NSASS dated October 2024 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 10/1/24, 10/2/24, 10/3/24, and 10/4/24. DSD stated there was no RN on duty for 8 hours a day on those days.</p> <p>During a concurrent interview and record review on 1/8/25 at 12:05 p.m. with DSD, the NSASS dated November 2024 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 11/4/24, 11/5/24, 11/6/24, and 11/8/24. DSD stated there was no RN on duty for 8 hours a day on those days.</p> <p>During a concurrent interview and record review on 1/8/25 at 12:10 p.m. with DSD, the NSASS dated December 2024 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 12/2/24, 12/3/24, 12/4/24, 12/5/24, 12/6/24, 12/30/24, and 12/31/24. DSD stated there was no RN on duty for 8 hours a day on those days.</p> <p>During a concurrent interview and record review on 1/8/25 at 12:15 p.m. with DSD, the NSASS dated January 2025 was reviewed. The NSASS indicated, there was no RN for 8 hours a day on 1/1/25, 1/2/25, and 1/3/25. DSD stated there was no RN on duty for 8 hours a day on those days.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, 8/2022, the P&P indicated, A registered nurse provides services at least (8) consecutive hours every 24 hours, seven (7) days a week.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39356</p> <p>Based on interview and record review, the facility failed to follow their policy and procedure (P&P) titled, Anti-coagulation [medication used to thin blood] Clinical Protocol to monitor for possible complications for two of two sampled residents (Resident 10 and Resident 57) on an anti-coagulant. This failure had the potential for Resident 10 and Resident 57 to have adverse effects.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 1/9/25 at 2:03 p.m. with Assistant Director of Nursing (ADON), Resident 10's Medication Administration Record (MAR) dated 12/1/24 - 12/31/24 and 1/1/25 - 1/9/25 were reviewed. The MARs indicated, Give Eliquis [medication to prevent blood clots] 2.5 mg [milligram] Give 1 tablet by mouth two times a day for DVT [deep vein thrombosis - blood clot] prevention. ADON stated there was no documentation that the blood thinning medication was monitored for adverse effects and there should be.</p> <p>46958</p> <p>During a concurrent interview and record review on 1/9/25 at 11:12 a.m. with Minimum Data Set (MDS - a federally mandated resident assessment tool) Consultant (MDSCL), Resident 57's Order Summary Report (OSR), dated 1/9/25 was reviewed. The OSR indicated, Xarelto [medication to prevent blood clots] oral [NAME] 20 MG . give 1 tablet by mouth one time a day for DVT. MDSCL stated there was no documentation that the blood thinning medication was monitored for adverse effects and there should be.</p> <p>During a review of the facility's P&P titled Anticoagulation- Clinical Protocol, dated 11/2018, the P&P indicated, The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. a. If an individual on anticoagulation therapy shows sign of excessive bruising, hematuria [blood in the urine], hemoptysis [coughing up blood], or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>39356</p> <p>Based on observation, interview and record review, the facility failed to:</p> <ol style="list-style-type: none"> 1. Implement their policy and procedure (P&P) titled, Expired Medication for two of two sampled residents (Resident 68 and Resident 41) when expired medications were not removed from medication administration carts. This failure had the potential for expired medications to be administered to Resident 68 and Resident 41. 2. Ensure Resident 15's medications were safely and securely stored from unauthorized personnel and other residents. This failure had the potential for medication to be accessed by unauthorized staff and residents. <p>Findings:</p> <ol style="list-style-type: none"> 1a. During a concurrent observation and interview on 1/8/25 at 9:01 a.m. with Licensed Vocational Nurse (LVN) 3, in the South Hallway, Resident 68 had three expired medications stored in the south medication cart: <ul style="list-style-type: none"> a. Hyosyne [used to decrease stomach acid] 0.125 mg/ml [milligram per milliliter] oral drops, with an expiration date of 9/19/24; b. Acetaminophen [pain medication] 650 mg 2 suppositories [medication administered in the rectum] with an expiration date of 9/19/24; c. Bisacodyl [used to treat constipation] 10 mg 2 suppositories with an expiration date of 9/19/24. <p>LVN 3 stated it was the responsibility of the licensed staff to check the medication carts and to remove all expired medications.</p> <ol style="list-style-type: none"> 1b. During a concurrent observation and interview on 1/8/25 at 9:42 a.m. with LVN 4, in the medication storage room, Resident 41 had one artificial tears lubricant eye drops bottle with an expiration date of 8/2022 stored in the center medication cart. LVN 4 stated checking for expired medications was the responsibility of licensed staff and expired medication should not be in the medication carts. <p>During a review of the facility's P&P titled, Expired Medication [undated], the P&P indicated, Expired medication will be not be given to any resident or responsible part [sic], nor retained in the community. Procedure 1. Expired medications are not used. 2. The Designated staff person inspect containers regularly for expiration dates.</p> <p>46958</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During a concurrent observation and interview on 1/6/25 at 11:18 a.m. with LVN 5 in Resident 15's room, Resident 15 had five closed vials of Refresh Digital PF (used to treat dry eyes) and a medication cup of (unlabeled) cream on bedside table. LVN 5 stated Resident 15 has an order for Refresh eye drops and Voltaren gel (used to treat joint pain). LVN 5 stated the cream in the medication cup was Voltaren gel. LVN 5 stated there was not an order for Resident 15 to keep medication at her bedside, and a self-medication evaluation should be done.</p> <p>During a review of Resident 15's Order Summary Report (OSR), dated 1/31/22, the OSR indicated, Refresh Optive Mega3 Solution 0.5-1-0.5%. Instill 1 drop in both eyes four times a day related to blepharospasm (uncontrollable blinking or twitching of the eyelids) and Voltran Arthritis pain external gel 1%. Apply to RT [right] knee topically [on the skin] two times a day for arthritis [painful joints] type pain.</p> <p>During a concurrent interview and record review on 1/9/25 at 9:45 a.m. Assistant Director of Nursing (ADON), Resident 15's clinical record was reviewed. ADON stated Resident 15 was not assessed for self-administration medication assessment. ADON stated self-administration assessment should be completed before a resident is allowed to self administer medication.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, Dated 2/2023, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys</p> <p>During a review of the facility's P&P titled, Self-Administration of Medications, dated 11/2021, the P&P indicated, 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each residents' cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>39356</p> <p>Based on observation, interview, and record review, the facility failed to follow the physician prescribed therapeutic (person-centered) diet for one of one sampled resident (Resident 64) which had the potential for adverse outcomes to Resident 64.</p> <p>Findings:</p> <p>During a review of Resident 64's Order Summary Report (OSR) dated 3/12/24, the OSR indicated, Regular Diet Regular with chopped meat texture, Thin Liquids consistency.</p> <p>During a concurrent observation and interview on 1/9/25 at 12:45 p.m. with Licensed Vocational Nurse (LVN) 1 and Resident 64, in Resident 64's room, the chicken fried steak on Resident 64's food tray was not chopped and uneaten. Resident 64 stated, look at my teeth, I cannot eat it. Resident 64 opened her mouth and had multiple missing teeth. LVN 1 stated, Resident 64's chicken fried steak was not chopped and should be chopped.</p> <p>During a review of the facility's policy and procedure (P&P) dated 10/2017, the P&P indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. 1. Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>42148</p> <p>Based on interview and record review, the facility failed to ensure the terms and conditions of the facility's arbitration agreement (a contract in which you agree to settle out of court, any dispute that arises with the other party) was clearly explained to five of eight sampled residents (Resident 26, Resident 57, Resident 70, Resident 80, and Resident 135) in a form and manner that they understood. This failure resulted in Resident 26, Resident 51, Resident 57, Resident 70, Resident 80, and Resident 135 signing the arbitration agreement without fully understanding that they had given up their rights to a court proceeding should a dispute happen.</p> <p>Findings:</p> <p>1. During a review of Resident 26's Admission Record (AR), dated 1/19/23, the AR indicated, Resident 26's primary language was Spanish.</p> <p>During a review of Resident 26's Minimum Data Set [MDS-an assessment tool] Section C- Cognitive Patterns (MDSCP), dated 10/15/24, the MDSCP indicated, Resident 26 had a Brief Interview for Mental Status (BIMS, cognition assessment tool, 15-point scale: 0-7 severe impairment, 8-12 moderate impairment, 13-15 cognitively intact) of 9 (moderate impairment).</p> <p>During a review of Resident 26's Confidential Arbitration Agreement (CAA), dated 9/4/19, the CAA indicated, the agreement was written in English and Resident 26 electronically signed the agreement and co-signed by a facility employee.</p> <p>2. During a review of Resident 57's AR, dated 9/13/21, the AR indicated, Resident 57's primary language was Spanish.</p> <p>During a review of Resident 57's MDSCP, dated 12/9/24, the MDSCP indicated, Resident 57 had a BIMS of 14 (cognitively intact).</p> <p>During a review of Resident 57's CAA, dated 10/19/21, the CAA indicated, the agreement was written in English and Resident 57 electronically signed the agreement and was later co-signed by a facility employee on 11/2/21.</p> <p>3. During a review of Resident 70's AR, dated 8/29/24, the AR indicated, Resident 70's primary language was Spanish.</p> <p>During a review of Resident 70's MDSCP, dated 12/30/24, the MDSCP indicated, Resident 70 had a BIMS of 13 (cognitively intact).</p> <p>During a review of Resident 70's CAA, dated 7/10/23, the CAA indicated, the agreement was written in English and Resident 70 electronically signed the agreement and was co-signed by facility employee on 7/11/23.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. During a review of Resident 80's AR, dated 12/12/24, the AR indicated, Resident 80's primary language was Spanish.</p> <p>During a review of Resident 80's MDSC, dated 12/30/24, the MDSCP indicated, Resident 80 had a BIMS of 14 (cognitively intact).</p> <p>During a review of Resident 80's CAA, dated 12/14/24, the CAA indicated, the agreement was written in English and Resident 80 electronically signed the agreement and was co-signed by facility employee, Certified Nursing Assistant (CNA) 7 on 12/14/24.</p> <p>During an interview on 1/9/25 at 3:05 p.m. with Resident 80, Resident 80 stated, I do not remember what I signed when I was admitted . I was very sick. I'm not sure if the papers were in English or Spanish. They just told me to sign. Resident 80 stated he does not speak English.</p> <p>5. During a review of Resident 135's AR, dated 12/29/24, the AR indicated, Resident 135's primary language was Spanish, Castilian.</p> <p>During a review of Resident 135's MDSCP, dated 1/4/25, the MDSCP indicated, Resident 135 had a BIMS of 12 (moderate impairment).</p> <p>During a review of Resident 135's CAA, dated 12/19/24, the CAA indicated, the agreement was written in English and Resident 135 electronically signed the agreement and was co-signed by CNA 7 on 12/19/24.</p> <p>During a concurrent interview and record review on 1/9/25 at 3:30 p.m. with Director of Marketing (DM), Resident 26, Resident 57, Resident 70, Resident 80, and Resident 135's AA were reviewed. The AAs indicated, the agreements were in English and electronically signed by Resident 26, Resident 57, Resident 70, Resident 80, and Resident 135. DM stated the arbitration agreement is part of the facility's admission process. DM stated she discussed arbitration agreements along with the admission paperwork. I encourage every resident to sign it. I sell it. I think arbitration is a great thing. DM was unable to provide the number of residents that have refused to sign AA and stated, Most residents here have it [arbitration agreement]. DM stated the facility does not have an arbitration agreement in Spanish or any other language, just in English. DM stated, she does not speak Spanish and has a co-worker that will translate for her for any Spanish speaking residents. DM stated Resident 26, Resident 57, Resident 70, Resident 80, and Resident 135's primary language is Spanish and that a certified Spanish interpreter was not used when residents signed their arbitration agreements.</p> <p>During an interview on 1/9/25 at 3:45 p.m. with CNA 7, CNA 7 stated she helps with admission paperwork and translates for residents when they sign arbitration agreements. CNA 7 stated, The arbitration agreements are presented to the residents with the admission packet and residents are encouraged to sign them CNA 7 stated the facility does not have any agreements that are written in Spanish. CNA 7 stated she is not certified by the state to translate legal verbiage or medical terminology. She stated, I don't use the language line [interpreter services], because I am fluent in Spanish.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/09/25 at 4:17 p.m. with Administrator, Administrator stated, the arbitration agreement is part of the facility's admission process and is presented to each resident at time of admission and the resident is encouraged to sign it. Administrator stated that if a resident doesn't speak English, it is the expectation that an employee will use a language line to interpret in a language the resident will understand. Administrator stated none of the employees at this facility are certified Spanish interpreters.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, dated 11/23, the P&P indicated, Residents are informed of the nature and implications of any proposed binding arbitration agreements so as to make informed decisions on whether to enter into such agreements. 4. Binding arbitration agreements are voluntary for the residents. Residents are not compelled, pressured, or coerced to enter into a binding arbitration agreement. It is unambiguously communicated to resident that binding arbitration agreements are optional and not required as a condition of admission or to receive care at this facility. 5. The terms and conditions of a binding arbitration agreement are explained to the resident in a way that ensures his or her understanding of the agreement, including that the resident may be giving up his or her right to have a dispute decided in a court proceeding. 6. The terms and conditions of a binding arbitration agreement are explained to the resident in a form and manner that he or she understands, taking in to consideration the residents language, literacy and stated preference for learning. 7. After the terms and conditions of the agreement are explained, the resident must acknowledge that he or she understands the agreement before being asked to sign the document. A. A signature alone is not sufficient acknowledgment of understanding. B. The resident must verbally acknowledge understanding, and the verbal acknowledgment documented by the staff member who explains the agreement. 9. If arbitration agreements are embedded within other contracts or agreements (for example, the admission agreement), the facility will ensure that the arbitration agreement is distinguished from the other agreement and explain to the resident that her or she [sic] may accept or decline each agreement separately. 11. Any facility personnel who are responsible for explaining the terms and conditions of binding arbitration agreements to the resident are trained in the specifics of this policy.</p> <p>40516</p>		