STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055412	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute Care	101 S Orchard Ave Vacaville, CA 95688

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to implement their policy on change of condition/ notification for one of two sampled residents (Resident 1) when Resident 1's Responsible Party was not notified of Resident 1's new sheared skin (one of the major causes of skin breakdown in sitting and occurs during transfers, reaching, weight shifts or repositioning) to his coccyx (small bone at the bottom of the spine). This failure did not ensure Resident 1's Responsible Party could exercise her right to be informed and to participate with Resident 1's care and treatment. Findings: During a telephone interview with Family Member A on 4/29/24 at 2:21 p.m., Family Member A stated Resident 1 was admitted to the facility with no skin issues. Family Member A stated on the day Resident 1 was discharged home, she noticed blood on Resident 1's underwear while assisting him to the toilet and found a wound on his buttocks. She stated the facility did not notify her of Resident 1's new wound. A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including but not limited to Cerebral Infarction (also known as stroke); Diabetes Mellitus (disease that result in too much sugar in the blood); and Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of the document titled Order Summary Report dated 4/10/24 indicated a physician's order written on 3/27/24 stating Resident 1 does not have the capacity to make health care decisions. A review of the facility document titled SBAR (Situation, Background, Assessment and Recommendation - a tool used by health care professionals to communicate with each other about critical changes in patient's status) Communication Form and Progress Note dated 4/04/24 indicated Resident 1 had skin shearing to coccyx which started on 4/04/24. The document indicated Resident 1 was notified of the new skin issue. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Staff B on 4/30/24 at 11:48 a.m., when Licensed Staff B was asked about the facility's policy when a resident was found to have a new skin issue, Licensed Staff B stated she would notify the doctor, the Director of Nursing (DON), and the wound treatment nurse. When Licensed Staff B was asked should resident's responsible party be notified of the new skin issue, she stated if the resident had cognitive impairment, she would notify the responsible party and would document who was notified. During an interview with the DON on 4/30/24 at 12:01 p.m., when the DON was asked if Resident 1's responsible party was notified of Resident 1's new sheared skin to his coccyx, the DON stated Family Member A was not notified because Resident 1's admission record indicated he was responsible for himself. However, the DON stated Resident 1's physician wrote an order on 3/27/24 indicating Resident 1 did not have the capacity to make health care decisions and concurred that Family Member A should have been notified of the new skin issue. A review of the Facility policy and procedure titled Change Of Condition / Notification with effective date 11/2016 indicated, A facility must immediately inform the resident; consult with the resident's physician, and if known, notify the representative or an interested family member when there is an accident or incident, significant change, a need to alter treatments, or a transfer or change in roommate.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44968 Based on interviews and records review, the facility failed to safeguard resident's property for one of two sampled residents (Resident 1). This failure resulted in Resident 1's missing clothes upon discharge from the facility. Findings: During a telephone interview with Family Member A on 4/29/24 at 2:21 p.m., Family Member A stated Resident 1 lost his gray pants, compression socks, underwear, and black shirt during his thirteen days stay at the facility. Family Member A stated she told the facility staff of the missing clothes; however, Family Member A was only told that they will look for it. Family Member A stated clothes from other residents were sent home with Resident 1. A review of the Admission Record indicated Resident 1 was admitted to the facility on [DATE] with diagnosis including but not limited to Cerebral Infarction (also known as stroke); and Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). A review of the Minimum Data Set (MDS -health status screening and assessment tool used for all residents) dated 3/31/24 indicated Resident 1 had a BIMS score of 7 out of 15 points (Brief Interview for Mental Status - a 15-point cognitive [relating to the mental process involved in knowing, learning, and understanding things] screening measure that evaluates memory and orientation. A score of 00 to 07 is severe impairment). A review of the Progress Note dated 4/10/24 indicated Resident 1 was discharged home. The Progress Note indicated, [Resident 1's] inventory sheet signed upon discharge. [Resident 1] verbalized all belongings are with resident upon discharge from facility. A review of the facility document titled Inventory of Personal Effects for Resident 1 indicated the following items were listed on 3/26/24: one black shirt, one hat, one gray jacket, one black slip on shoes, one gray sweatpants and one gray sweat top, upper and lower dentures and one ring. The document indicated, Upon discharge, use the checkmark columns to indicate that all personal belongings are accounted for. However, the checkmark columns were left blank upon discharge. The document indicated Resident 1's signature and an unknown CNA's (Certified Nursing Assistant) signature on 4/10/24. During an interview with Licensed Staff B on 4/30/24 at 11:48 a.m., when Licensed Staff B was asked about the facility's policy to ensure resident's belongings were returned to them upon discharge, Licensed Staff B stated nurses and CNAs were responsible of recording all items brought to the facility on admission. She stated either the CNA or the nurse will go over the list of items returned to the resident or responsible party upon discharge, then the resident or the responsible party would sign the inventory list to acknowledge what they received. When Licensed Staff B was asked if residents with cognitive impairment were allowed to sign the document, she stated no. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Staff C on 4/30/24 at 12:26 p.m., when asked about the facility's policy to ensure resident's belongings were returned upon discharge, Licensed Staff C stated all items listed on the inventory list will be returned to the resident. She stated for missing items, facility staff will start to search, and if unfound, the Social Service Director (SSD) will be notified of the lost items. When Licensed Staff C was asked if Family Member A reported that some of Resident 1's clothes were missing at the time of discharge, Licensed Staff C stated she could not remember. During an interview with the SSD on 4/30/24 at 12:38 p.m., when the SSD was asked about the facility's policy for resident's reported missing items, the SSD stated facility staff will search for the missing items, and if unable to locate, staff will fill out the form for lost items and submit to SSD for processing. When the SSD was asked if she was notified of Resident 1's missing clothes upon discharge, she stated no. A review of the Facility policy and procedure titled Theft and Loss revised on 5/2017 indicated, The facility shall maintain resident belongings in a safe manner to prevent theft and loss to the extent possible; On discharge of a resident, the resident/representative will sign the inventory sheet stating they have taken possession of the resident's personal property.