

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

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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 01/15/2026
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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management interventions were safely implemented and monitored for one of thirty sampled residents (Resident 71). Specifically, licensed nurses failed to appropriately monitor and reassess the resident following administration of prescribed opioid pain medication (morphine sulfate) and failed to identify and respond to adverse effects related to pain treatment. As a result of these failures, Resident 71 experienced opioid-induced over-sedation and respiratory depression, requiring emergency transfer to a general acute care hospital (GACH), treatment for opioid overdose including administration of Narcan (reverses opioid overdose), intubation (insertion of a tube to aid in breathing) for respiratory support, and a seven-day hospitalization beginning 12/12/25. This resulted in actual harm to the resident. Findings: During a concurrent observation and interview on 1/15/26 at 8:41 a.m., with Resident 71, in her room, Resident 71 was lying in bed, receiving two liters (unit of measure) of oxygen via nasal cannula (plastic tube delivering oxygen). Resident 71, who was alert and oriented, stated she was taking morphine medication at times because she had severe left shoulder blade pain. Resident 71 also stated she did not remember why she went to the hospital on [DATE], but her son told her she had slept for three days. During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a condition caused by damage to the airways or other parts of the lung and fibromyalgia (chronic condition causing widespread musculoskeletal pain, fatigue, sleep problems, and cognitive difficulties). During a review of Resident 71's Nursing Progress Notes (NPN), written by LVN 3, dated 12/11/25, the NPN indicated, on 12/11/25 at 7:35 a.m., Resident 71 went out on a leave of absence to an appointment. Resident 71 was transported in facility van along with staff. Resident was in good spirits and is in stable condition. Resident 71 complained of pain before leaving and PRN (as needed) morphine was administered. During a review of Resident 71's Nursing Progress Notes (NPN), written by LVN 3, the NPN indicated on 12/11/25 at 10:40 a.m., Resident 71 returned to the facility after not receiving care and services at her ophthalmology appointment because she was over-sedated on arrival. Resident 17's physician was notified of Resident 71's status, and he changed the morphine order to oral tablet 15 mg, give 0.5 (7.5mg) tablet by mouth every 12 hours as needed for moderate to severe pain. Upon returning to the facility, Resident 71 refused all scheduled medications. During a review of Resident 71's Medication Administration Record (MAR), dated 12/11/25, the MAR indicated Resident 71 refused her scheduled medications at 1 p.m., 2 p.m., 8 p.m., and 9 p.m. During a review of Resident 71's Nursing Progress Notes (NPN), dated 12/12/25, the NPN indicated on 12/12/25 at 2:56 a.m., Resident 71 had a change in condition. Resident 71 began throwing up green liquid repeatedly and it was hard to arouse Resident 71. Resident 71's physician was notified and ordered her to be transferred to GACH for evaluation. During a review of Resident 71's GACH Progress Notes, dated 12/12/25, the GACH PN indicated, on admission, per Emergency Medical Services (EMS), Resident 71 had pinpoint pupils for which she was given 1 dose of Narcan (reverses opioid overdose). Resident 71 was on high doses of morphine that may have caused the opioid induced respiratory depression. The GACH PN, indicated In (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
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F 0697 Level of Harm - Actual harm Residents Affected - Few	setting of opioid induced acute encephalopathy [brain dysfunction], she aspirated [inhaled] sputum. Do not send patient home on same pain regimen as on admission given her presentation concerning for opioid overdose requiring intubation (insertion of a tube to aid in breathing). During an interview on 1/15/26 at 9:44 a.m., with LVN 3, who was Resident 71's assigned nurse on 12/11/25, LVN 3 stated she did not monitor Resident 71 for sedation (morphine adverse effects) on 12/11/25 when she returned to the facility from her medical appointment. LVN 3 stated Resident 71 was sedated the rest of her shift, and that Resident 71 refused her scheduled medications because she was so sedated. During a review of Resident 71's Order Summary Report, (OSR), the OSR, dated 12/5/25, indicated an order since 6/3/25 for morphine 15 mg (milligram-unit of measure) one tab every four (4) hours as needed for moderate to severe pain (level 4-9), hold if respirations less than 12 and/or oxygen saturation less than 90%.During a concurrent interview and record review on 1/15/26 at 10:06 a.m., with the Assistant Director of Nursing (ADON), Resident 71's Medication Administration Record (MAR) indicated Resident 71 received a morphine 15 mg tablet on 12/11/25 at the following times:a. 4 a.m.b. 7:19 a.m. (41 minutes early)ADON stated the second dose should have been administered every four hours as needed, and as a result the second dose of morphine was given too early.During Resident 71's medical record review, ADON confirmed Resident 71 was over sedated when she returned to the facility from her ophthalmology appointment on 12/11/25 at 10:40 a.m. ADON was unable to locate documented evidence to show the licensed nurses monitored Resident 71 for over sedation (a change in condition) starting on 12/11/25, upon her return to the facility. ADON confirmed Resident 71 was repeatedly vomiting green liquid, and she was hard to arouse on 12/12/25 at approximately 3 a.m. ADON stated the licensed nurses identified a change in Resident 71's condition at that time, and she was transferred to the GACH for evaluation. During an interview on 1/15/26 at 11:13 a.m., with the Director of Nursing (DON), the DON stated that licensed nurses should have implemented the facility's policies and procedures (P&P) for Administering Pain Medication and Change in a Resident's Condition or Status on 12/11/25 when Resident 71 returned to the facility over sedated from the 12/11/25 at 7:19 a.m. morphine administration. The DON stated there should have been monitoring to prevent adverse reactions (morphine black box warning) sedation, respiratory depression, coma, and death.During an interview on 1/15/26 at 11:55 a.m., with Pharmacy Consultant (PC), the PC stated monitoring for morphine adverse effects was a nursing measure. The PC stated licensed nurses should monitor residents receiving morphine for adverse reactions sedation, respiratory depression, coma, and death.During a review of the facility policy titled Administering Pain Medication, dated 4/2025, the policy indicated .When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. a. Any resident who uses opioids for long-term management of chronic pain is at risk for opioid overdose .Administer pain medication as ordered .During a review of the facility policy titled Change in a Resident's Condition or Status, dated 2/2021, the policy indicated .The nurse will notify the resident's attending physician.when .adverse reaction to medication .The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility did not comply with its policy for securely disposing of controlled medications on two of four medication carts. This failure poses a risk of diversion, where legally prescribed controlled substances could be transferred to individuals other than those for whom they were prescribed for illegal use. Findings: During a concurrent observation and interview on 1/13/26 at 2:48 p.m., with Licensed Vocational Nurse (LVN) 3, the bottom drawer of the South 1 Medication Cart contained a pharmaceutical waste container with a removable lid. The pharmaceutical waste container contained multiple intact pills. LVN 3 stated that there were multiple medications in the container which included any wasted medications including narcotics. LVN 3 stated if a narcotic was not given in an event the resident refused, or if the medication was dropped on the floor, she would discard the narcotic in the waste container after verifying with another nurse. During a concurrent observation and interview on 1/13/26 at 2:58 p.m., with LVN 4, the bottom of the North 2 Medication Cart contained a pharmaceutical waste container with a removable lid. The pharmaceutical waste container contained multiple intact pills. LVN 4 stated that there were multiple medications in the container which included any wasted medications including narcotics. LVN 4 stated if a narcotic was not given in an event the resident refused, or if the medication was dropped, she would discard the narcotic in the waste container after verifying with another nurse. LVN 4 also stated she would take the full pharmaceutical waste container to the biohazard room. During an interview on 1/14/25 at 9:09 a.m., with the Pharmacy Consultant (PC), the PC stated when a narcotic medication was wasted, the Licensed Nurses would dispose of the medication with other non-controlled medications in the pharmaceutical waste container with a removable lid. The PC stated if a staff member wanted to take medication out of the container they could and that there could be a safer way to discard narcotics to reduce the risk. During a concurrent observation and interview on 1/14/26 at 9:26 a.m. with the Director of Nurses (DON), South 1 and North 2 Medication Carts were observed. The DON opened the removable lid of the pharmaceutical waste container and stated there was a risk for diversion. The DON validated that both containers contained multiple intact medications. During a review of the facility policy and procedure (P&P) titled, Disposal of Medications and Medication-Related Supplies, dated 2019, the P&P indicated, .Controlled substances are retained in a securely locked area with restricted access until destroyed by Director of Nursing and Consultant Pharmacist. Controlled medications given to the Director of Nursing for destruction shall be recorded in a perpetual inventory log. non-controlled medications destruction occurs only in the presence of (two) individuals .		

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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** Based on observation, interview, and record review, the facility failed to implement appropriate infection control measures when: 1. Resident 57's oxygen humidifier bottle was not changed weekly. 2. Clean linen and clean diapers were stored on the floor in a resident's room. 3. Certified Nursing Assistant (CNA) 2 did not wash her hands before and after resident care in room [ROOM NUMBER]. These failures could contribute to the spread of infectious diseases among residents, staff, and visitors. Findings: 1. During a review of Resident 57's admission Record (AR), the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses that included shortness of breath. During an observation on 1/12/26 at 2:05 p.m., in Resident 57's room, Resident 57 was receiving two liters of oxygen via a nasal canula (flexible plastic tube). The oxygen humidifier bottle was dated 12/28/25. During an interview on 1/12/26 at 4:16 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 57's oxygen humidifier bottle was dated 12/28/25 and should have been changed weekly. During a concurrent interview and record review on 1/14/26 at 10:00 a.m., with the Infection Preventionist (IP) the policy and procedure titled, Respiratory Therapy-Prevention of Infection, dated 11/2011, the policy indicated, . The purpose of this procedure is to guide prevention of infection associated with respiratory therapy .Use distilled water humidification per facility protocol .Mark bottle with date upon opening and discard according to the MD orders . The IP stated the humidifier should be changed weekly to prevent infection and ensure sufficient water was in the bottle. 2. During a concurrent observation and interview on 1/13/26 at 8:58 p.m. with Licensed Vocational Nurse (LVN) 1 and Certified Nurse Assistant (CNA) 1, one bag of clean linen and clean diapers were observed on the floor in resident's room. LVN 1 stated clean linen, and clean diapers should not be on the stored on the floor. CNA 1 stated she should not have left the clean linen and clean diapers on the floor. During a review of the facility's policy and procedure (P&P) titled, Departmental (Environmental Services) - Laundry and Linen, version 2.2(H5MAPR0097) undated, indicated under 7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination . 3. During a concurrent observation and interview on 1/13/26 at 10:10 p.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 was observed entering and exiting room [ROOM NUMBER] to respond to a call light. CNA 2 did not perform handwashing before entering and exiting the resident's room. CNA 2 confirmed she was in the resident's room to perform bedside care and stated she should have performed handwashing before entering and exiting the resident's room. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene dated October 2023, indicated, 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Indications: Hand hygiene is indicated:a. immediately before touching a residentd. after touching a residente. after touching the resident's environmentg. immediately after glove removal		

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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 observation, interview, and record review, the facility failed to meet professional standards of quality for two of thirty sampled residents (Resident 51 and Resident 98) when Licensed Vocational Nurse (LVN) 2 did not follow the policy and procedure titled, Insulin Pen Administration. This failure placed Resident 51 and Resident 98 at risk for insulin dosing errors and had the potential to result in adverse side effects such as hypoglycemia or hyperglycemia. Findings: 1. During a review of Resident 51's admission Record, indicated Resident 51 had diagnoses which included Type 2 Diabetes (body's inability to produce enough insulin). During a review of Resident 51's Physician Order (PO), dated 12/5/25, the PO indicated, Insulin Lispro (fast acting insulin) inject as per sliding scale before meals. During medication pass observation on 1/14/26 at 11:13 a.m., LVN 2 administered Lispro 4 units (unit of measurement) SQ (subcutaneous injection given in the fatty tissue, just under the skin) to Resident 51 using an insulin pen. LVN 2 did not prime (remove bubbles from the needle) the insulin pen before administering the insulin to Resident 51. 2. During a review of Resident 98's admission Record, indicated Resident 98 had diagnoses which included Type 2 Diabetes (body's inability to produce enough insulin). During a review of Resident 98's Physician Order (PO), dated 12/5/25, the PO indicated, Insulin Lispro inject as per sliding scale before meals. During medication pass observation and interview on 1/14/26 at 11:24 a.m., LVN 2 administered Lispro 4 units SQ to Resident 98 using an insulin pen. LVN 2 did not prime the insulin pen before administering the insulin to Resident 98. LVN 2 inaccurately described the process of priming the insulin pen. During a concurrent interview and record review on 1/15/26 at 11:32 a.m. with the Director of Nursing (DON) the facility policy and procedure titled, Insulin Pen Administration, dated 2019 was reviewed. The policy indicated .To provide for the safe and accurate administration of Insulin Pen medications .Before each injection, do a safety test as follows: a. Turn dose selector to select 2 units b. Hold insulin pen upright, tap the cartridge gently a few times. c. Press the push-button all the way ind. The dose selector returns to 0 .The DON stated the insulin pen should be primed before each use to ensure the resident does not receive too much or too little insulin.		

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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 observation, interview, and record review, the facility did not adhere to its policy and procedures for one of the 30 sampled residents (Resident 57) when: Resident 57's fingernails and toenails were not trimmed. Resident 57 had untreated lacerations on the right great toe of unknown origin. The physician was not informed about the resident's change in condition. These failures resulted in substandard quality of care for Resident 57. Findings: During a review of Resident 57's admission Record, the admission Record indicated Resident 57 was admitted to the facility on [DATE], with diagnoses of Parkinsonism (neurological disorder that cause movement problems), muscle weakness and dependence on wheelchair. During a concurrent observation and interview on 1/12/26 at 2:21 p.m., with Resident 57, in Resident 57's room, Resident 57 was lying in bed with his feet exposed. Resident 57 had untrimmed fingernails and toenails. Resident 57's inner area of the right great toe had three scabs (forms over a cut or wound during healing) Resident 57, who was alert and oriented, stated about a week ago when he was transferred from his bed, his left foot nail dug into his right great toe causing a cut. Resident 57 stated licensed nurses did not treat his cut. Resident 57 also stated his nails were too long, and he wished for somebody to cut his nails. During a concurrent observation and interview on 1/14/26 at 10:29 a.m., with Licensed Vocational Nurse (LVN) 5, in Resident 57's room, Resident 57 was lying in bed with his feet exposed. LVN 5 confirmed Resident 57 fingernails and toenails were untrimmed. LVN 5 confirmed Resident 57's inner right great toe had scabs. LVN 5 stated he was unaware of Resident 57's injury of unknown origin prior to the current observation and there was no treatment ordered. LVN 5 stated that Resident 57's untrimmed toenails and movement disorder could have caused the injury of unknown origin. LVN 5 also stated it was the Certified Nurse Assistants (CNA) responsibility to trim fingernails, and toenails should have been trimmed by podiatry services. During a review of Resident 57's physician current orders for 1/2026, the physician orders indicated, Podiatry care for nail treatment as indicated. During an interview on 1/14/26 at 10:42 a.m., with Social Worker (SW), SW stated the process of scheduling podiatry was for licensed nurses to verbally tell her or place note in her in-box. SW stated that she was not informed by the LVNs that Resident 57 needed podiatry services. During an interview on 1/15/26 at 11:33 a.m., with the Director of Nursing (DON), the DON stated it was CNAs responsibility to trim resident fingernails and podiatry services trim toenails. The DON stated while staff were providing care they should do skin assessments. The DON stated there should have been a change in condition completed and physician notification to monitor and treat Resident 57's right great toe laceration. During a review of the facility policy and procedure titled, Fingernails/Toenails, Care of, dated February 2018. The policy indicated, .The purpose of this procedure is to clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care includes daily cleaning and regular trimming .Proper nail care can aid in the prevention of skin problems around the nail bed .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .During a review of the facility policy and procedure titled, Podiatry Services undated. The policy indicated, .to ensure residents receive proper treatment and care .Employees should refer any identified need for foot care to the social worker or designer .During a review of the facility policy and procedure titled, Change in a Resident's Condition or Status, dated February 2021. The policy indicated, .Our facility notifies the resident .attending physician .where there has been .accident or incident involving the resident .discovery of injuries of an unknown source .		

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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. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment when one soiled dish towel was placed on the surface of a table tray that contained clean cups. This failure had the potential to result in cross-contamination. Findings: During a concurrent observation and interview on 1/12/26 at 2:25 p.m., with the Dietician in the kitchen, one soiled dish towel was observed on the surface of a table tray that contained clean cups. The Dietitian stated the soiled dish towel should have been disposed of in the soiled linen container. During a review of the facility's policy and procedure (P&P) titled, Sanitation Section 8, dated 2023, the P&P indicated, 16. Kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures and the hood over stove, which will be cleaned by the maintenance staff. 22. Do not use cleaning products or sanitizers in the food preparation or food storage areas in any way that could result in contamination of exposed food items. This includes spraying or pouring cleaning products near food items during preparation or cooking.		