

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055916	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/14/2025
NAME OF PROVIDER OR SUPPLIER Sequoia Vista		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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. (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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, interview, and record review, the facility failed to:1. notify the responsible party (RP) when one of three sampled residents (Resident 1) was involved in a resident-to-resident altercation.2. assess, treat, monitor and notify the physician and the responsible party (RP) when one of three sampled residents (Resident 1) had a cut under his left eye, bruising on his left cheek and scabs to the left side of his nose and under his left eyebrow. These failures resulted in the physician and the RP being unaware of the wounds and the RP being unaware of the resident-to-resident altercation. Findings:During an interview on 11/14/25 at 8:59 a.m. with Family Member (FM/RP) 1, FM 1 stated when she was visiting Resident 1 on 11/12/25, and noted Resident 1 had a black eye and she was not made aware of the black eye or the resident-to-resident altercation Resident 1 was involved in. During a review of Resident 1's S (situation) B (background) A (appearance) R (Review and Notify) (SBAR-used to notify the physician of a change of condition) dated 11/11/25, the SBAR indicated, Resident to resident abuse. primary care clinician notified. yes. RP notified 11/11/25. 9:10 p.m. During a review of Resident 1's Progress Notes (PN) dated 11/12/25, the PN indicated, RP of (Resident 1's room number) approached writer asking what had happen to residents face. Writer explained that I noticed a reden [sic] area on nose. Writer explained that there was an incident on another shift. RP asked why she was not contacted, at this point writer call ADON (Assistant Director of Nursing) and SS (Social Services). During a review of the facility's 5-day report (DR) dated 11/18/25, the DR indicated, CNA (certified nursing assistant) staff informed social services and Administrator that resident A (Resident 3) pushed Resident B (Resident 1) when he got too close to him causing resident B to stumble back. During an interview on 11/20/25 at 11:11 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to Resident 1 on 11/11/25 at the time of the resident-to-resident altercation. LVN 1 stated she documented on the Change of Condition form that the RP was notified but she was not the one that notified the RP. LVN 1 stated the Director of Nursing (DON) was supposed to notify the RP of the incident. During an interview on 11/14/25 at 2:19 p.m. with ADON, ADON stated the wife spoke with her the next day after the resident-to-resident altercation and was unaware of the incident. ADON stated the RP was upset that she was not notified. ADON stated when she talked to LVN 1 regarding notifying the RP of the resident-to-resident altercation LVN 1 told her she documented it but could not remember if she spoke with the RP. 2. During an interview on 11/14/25 at 1:46 p.m. with CNA 1, CNA 1 stated she had taken care of Resident 1 for two consecutive days, and Resident 1 had a cut under his left eye, bruising on his left cheek and scabs to the left side of his nose and under his left eyebrow for the two days she had cared for him. CNA 1 stated she did not know what caused the injuries to Resident 1. During a concurrent observation and interview on 11/14/25 at 2:14 p.m. with Administrator, in Resident 1's room, Resident 1 was sitting on the bed and had a cut under his left eye, bruising on his left cheek and scabs to the left side of his nose and under his left eyebrow. Administrator stated he was not aware Resident 1 had wounds. During a concurrent observation and interview on 11/14/25 at 2:19 p.m. with ADON, in Resident 1's room, Resident 1 was lying on the bed and had a cut under his left eye, bruising to his left cheek and scabs to the left side of his nose and under his left eyebrow. ADON stated the day after the altercation with Resident 2, she had observed a cut under Resident 1's left eye but was unaware of the bruising and the scabs. ADON stated when she noticed the cut she spoke to Resident 1's nurse and the nurse said the cut was there prior to the altercation. ADON stated that when the cut, bruising and scabbing were identified a change of condition should have been made to notify the physician to obtain treatment orders, the RP should have been notified and the areas monitored. During a concurrent interview and record review on 11/14/25 at 2:25 p.m. with ADON, Resident 1's clinical record was reviewed. ADON was unable to provide documentation of any assessment, treatment, monitoring and notification to the physician and RP being done. During a review of the facility's policy and procedure (P&P) titled, Notification of Changes dated 3/2025, the P&P indicated, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. accidents. potential to require physician intervention. circumstances that require a need to alter treatment. This may include. new treatment. During a review of the facility's policy and procedure (P&P) titled, Skin assessment dated 3/25, the P&P indicated, The assessment may also be performed after a change of condition or after any newly identified pressure injury.</p>		