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	04/13/2026

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 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. Based on interview and record review, the facility failed to notify the physician when one of three sampled residents (Resident 1) was refusing multiple doses of medications. This failure resulted in the physician being unaware of Resident 1's refusals and the potential for Resident 1 to experience adverse side effects.Findings:During a review of Resident 1's Order Summary Report (OSR-physician's orders) dated 4/1/26, the OSR indicated, buspirone (medication used to treat anxiety).give one tablet by mouth two times a day.start date 12/25/25.citalopram (medication used to treat depression).give one tablet by mouth one time a day.start date 3/4/26.Valporic acid (used to treat psychiatric disorders).give 10 ml (milliliters-unit of measurement) by mouth two times a day.start date 3/31/26.During a review of Resident 1's Medication Administration Record (MAR) dated 4/1/26-4/30/26, the MAR indicated, citalopram was refused on 4/1, 4/5, 4/7, 4/8 and buspirone and valproic acid were refused on 4/1, 4/2, 4/4, 4/5, 4/6, 4/7 and 4/8.During a concurrent interview and record review on 4/13/26 at 11:30 a.m. with Interim Director of Nursing (IDON), Resident 1's Progress Notes (PN) dated 4/1/26-4/8/26 were reviewed. IDON was unable to provide documentation of the physician being made aware of the medication refusals. IDON stated the physician should have been notified when Resident 1 refused the medications three times.During a review of the facility's policy and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directives undated, the P&P indicated, Should the resident refuse treatment of any kind, the facility will document the following in the resident's chart.a. What the resident refused. B. The reason for the refusal. C. How the resident was educated regarding the consequences of refusal.f. That the physician was notified of refusal and the resident's response to education/offering of alternatives.

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

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	04/13/2026

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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 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 interview and record review, the facility failed to ensure the physician was notified when one of three sampled residents (Resident 1) anti-psychotic medication (used to manage psychotic symptoms such as delusions [false belief], hallucinations [perception of something not present], paranoia [irrational and excessive mistrust], and disordered thought [disruption in the ability to organize, process, and articulate thoughts] was not available. This failure had the potential to result in Resident 1 experiencing an adverse reaction and/or an increase in behaviors.Findings:During a review of Resident 1's Psych (psychological) Eval (evaluation), & Medication Recommendation (PEMR) dated 3/30/26, the PEMR indicated, The patient (Resident 1) was evaluated following two recent episodes of significant aggressive acting out behavior within the facility.Recommendation for Medication Adjustments. increase Risperdal Consta (anti-psychotic medication) to 37.5 mg (milligrams-unit of measurement)/IM (intramuscularly) every 2 weeks.During a review of Resident 1's Order Summary Report (OSR-physician's orders) dated 4/1/26, the OSR indicated, Risperdal Consta.Inject 37.5 mg intramuscularly in the evening every 14 day(s) related to unspecified dementia (decline in mental ability such as memory, reasoning, and thinking severe enough to interfere with daily life), unspecified severity, with anxiety (feeling of apprehension, dread, or uneasiness).start date 3/31/26.During a review of Resident 1's Medication Administration Record (MAR) dated 3/1/26-3/31/26, the MAR indicated, Risperdal Consta was to be administered at 4 p.m. on 3/31 and a 5 was documented indicating the medication was not administered and to see the progress notes.During a review of the Progress Note (PN) dated 3/31/26 at 9:27 p.m., the PN indicated, EMAR (electronic medication administration record)-Administration Note.Risperdal Consta.Inject 37.5 mg intramuscularly in the evening every 14 day(s).pending pharmacy delivery.During a concurrent interview and record review on 4/13/26 at 12:45 p.m. with Interim Director of Nursing (IDON), Resident 1's clinical record was reviewed. IDON stated on 3/31/26 the physician was not notified of the Risperdal Consta not being available for administration and the physician should have been notified.During a review of the facility's policy and procedure (P&P) titled, Unavailable Medications undated, the P&P indicated, If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication.