STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055706	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchard - Post Acute Care	12385 E. Washington Blvd Whittier, CA 90606

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide necessary care and services for one of 4 sampled resident (Resident 1) who was at risk for developing pressure ulcer (PU- a skin damage or injury due to poor circulation or prolonged unrelieved pressure) and complications from PU, in accordance with the facility ' s policy and procedure, care plan and the physician ' s order by failing to: 1. Ensure the facility ' s licensed staff was referred and followed up on Resident 1 ' s referral and appointment with a vascular physician (a doctor who specializes in the diagnosis, treatment, and prevention of diseases that affect the blood vessels, including arteries and veins), in accordance with Nurse Practitioner (NP) 1 ' s recommendations on 9/24/2024. Resident 1 was not evaluated until 1/17/2025 when Resident 1 was transferred to the GACH (General Acute Care Hospital) 1 emergency room (ER). 2. Ensure the facility ' s licensed staff identified and addressed Resident 1 ' s diagnoses of peripheral vascular disease and develop a comprehensive care plan starting 12/18/2024 upon receipt of the arterial doppler result indicating the findings was consistent with moderate PVD of the bilateral lower extremities to ensure appropriate treatment measures are provided to the resident. 3. Ensure the facility ' s licensed staff referred and followed up on Resident 1 ' s referral and appointment with a wound specialist to assess the Resident ' s right foot wound, in accordance with NP 1 ' s recommendations and orders on 12/25/2024. The physician ' s order was placed by the facility staff on 1/13/2025 (19 days from NP 1 ' s order to refer Resident 1 to a wound specialist) and was seen by the wound specialist for an outpatient appointment on 1/17/2025. These deficient practices resulted in delays of Resident 1 ' s wound assessment and interventions to the right and left foot. On 1/17/2025, Resident 1 was transferred to GACH (General Acute Care Hospital) 1 emergency room (ER) as ordered by the wound specialist due to infection and gangrenous changes to the right heel and left second toe. In GACH 1, Resident 1 was found to have worsening lower extremity gangrene that included malodorous (an unpleasant or offensive odor, often associated with rotting or decaying matter) dry gangrenous right heel ulcer with surrounding erythema (abnormal redness) and tenderness to palpation, left second toe with dry gangrene. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Resident 1 was discharged from GACH 1 on 1/29/2025 to hospice care (a specialized form of end-of-life care that provides comfort, support, and medical assistance to terminally ill patients and their families) and passed away on 2/18/2025. The Certificate of Death indicated Resident 1 ' s immediate cause of death was sepsis (a life-threatening emergency that happens when your body's response to an infection damages vital organs and, often, causes death) secondary to osteomyelitis (infection in the bone that can cause inflammation, pain and damage to the bone), peripheral artery disease (also knows as peripheral vascular disease [PVD], is a circulatory condition where narrowed arteries reduce blood flow to the arms and legs, most commonly affecting the extremities), Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) Type II. Findings: During a review of Resident 1 ' s admission Record (AR), the AR indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including pneumonia (a severe infection and inflammation of the lungs), chronic kidney disease (a condition when kidneys have become damaged overtime and unable to filter out fluids and toxins in the body) diabetes mellitus, and Parkinson ' s Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 1 ' s Braden Scale for Predicting Pressure Injury Risk (a Braden Scale used to predict the risk of developing pressure sores/injuries. Early identification allows for preventative measure to be taken, such as repositioning, pressure relief measures, and nutritional support) dated 3/14/2024, the total score indicated was 14 (categorized at moderate risk for pressure injury). During a review of Resident 1 ' s Care Plan dated 6/30/2024, the care plan indicated Resident 1 was at risk for developing PU related to UTI (urinary tract infection- an infection in the bladder/urinary tract), ESRD (End Stage Renal Disease-irreversible kidney failure) on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). The care plan interventions included: the facility will assess/record/monitor wound healing, assess and document the wound perimeter (around the wound), report improvements and declines to the physician; administer treatment as ordered and monitor for effectiveness; provide pressure relieving/reducing device; weekly head to toe skin at risk assessment. During a review of Resident 1 ' s Podiatry (a medical care and treatment of the human foot) Evaluation and Treatment dated 8/19/2024, the Podiatry Evaluation indicated Resident 1 had absent hair growth on the foot and skin temperature was cool to touch. The evaluation indicated Resident 1 was assessed having onychomycosis (a fungal infection of the nails). During a review of Resident 1 ' s Braden Scale for Predicting Pressure Injury Risk dated 9/16/2024, indicated the total score was 14 (categorized at moderate risk for pressure injury). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Podiatry Evaluation and Treatment dated 10/22/2024, the Podiatry Evaluation indicated Resident 1 had absent hair growth on the foot with skin temperature cool to touch. The evaluation indicated Resident 1 was assessed having onychomycosis, The Podiatry evaluation added another diagnosis during this assessment and indicated Resident 1 had Type II Diabetes with PVD without gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection). Resident 1 ' s records did not indicate any other follow up Podiatry Evaluations after this visit on 10/22/2024. During a review of the Progress Notes dated 11/21/2024 indicated Resident 1 had a change in skin condition of the right heel which was noted with cracked skin, scant (small amount) bleeding and redness. The Progress Notes did not indicate the type of wound and/or measurement of the wound. During a review of Resident 1 ' s Care Plan, dated 11/21/2024 indicated Resident 1 had PU on right heel related to history of ulcers and immobility. The care plan interventions included placing heel protectors, assessing/recording/monitoring wound healing, wound perimeter, measure length, width, and depth of the wound. wound bed, and healing progress. The interventions also included reporting improvements and declines of the skin condition to the physician. During a review of Resident 1 ' s Skin Evaluation PRN (as needed) /Weekly dated 11/25/2024 indicated, Resident 1 ' s right heel was noted with a pressure wound measuring 1 centimeter (cm) x 1 cm with no staging (no documentation of the stage or depth of the wound/ulcer). Additional comments indicated Resident 1 ' s right heel had cracked skin. During a review of Resident 1 ' s Skin PU Weekly assessment dated [DATE] indicated, Resident 1 ' s right heel PU was reclassified to SDTI measuring 3 cm x 4 cm, with 100% (percent) maroon/purple discoloration and pain, the wound bed was assessed to have normal skin. The intervention was to clean with normal saline, pat dry, paint with Betadine (a solution that kills virus and bacteria) and cover with dry dressing, and offload (lift or remove) from pressure. During a review of the Minimal Data Sheet (MDS- a resident assessment tool) dated 11/29/2024, indicated Resident 1 had severe cognitive impairment (a condition that makes it very difficult for a person to think, learn, and remember) and had no behavior of refusal or rejection of care. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort, lifts, holds, or supports trunk or limbs, but provides less than half the effort) on rolling left and right, sitting to lying, lying on side of bed, and chair/bed-to-chair transfer and personal hygiene. The MDS indicated Resident 1 was assessed with one unstageable pressure injury presenting as deep tissue injury. Further review of the MDS indicated Resident 1 was not assessed as having any other issues or foot problems that included infection of the foot, diabetic foot ulcer (an open sore or wound on the foot of a person with diabetes, often located on the bottom of the foot) and/or other open lesions on the foot. During a review of Resident 1 ' s Care Plan dated 11/29/2024, indicated that Resident 1 had PU staged as SDTI on right heel related to immobility. The care plan interventions further indicated heel protectors (a medical device, often made of cushioned materials like foam or air, designed to protect and support the heels of individuals who are bedridden) in place, right heel open wound to be cleaned with normal saline, pat dry, and paint with betadine and cover with dry dressing, and off load from pressure. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Care Plan dated 12/9/2024, the care plan indicated Resident 1 ' s potential for complications due to pain on bilateral lower extremities and bilateral plantar foot. The care plan interventions included administering Neurontin 300 mg daily (medication for nerve pain) as ordered and monitoring the site and location of pain. During a review of Resident 1 ' s Braden Scale for Predicting Pressure Injury Risk dated 12/9/2024, the record indicated the total score was 15 (categorized at low risk for pressure injury). During a review of Resident 1 ' s Condition Follow Up Note dated 12/16/2024, the Note indicated Resident 1 had a new ischemic ulcer (an open sore or wound that develops due to lack of oxygen and nutrients to the tissues, caused by reduced blood flow in the arteries) on the right foot lateral and right fifth toe. The Note indicated Family 1 was made aware and informed of the new order for arterial doppler ultrasound to the bilateral lower extremities to check for circulation. During a review of Resident 1 ' s Skin Evaluation PRN/Weekly dated 12/16/2024, the assessment indicated the following: New skin changes with two closed wounds on right fifth toe and right metatarsal (lateral foot), measuring 0.8 cm x 0.7 cm x (UTD) -Unstageable Tissue Damage a condition where the stage of a pressure ulcer cannot be accurately determined because the wound bed is obscured by eschar or slough)) cm and 1.5 cm x 1 cm x UTD cm respectively, and both wounds were noted 100% maroon discoloration. Right heel SDTI measured 3 cm x 4 cm x UTD no documented evidence about wound assessment including description of the wound. During a review of Resident 1 ' s Care Plan dated 12/16/2024, the Care Plan indicated Resident 1 had a right metatarsal closed wound. The care plan interventions included to clean with normal saline (sterile water with salt that removes bacteria from the wound), pat dry, and paint with betadine and leave open to air, and keep skin clean and dry. During a review of Resident 1 ' s Physician Order dated 12/16/2024, the order indicated to obtain arterial ultrasound (a test that looks at the blood circulation in the arteries of upper or lower extremities [limbs]) on bilateral lower extremities due to pain. During a review of the Radiology (high-energy radiation) Interpretation report dated 12/18/2024 indicated an arterial doppler of the bilateral lower extremity was performed for Resident 1 due to pain in the right and left leg. The arterial doppler findings showed moderate plaque (hard substance around the artery) noted within visualized arteries bilaterally. The report indicated the findings was consistent with moderate peripheral vascular disease without occlusion, bilateral lower extremities. The arterial doppler findings further indicated moderate stenosis (narrowing or constriction of an opening/passage) between left popliteal artery and posterior tibial artery. A handwritten note on the document indicated Texted [Physician 1] and [NP 1] [on] 12/19/2024 at 6:50 pm. Awaiting response. NNO (No New Order). During a review of Resident 1 ' s Skin Evaluation PRN/Weekly dated 12/23/2024 indicated Resident 1 ' s wounds on right fifth toe and right lateral foot, measuring 0.8 cm x 0.7 cm x udt (unable to determine) cm and 1.5x1.0x UDT cm respectively, both were staged as SDTI and noted with dark maroon/ purple discoloration. No other details of PU assessment were documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Physician Progress Note dated 12/25/2024, authored by NP 1, the progress note indicated right foot wound was observed. NP 1 ' s notes indicated to see orders to follow up with a wound specialist (healthcare personnel specializing in wound care). During a review of Resident 1 ' s Physician Order dated 12/25/2024, indicated to obtain an Xray (photographic or digital image of the inside of the body) of right foot to rule out osteomyelitis. During a review of Resident 1 ' s Skin PU Weekly assessment dated [DATE], the assessment indicated the following: 1. Resident 1 ' s right heel with suspected deep tissue injury measuring 4 cm x 4.5 cm, staged as SDTI, with 100% (percent) maroon/ purple discoloration and skin breakdown noted on 25% of wound bed. The wound bed was assessed to be black/brown (eschar). The intervention was to clean with normal saline, pat dry, and paint with Betadine and cover with dry dressing and offload from pressure. 2. Resident 1 ' s right fifth toe was staged as unstageable (slough/eschar) measuring 0.8 cm x 0.7 cm x UDT cm. The intervention was to clean with normal saline, pat dry, and paint with betadine and cover with dry dressing and offload from pressure. 3. Resident 1 ' s right metatarsal foot was staged as SDTI measuring 1.5 cm x1 cm x UDT cm, the wound bed was noted as black/eschar. The intervention was to clean with normal saline, pat dry, and paint with Betadine and cover with dry dressing and offload from pressure. During a review of Resident 1 ' s Skin PU Weekly assessment dated [DATE], the assessment indicated the following: 1. Resident 1 ' s right heel with suspected deep tissue injury measuring 4.0 x4.5 cm, staged as SDTI, with 100% (percent) maroon/purple discoloration, skin breakdown noted on 25% of wound bed. The wound bed was assessed as black/brown (eschar). The intervention was to clean with normal saline, pat dry, and paint with betadine and cover with dry dressing and offload from pressure. 2. Resident 1 ' s right fifth toe was staged as SDTI measuring 0.8 x 0.7 x udt cm, and the wound bed was noted as black/brown (eschar). The intervention was to clean with normal saline, pat dry, and paint with betadine and cover with dry dressing and offload from pressure. 3. Resident 1 ' s right metatarsal foot was staged as unstageable measuring 1.5 x 1.0xudt cm, the wound bed was noted as black/eschar. The intervention was to clean with normal saline, pat dry, and paint with betadine and cover with dry dressing and offload from pressure. During a review of Resident 1 ' s Progress Note dated 12/28/2024 to 1/12/2025 indicated no documented evidence that Resident 1 ' s right foot SDTI condition was reported to Physician 1 or NP 1. During a review of Resident 1 ' s Physician Order dated 1/3/2025, the order indicated a podiatry appointment was scheduled on 1/8/2025 timed at 3:30pm. During a review of Resident 1 ' s Nursing Note dated 1/8/2025 timed at 3:49 PM, the Nursing Note indicated Resident 1 returned from a Podiatry appointment with Family 1. The Note further indicated Resident 1 was not seen by the Podiatrist since the Podiatrist was not in the office. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Physician Order dated 1/8/2025, the order indicated the podiatry appointment was rescheduled for 1/13/2025 at 2:30 pm. During a review of Resident 1 ' s Physician Order dated 1/13/2025 (19 days from NP 1 ' s progress notes to refer Resident 1 to a wound specialist dated 12/25/2024), the order indicated a wound consultant appointment for Resident 1 ' s wounds on the foot was scheduled for 1/17/2025 at 1:30 pm. During a review of Resident 1 ' s Daily Skilled Note dated 1/15/2025 timed at 7:04 PM, the Note indicated under Skin/Wound Report as of 1/12/2025 showed multiple areas of concerns, including Right heel wound with increasing size and 100% necrotic tissue (dead tissue in the body that may be caused by lack of blood supply or injury), wound unstageable. Right fifth toe metatarsal with maroon/purple discoloration but no skin breakdown. Wound healing needs to be supported . The Note indicated Resident 1 has impaired skin integrity related to compromised circulation and nutritional status as evidenced by Increasing size of necrotic tissue on the heel and discoloration of the right foot. The Note indicated the facility ' s interventions included continuing Renal diet (a dietary plan designed for individuals with kidney disease), recommend liquid protein (Prostat, 30 milliliter [ml]) for wound healing and muscle maintenance, reinforce fluid restriction, offer high calorie/high protein snacks to address poor intake. The Note indicated for Skin/Wound Care, to monitor the wound status of Resident 1 regularly, Family 1 informed and well understood. During a review of Resident 1 ' s Nursing note dated 1/16/2025, the Note indicated Family 1 verbalized concerns about Resident 1 ' s ischemic wound to the right heel. The Note indicated that it was explained to Family 1 that Resident 1 was already scheduled for a wound consult for 1/17/2025 and informed Family 1 if the Wound Physician wants to proceed with further work-up, the facility will adhere to the Wound Physician ' s recommendations. The Note indicated that the TXN updates Family 1 with on a daily basis with Resident 1 ' s wound condition, as well as any new orders and interventions. The Note indicated Once again, [Family 1] was provided with a recap of what had been done with Resident 1 ' s right heel ischemic wound. The Note indicated that Family 1 was reminded that the facility continues with nutritional approaches to wound healing, offloading heels but resident keeps on removing devices and not being compliant. The Note further indicated that a Doppler Ultrasound that was performed [12/18/2024] for the bilateral lower extremities showed Resident 1 has PVD and stenosis which can delay and/or impaired wound healing. During a review of Resident 1 ' s Wound Specialist handwritten document titled Physician Orders dated 1/17/2025 timed at 2:20 PM, the document indicated Patient [Resident 1] with gangrenous changes of [Right] heel and left second toe. Ischemic (inadequate blood supply in one part of a body) and infected foot. Please admit [to the GACH] for IV [intravenous-through the vein] antibiotics and revascularization (a medical procedure aimed at restoring blood flow to a body part or organ, typically by surgical or minimally invasive methods, to address a blockage or narrowing of blood vessels). During a review of Resident 1 ' s Nursing Note dated 1/17/2025 timed at 3:12 PM, the Note indicated Resident 1 came back to the facility with Family 1 from the Wound Specialist appointment with an order to transfer Resident 1 to GACH 1 ER due to gangrenous changes of the right heel. During a review of Resident 1 ' s Nursing Note dated 1/17/2025 timed at 7:25 PM, the Note indicated Resident 1 was picked up by ambulance via gurney to transfer to GACH 1, in the presence of Family 1. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Physician Order dated 1/17/2025, the order indicated transfer Resident 1 to GACH emergency room per wound consultant for ischemic (reduced blood flow to an area of the body) and infected wound evaluation. During a review of Resident 1 ' s GACH 1 record titled ED [Emergency Department] Triage Note dated 1/17/2025 indicated Resident 1 arrived at GACH 1 ED on 1/17/2025 at 7:43 PM with a chief complaint of Lower Extremity Pain. The ED Triage Note indicated [Resident 1] presented with infection and gangrene of the right heel and left second toe. Patient [Resident 1] sent from nursing home. No fall or injury. She has diabetes and peripheral vascular disease. The ED Triage Note Physical Exam for Resident 1 indicated Resident 1 had Dry gangrene of the right heel with surrounding erythema and tenderness to palpation. Patient does have capillary refill to the toes. Left second toe with dry gangrene. The ED Triage Note ' s Medical Decision Making indicated Patient [Resident 1] presenting with gangrene of the right heel and left second toe. Lab [laboratory tests] shows leukocytosis (an increase in the number of white cells in the blood, especially during an infection), acute on chronic kidney disease, hypokalemia (low potassium level). [Resident 1] was given vancomycin and Zosyn. She [Resident 1] will be admitted . During a review of GACH 1 Right Foot X-ray date 1/17/2025 indicated an impression of Extensive vascular calcifications of peripheral arterial disease. During a review of Resident 1 ' s GACH 1 Physician History and Physical (H&P) dated 1/18/2025, indicated Resident 1 was admitted to GACH 1 due to Worsening lower extremity gangrene. The GACH 1 H&P indicated Resident 1 was unable to give any information but complained of lower extremity pain. During a review of GACH 1 ' s Interventional Radiology Consultation dated 1/18/2025, the record indicated Resident 1 was a poor historian but stated she has had an infection for about three months in her leg. The record indicated Resident 1 presented with gangrenous wounds to the feet. Unable to exam them (both feet) as [Resident 1] had severe pain with soft touch. Her [Resident 1] pain extends to both her calves bilaterally . Although she [Resident 1] appears to be a generally poor candidate for limb salvage due to her listed comorbidities, it is reasonable to try and conservatively heal her wounds depending on the severity, with wound care and angiogram (a medical imaging technique that uses X-rays to visualize blood vessels) for revascularization. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of GACH 1 Podiatry Consult dated 1/18/2025 timed at 5:21 PM, the Podiatry Consult indicated Resident 1 was seen at bedside with Family 1. The Podiatry Consult indicated The past few weeks her (Resident 1) toes and heel became red and discolored. [Family 1] stated that he talked to the [facility] staff who said it [toes and heel] looked okay and normal until it became black. [Resident 1] was referred to the [GACH 1] Wound Center and the Wound Physician referred Resident 1 to the GACh 1 ED for treatment. The Physical Exam indicated Non-palpable dorsalis pedis and posterior tibialis pulses bilaterally. No edema. Capillary filling time is delayed for toes 1 through 5. Digital hair growth is absent. Gangrenous changes to the distal tips of the lesser toes. Sensation is intact to touch and there is pain with palpation . Gangrenous changes to both third and fourth and fifth toes. Malodorous (an unpleasant or offensive odor, often associated with rotting or decaying matter) gangrenous right heel ulcer. Erythematous (exhibiting abnormal redness of the skin). No drainage. The exam further indicated Resident 1 ' s general appearance as No acute distress . pedal pulses absent. The Podiatry Consult further indicated under Problem List indicated severe peripheral arterial disease, diabetes mellitus with peripheral angiopathy with gangrene, gangrene of the right foot, bilateral toe gangrene. The Podiatry Consult indicated prognosis is guarded and awaiting arterial doppler and interventional radiology consultation. If there are large amounts of small vessel disease treatment with angioplasty (surgical repair or unblocking of a blood vessel), the heel may not heal and require below knee amputation. Continue offloading at this time. Order right ankle magnetic Resonance Imaging (MRI - to create detailed images of the body's internal structures) to assess heel ulcer. During a review of GACH 1 ' s Extremity Angiogram Unilateral with Intervention dated 1/22/2025, the record indicated Resident 1 ' s angiogram was performed to Resident 1 on 1/22/2025. The record indicated an impression that showed the following: 1. Chronic total occlusion of the distal superficial femoral artery successfully recanalized with balloon angioplasty. 2. Moderate popliteal and severe anterior tibial artery origin flow-limiting stenoses successfully treated 3 millimeters balloon angioplasty. 3. Severe microvascular disease of the foot. Chronically occluded peroneal and posterior tibial arteries without distal targets for recanalization (the process of restoring or reopening a blocked or narrowed vessel, particularly a blood vessel, to allow for improved blood flow). During a review of GACH 1 ' s Physician Discharge Summary documented on 1/30/2025, the Discharge Summary indicated Resident 1 was discharged from the facility on 1/29/2025. The discharge diagnoses include but not limited to acute osteomyelitis of the right foot, chronic heel ulcer, PAD, gangrene of the right foot, diabetes mellitus with peripheral angiopathy, ESRD on dialysis, obesity, malnutrition. During a review of Resident 1 ' s Certificate of Death (COD) signed by a physician on 2/20/2025, the COD indicated Resident 1 ' s date of death was 2/18/2025. The COD indicated Resident 1 ' s immediate cause (final disease or condition resulting in death) of death was sepsis. The COD indicated the list of conditions leading to the cause of death or the underlying cause of death (disease or injury that initiated the events resulting in death) were osteomyelitis, peripheral artery disease, Diabetes Mellitus type II. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a record review and concurrent interview on 4/28/25 at 10:20 am with the Treatment Nurse (TXN), the TXN state when Resident 1 ' s right heel cracked skin occurred on 11/21/2024, Resident 1 ' s right heel did not look like a PU, therefore staging was not indicated in the Change in Condition Progress Note. The TXN stated she documented the right heel as PU on Skin Evaluation PRN/Weekly dated 11/25/2024 while it looked like a cut on Resident 1 ' s right heel initially noted on 11/21/2024. During a record review and concurrent interview on 4/28/25 at 11:30 am with the TXN, the TXN stated she documented the measurement for Resident 1 ' s right heel SDTI on Skin PU Weekly dated 11/29/2024 but did not measure the right heel open wound. The TXN stated she should have measured and documented the right heel open wound. During a record review and concurrent interview on 4/28/25 at 1:20 pm The TXN stated she did not notify Physician 1 on 12/28/2024 when Resident 1 ' s right fifth toe and metatarsal PU were noted with black/eschar because Nurse Practitioner (NP) 1 visited Resident 1 on 12/25/2024 and knew about Resident 1 ' s wounds also ordered an Xray and a laboratory test. The TXN stated she thought the current wound treatment at that time was appropriate. TXN 1 stated that Resident 1 had been noncompliant with wearing the heel protector and offloading both heels. During an interview with NP 1 on 4/29/2025 at 10:40 am, NP 1 stated she had reviewed Resident 1 ' s arterial doppler of the bilateral lower extremity result on 12/19/2024. NP 1 stated that Magnetic Resonance Angiogram (MRA) and Computed Tomography Angiography (CTA) was not ordered right away because Resident 1 needed to be evaluated by a vascular surgeon. NP 1 stated We are trying to schedule for a vascular surgeon and podiatry consult. NP 1 stated that in her progress notes dated 9/24/24, she wrote that Resident 1 had a vascular physician appointment pending for Resident 1. NP 1 stated she was made aware by facility staff that Resident 1 ' s family had refused In-house Podiatry. NP 1 stated she did not have documentation of Resident 1 ' s family ' s refusal of inhouse podiatry but the facility staff noted it. NP 1 stated she did not know what happened to the pending vascular physician referral since 9/24/24. NP 1 stated she was not sure what to say why the facility did not refer Resident 1 right away when it was ordered on 12/25/2024. NP 1 stated she informed the facility ' s TXN to follow up the order for Resident 1 ' s wound specialist/consult. During a record review of Resident 1 ' s progress notes and concurrent interview with the TXN on 4/29/25 at 11:59 am, the TXN stated she was given a verbal order from NP 1 on 12/25/2024 about Resident 1 ' s podiatry and vascular physician referral but did not place the order in the resident ' s records. The TXN stated the facility did not make a referral or an appointment over the phone for Resident 1 because the phoneline was down at the GACH 1 medical group where Resident 1 needed to be referred during that time (December 2024). The TXN stated they had Resident 1 ' s Family 1 walk into the GACH 1 medical group to make the appointments for podiatry and wound physician/specialist for Resident 1. The TXN stated Family 1 was not able to make an appointment to a vascular physician during that time. The TXN stated the facility did not do anything when Family 1 was not able to make an appointment for the vascular physician. The TXN stated she could not find documented evidence documented on 12/2024 and January 2025 resident ' s records why Resident 1 was not referred to a wound specialist or vascular physician when it was written and ordered by NP 1 to follow up on 12/25/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055706	A. Building B. Wing	04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchard - Post Acute Care	12385 E. Washington Blvd Whittier, CA 90606

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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 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON on 4/29/2025 at 11:15 am, the Director of Nursing (DON) stated, the facility did not think about getting another wound specialist for Resident 1 if there was difficulty getting an appointment for Resident 1. The DON stated she could not remember why the vascular physician appointment were not made and could not find documented evidence anywhere in resident ' s records why Resident 1 was not referred to a vascular physician when it was recommended since September 2024 and December 2024. During a record review and concurrent interview on 4/29/25 at 1:40 pm with the DON, the DON stated the wound specialist referral was not scheduled immediately due to a systemwide problem experienced by the GACH 1 medical group in December 2024 and was unable to make appointments thru the GACH 1 medical group online system where Resident 1 needed to be referred to for the wound specialist in December 2024. The DON stated the facility did not make other attempts to make an appointment prior to [1/13/2025]. The DON stated she was not aware of the change in condition for Resident 1 ' s wounds on the right and left feet on 12/28/2024 compared with 12/16/2024. The DON stated Resident 1 was not referred to a different wound specialist or a vascular physician at a different medical group that was not affected by the GACH 1 systemwide problem. The DON stated she was not aware of the verbal order of NP 1 to the TXN for vascular and wound specialty referral. The DON stated the facility should have made the necessary appointments for Resident 1 and ensured care and services were not delayed. The DON stated she could not find documented evidence that a comprehensive care plan was developed for Resident 1 ' s PAD/PVD or for stenosis or occlusion/plaques found during Resident 1 ' s arterial doppler performed on 12/18/2024. The DON stated NP 1 did not point out or informed a licensed nurse about the wound specialist follow up note written in NP 1 ' s progress notes on 12/25/24, so nobody saw the note until 1/13/25, when facility staff placed the referral order in the physician progress notes. During an interview with Family[TRUNCATED]