STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055916	A. Building B. Wing	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoia Vista	3710 West Tulare Avenue Visalia, CA 93277

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record, review the facility failed to:Provide an advance written notice of a new roommate assignment for one of six sampled residents (Resident 2).Monitor compatibility (being a good match, getting along well) for one of six sampled residents (Resident 2) when Resident 3 was moved into Resident 2's room.These failures resulted in a resident-to-resident altercation between Resident 2 and Resident 3, Resident 2 unable to sleep and violation in Resident 2's rights.Findings:During a concurrent observation and interview on 6/24/25 at 12:29 p.m. with Resident 2, Resident 2 was in his room lying in bed. Resident 2 stated he was not given notification prior to Resident 3 moving into his room on 6/10/25.During an interview on 6/24/25 at 1:47 p.m. with Social Service Assistant (SSA), SSA stated on 6/10/25 Resident 3 was moved to Resident 2's room. SSA reviewed Resident 2's clinical record and was unable to find documented evidence that a notice of a new roommate was provided to Resident 2.During an interview on 6/24/25 at 2:30 p.m. with Director of Nurses (DON) and Assistant Director of Nurses (ADON), ADON stated Resident 3 was moved into Resident 2's room on 6/10/25. ADON Resident 2's clinical record and was unable to find documented evidence that a notice of a new roommate was provided to Resident 2.2. During a concurrent observation and interview on 6/24/25 at 12:29 p.m. with Resident 2, Resident 2 was in his room lying in bed. Resident 2 stated on 6/10/25, Resident 3 was moved into his room. Resident 2 stated Resident 3 made constant outburst, continuous yelling throughout day and night preventing Resident 2 from sleeping. Resident 2 stated on 6/15/25 Resident 3 kept making loud noises and would not stop. Resident 2 stated he threw his hat at Resident 3 to make him stop making loud noises. Resident 2 stated he told several staff members he was unable to sleep due to Resident 3 making loud noises. Resident 3 stated nothing was done. During a concurrent observation and interview on 6/24/25 at 12:36 p.m. with Certified Nursing Assistant (CNA 3), CNA 3 was observed feeding Resident 3 in his room. CNA 3 stated Resident 3 was confused and would have outburst continuous yelling. CNA 3 stated Resident 2 was calm, like watching television, and taking naps. CNA 3 stated Resident 2 and Resident 3 were not compatible being roommates.During an interview on 6/24/25 at 12:50 p.m. with Licensed Vocational Nurse (LVN 1) LVN 1 stated on 6/10/25 Resident 3 was moved into Resident 2's room. LVN 1 stated it was the facility practice to monitor for 72 hours to ensure both roommates were compatible with each other. LVN 1 reviewed the clinical records for Resident 2 and was unable to find documented evidence Resident 2 was monitored for 72 hours for having a new roommate. During an interview on 6/24/25 at 12:57 p.m. with LVN 2, LVN 2 stated Resident 2 doesn't like noise, doesn't like to hear yelling, and kept to himself. LVN 2 stated Resident 3 randomly yells and spits. LVN 2 stated Resident 2 and Resident 3 were not compatible being roommates.During an interview on 6/24/25 at 2:30 p.m. with ADON, ADON stated Resident 3 was moved into Resident 2's room on 6/10/25. ADON stated it was the facility practice to monitor both roommates for 72 hours to make sure both residents are getting along, no emotional distress. ADON reviewed Resident 2's clinical records. ADON stated Resident 2 was not monitored for compatibility when Resident 3 moved into his room.During a review of the facility's policy and procedure (P&P), titled, Change of Room or Roommate, dated 7/2022, the P&P indicated, 4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review the facility failed to provide written grievance decision for one of six sampled residents (Resident 1). This failure resulted in violation of Resident 1's rights. Findings:During an interview on 6/23/25 at 9:59 am with Resident 1's Responsible Party (RP), RP stated a grievance was filed on 6/14/25 regarding Resident 1 having soiled gown. RP stated she has not received a written notice of decision.During a review of the facility log titled, Grievance/Concern Log the log indicated a grievance report was filed by RP on 6/14/25.During a concurrent interview and record review on 6/24/25 at 4:13 p.m. with Administrator, Administrator reviewed the grievance log and confirmed a grievance was filed on 6/14/25 by Resident 1's RP. Administrator stated the grievance has been resolved but was unable to find documented evidence that a written decision was given to Resident 1's RP.During a review of the facility's policy and procedure (P&P) titled, Resident and Family Grievances, dated 7/2022, the P&P indicated, g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will be included at a minimum: i. The date the grievance was received. ii. The steps taken to investigate the grievance. iii. A summary of the pertinent findings or conclusions regarding the resident's concern (s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. Any corrective action taken or to be taken by the facility as a result of the grievance . vi. The date the written decision was issued.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure supervision was provided for one of six sampled residents (Resident 5) with a known behavior of attempting to leave the facility unsupervised. This failure resulted in Resident 5 eloping from the facility without staff knowledge and having the potential for injury. Findings:During a review of Resident 5's Minimum Data Set (MDS-resident assessment tool) dated 5/13/25, the MDS indicated, Cognitive Patterns.BIMS (brief interview for mental status-evaluates residents cognitive ability (mental processes involved in acquiring knowledge and understanding through thought, experience, and the senses).12 (moderate cognitive function).Functional abilities.walk 50 feet with two turns. 05 (helper assist only prior to or following the activity).During a review of Resident 5's S (situation) B (background) A (appearance) R (review and notify) (SBAR-used to communicate with physician) dated 6/17/25 at 4:20 a.m., the SBAR indicated, Came out from break room during lunch break and was notified by CNAs [Certified Nursing Assistant] that resident is missing. Staff checked all the rooms at facility and was still not found. Called [police department] [at] 3:39 a.m. and reported resident missing from facility. About 4 a.m. resident was found by [police department], next to the church [next door].During a review of Resident 5's Progress Note (PN), dated 8/19/24 (approximately 10 months prior to elopement on 6/17/25) at 10:35 a.m., the PN indicated, Resident [5] left out the facility of the back hall with statement of wanting to go to Mexico. During an interview on 6/24/25 at 12:55 p.m. with CNA 1, CNA 1 stated on pm shift and night shift, Resident 5 would attempt to leave the facility. CNA 1 stated Resident 5 would peak out into the hall to see if there were any staff present. CNA 1 stated Resident 5 opened the door a couple of times, set off the door alarm and asked the staff to open the door when attempting to leave the facility. CNA 1 stated Resident 5 demonstrates the behaviors approximately every two weeks.During an interview on 6/24/25 at 3:02 p.m. with CNA 2, CNA 2 stated Resident 5 had tried to get out of the facility in the past and would stand at the door of her room and spy down the hall, appearing as if she was planning to leave the facility. CNA 2 stated Resident 5 had packed her clothes in a bag in the past. CNA 2 stated she had reported the behavior to the nurse.During an interview on 6/24/25 at 4:17 p.m. with Administrator, Administrator stated when staff were aware of Resident 5's behavior of attempting to leave the facility it should have been reported right away. During an interview on 7/21/25 at 9:05 a.m. with Assistant Director of Nursing (ADON), ADON stated when Resident 5 was demonstrating exit seeking behaviors staff should have reported it right away so Resident 5 could be assessed and interventions could have been implemented. During a review of the facility's policy and procedure (P&P) titled, Elopements and Wandering Residents undated, the P&P indicated, a. Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team. b. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. c. interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff. d. Adequate supervision will be provided to help prevent accidents or elopements. e. Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly.