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	12/18/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor and document whereabouts (the place where someone is) every hour according to the care plan (CP) for one of two sampled residents (Resident 1) when Resident 1 was a known high risk for elopement (occurs when a resident leaves the facility without authorization and/or any necessary supervision). This failure resulted in staff being unaware of Resident 1 leaving the facility unaccompanied, missing for approximately 10 hours, exposing Resident 1 to environmental dangers, experiencing exposure hypothermia (dangerous drop in body temperature), leukocytosis with left shift (higher-than-normal blood count of white blood cells in the blood), and metabolic acidosis (a serious condition where too much acid builds up in the body fluids, often because the kidneys cannot remove enough acid or the body produces too much), and requiring hospitalization.Findings:During a review of the admission Record (AR) dated 12/18/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of schizophrenia (chronic brain disorder that disrupts how a person thinks, feels, and behaves, causing them to lose touch with reality through symptoms like hallucinations [hearing/seeing things] and delusions [false beliefs], anxiety disorder (mental condition characterized by excessive fear of or apprehension about real or perceived threats), major depressive disorder (serious mood disorder causing persistent sadness and loss of interest, affecting feelings, thoughts, and behavior).During a review of the facility's Investigation Follow Up (IFU) dated 6/23/25 (history of elopement, approximately six months prior to the 12/13/25 incident), the IFU indicated, Nurse on duty was notified by staff that Resident [1] is missing. Staff checked all the rooms at the facility and were still not found. At about 4 a.m. residents [Resident 1] were found by VPD [Police Department] next to the church.During a review of Resident 1's Care Plan (CP) dated 9/30/25, the CP indicated, [Resident 1] is an elopement risk/wanderer r/t [related to] history of attempts to leave facility unattended, impaired safety awareness. Elopement Risk Score: 14.0 High [risk]. Interventions: Monitor her whereabouts every hour.date initiated: 10/21/2025.During a review of the Minimum Data Set (MDS-resident assessment tool) dated 11/14/25, the MDS indicated Resident 1 had a BIMS (brief interview for mental status - cognitive screening) Summary Score of 9 (score of 8-12 means moderate impairment) and functional abilities: able to walk.During a review of Resident 1's POC (Point of Care) Response History (POCRH-used by staff to document Resident 1's monitoring and whereabouts), dated 12/13/25, the POCRH indicated Task: Monitor resident whereabouts every 1 hour. The POCRH indicated check marks on the following dates and times:a) On 12/13/25 at 5 a.m., 8:34 a.m., 11:31 a.m., 2:38 p.m., 5:48 p.m., and 7:04 p. m. (7:04 p.m. was the last documented time Resident 1 was checked before Resident 1 was discovered missing at 9:30 p.m.) b) On 12/12/25 at 5:09 a.m., 8:21 a.m., 1:02 p.m., 8:34 p.m., 9:03 p.m., and 11:51 p.m. c) On 12/11/25 at 5:01 a.m., 8:57 a.m., 10:47 a.m., 1:02 p.m., and 5:06 p.m.The document showed Resident 1's whereabouts were not monitored every hour. During a review of Resident 1's Progress Notes (PN) dated 12/14/25 at 2:34 a.m., the PN indicated, Resident [1] last seen at facility (12/13/24) around 8:40 p.m. by CNA [Certified Nursing Assistant]. They were [sic] [Resident 1] in room sleeping covered by blanket. Resident [1] was noticed missing around 9:30 p.m. CNA reported it to nurse at that time. All the facility was searched each bathroom and room, no sign of resident present inside. DON [Director of Nursing] .called at 9:53 p.m. to report that resident was unable to be found. Staff then continued to search outside and drive around neighborhood to see if they can find resident. Police were called around @ [at] 10:40 p.m. and report was filed. Police arrived to facility and took report from charge nurse and staff to get accurate description of resident [1]. Each staff member wrote statements. They [staff] then searched facility for possible exits resident may have taken. Police stated to charge nurse that door near resident's room was tested x3 [times three] and no alarm went off. Rp [responsible party] public guardian left message and Dr [doctor] made aware.During a review of the Ambulance Documentation (AD) dated 12/14/25 at 7:09 a.m., the AD indicated, Patient Condition hypothermia/cold injury.complaint.skin numbness.Per [name of town] PD [police department] the patient has been missing since approximately 8:00 p.m. last night.the patient was cold to the touch. EMS [emergency medical services] removed the patients wet socks once she was on the gurney and placed hot packs on her feet. EMS also gave the patient hot for her hands and armpits.EMS noted that the patient's heart rate was elevated at 142 sinus tachycardia [heart rate faster than normal, normal heart rate is 60-100].During a review of Resident 1's PN dated 12/14/25 at 9:28 a.m., the PN indicated, Investigator informed staff of resident being found around 7:00 a.m. and transferred to [hospital]. writer spoke with ER