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	07/15/2025

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on interview and record review, the facility failed to implement its policy and procedure (P&P) for one of three sampled residents (Resident 1) when the Inventory of Personal Effects (IPE) was not signed by the resident upon admit. This failure had the potential to result in missing personal effects.Findings:During a review of Resident 1's Inventory of Personal Effect (IPE) dated 4/10/25, the IPE indicated, Certification of Receipt.on admission.signed resident or resident representative. (blank indicating the resident did not sign the IPE).During a concurrent interview and record review on 7/15/25 at 1:10 p.m., with Social Service Director (SSD), Resident 1's IPE was reviewed. SSD stated when Resident 1 was admitted the IPE should have been signed by Resident 1, indicating all of Resident 1's belongings were inventoried.During a review of the facility policy and procedure (P&P) titled Resident Personal Belongings dated 2/2025, the P&P indicated, All resident personal items will be inventoried at the time of admission by the social services designee, or another designated Inventories of all items are to be reviewed and examined by Social Services designee and the resident's representative.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) choice to stay in room during a routine deep cleaning was respected and followed. This failure resulted in Resident 1 being forced out of her own room, in her bed and into the hallway for approximately one hour and resulted in Resident 1 feeling anxious (feeling of unease), almost in tears and violation of Resident 1's rights. Findings:During a review of Resident 1's admission Record (AR), dated 7/2025, the AR indicated Resident 1 was initially originally admitted on [DATE]. The AR indicated, Diagnosis.Major Depressive Disorder (mood causes persistent feeling of sadness and loss of interest) disorder that .social anxiety (intense fear of social situations), .During a review of Resident 1's annual Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 6/10/25, the MDS indicated Resident 1 had a BIMS (Brief Interview for Metal Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 14 (13-15 cognitively intact). During a review of Resident 1's Care Plan (CP) titled, ACTIVTIES date initiated 6/1/23, the CP indicated, [Resident 1] has activities deficit related to: social anxiety, preference to stay in her room watching television, and socializing 1:1.During an interview on 7/9/25 at 8:40 a.m. with Resident 1, Resident 1 stated she has social anxiety and does not like leaving her room. Resident 1 stated on 6/30/25 she was forced to go outside of her room and into the hallway for a scheduled deep cleaning (involving a more detailed cleaning). Resident 1 stated she has been in the facility for eight years and has never been forced to leave her room. Resident 1 stated she was almost in tears while she was outside the hallway in her bed while she waited for over an hour to be returned to her room.During an interview on 7/9/25 at 12:35 pm with Social Service Designee (SSD), SSD stated Resident 1 has been in the facility for many years, prefers to stay in room, very anti-social (not wanting company of others).During an interview on 7/9/25 at 12:51 p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 was alert and oriented, does not walk, does not like to be around people, gets anxious when she is up in her wheelchair. LVN 1 stated Resident 1 has the right to stay in her room during deep cleaning and should not have been forced to leave.During an interview on 7/9/25 at 1:07 p.m. with Certified Nursing Assistant (CNA), CNA stated Resident 1 likes to keep to herself, does not like to come out, prefers to stay in room, gets anxiety, does not like to be around other people. CNA stated on 6/30/25 she was told to remove Resident 1 out of her room for a deep cleaning. CNA stated Resident 1 remained in the hallway in her bed for approximately one hour while Resident 1 waited for her room to be cleaned. CNA stated Resident 1 should have been given the option to stay in room.During an interview on 7/9/25 at 1:45 p. m. with Administrator, Administrator stated Resident 1 should not have been removed from her room for a deep cleaning. Administrator stated, if she (Resident 1) refused, it is her right to stay in there (room).During an interview on 7/10/25 at 12:20 p.m. with Housekeeper (HSK), HSK stated on 6/30/25, Resident 1 had refused to be removed from her room for a deep cleaning. HSK stated Resident 1 usually never wants to come out usually refuses. it's her room, it's her right HSK stated on 6/30/25, someone had brought Resident 1 out in the hallway in her bed. HSK stated Resident 1 waited approximately one hour in the hallway in her bed.During an interview on 7/15/25 at 12:21 p.m. with Director of Nurses (DON), DON stated Resident 1 had the right to stay in her room during deep cleaning. DON stated Resident 1 should not have been taken out of her room for deep cleaning when she refused.During a review of the facility's policy and procedure (P&P), titled, Resident Rights, dated 2/2025, the P&P indicated, 5. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to: .b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.