

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER The Orchard - Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document a resident's left leg bruising (a mark on the skin caused by broken blood vessels under the surface, which happened after an injury, like a bump or blow) and swelling for one of four sampled residents (Resident 1). This deficient practice that the potential to negatively affect Resident 1's physical comfort and psychosocial well-being. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included abnormalities of gait and mobility (a change to your walking pattern), spondylosis (a common type of arthritis in the spine that resulted from the natural wear and tear on the bones and soft tissues as you age), and osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D). During a review of Resident 1's History and Physical (H&P) dated 8/23/2025 at 7:08 PM, the H&P indicated the resident had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 8/25/2025, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). The MDS indicated that the resident did not have a fall since admission/entry, reentry or the prior assessment. During a review of Resident 1's Change in Condition Evaluation dated 9/17/2025 at 10:27 AM, the Evaluation indicated the resident slid out of the wheelchair in the morning and was unable to determine the resident's signs or symptoms since the change in condition. The Evaluation indicated the resident did not have any changes in skin and the resident had no pain. The Evaluation indicated the resident's representative and the physician were notified with orders for a 72-hour neuro check (a period of increased monitoring after a resident fell to catch any missed injuries, especially those affecting the brain). During a review of Resident 1's Physical Therapy (PT) Treatment Encounter Notes and Progress Reports dated 9/17/2025 through 10/2/2025, both documents did not disclose the resident had any bruising to the left leg. During a review of Resident 1's Post-Event Interdisciplinary Team (IDT) Review dated 9/18/2025 at 11:01 AM, the IDT review indicated the resident was in the dining room for daily activities and a facility staff member witnessed the resident slide down to the floor from the wheelchair. The IDT Review indicated recommendations to educate Resident 1 to call staff for assistance, safety training, and for the rehabilitation department (rehab department provided services to help people regain abilities they have lost due to illness, injury, or disability) to conduct a post fall screening. During a review of Resident 1's Change in Condition Evaluation dated 10/2/2025 at 11:30 AM, the Evaluation indicated the resident had leg pain in the morning and signs or symptom stayed the same. The Evaluation indicated the resident was able to move her left leg and no edema or redness was noted. The Evaluation indicated the resident had a pain level of four on a pain scale from zero to 10 (0 was no pain, 4-5 was moderate pain, and 10 was excruciating pain) and received as needed pain medication. The Evaluation indicated the resident's representative and physician were notified with orders to get an x-ray to left leg and doppler (a technology that used the doppler effect to measure motion, most commonly blood flow in medical ultrasound). During a review of Resident 1's Physician's Order dated 10/2/2025 at 6:07 PM, the Physician's Order indicated for the resident to (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055706	Facility ID: 055706 If continuation sheet Page 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER The Orchard - Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have an x-ray (a form of electromagnetic radiation that creased images of the inside of the body, like a shadow picture, by passing through different tissues at different rates) left hip, left knee, and left tibia/fibula (the two bones in the lower leg) one time only related to muscle weakness (decrease in muscle strength) - generalized for one day. During a review of Resident 1's Change in Condition Evaluation dated 10/2/2025 at 10 PM, the Evaluation indicated the resident had a left distal femoral fracture in the afternoon and was unable to determine the resident's signs or symptoms since the change in condition. The Evaluation indicated that the resident's representative and physician were notified with orders to transfer to the general acute care hospital (GACH) Emergency Room. During a review of Resident 1's Physician's Order dated 10/2/2025 at 10:53 PM, the Physician's Order indicated for the resident to transfer to the emergency room with a diagnosis of left distal femoral fracture (a break in the lower part of the left thigh bone, near the knee joint). During a review of Resident 1's General Acute Care Hospital (GACH) Records dated 10/3/2025, the GACH Records indicated the resident had a distal left femur oblique fracture (a diagonal break in the lower part of your left thigh bone, near the knee) and because of the resident's complex medical history orthopedic surgical intervention (involved a doctor using tools to repair a broken bone to relieve pain and restore movement and function) was not required at that time. During an interview on 11/19/2025 at 11:42 with the Physical Therapist (PT), the PT stated initially the facility did not know about the fracture and would work around Resident 1's pain that was in her leg and that the resident did not want to get out of bed. The PT stated there was bruising to Resident 1's left leg and the resident would say Don't touch me and don't touch the blanket. The PT stated the nursing staff was informed of the bruise but did not recall the nursing staff who was informed. The PT stated there was no documentation of the observation or that the nursing staff were informed but there should have been. The PT stated without documentation there would not be a way to tract the bruising whether the bruise was decreasing or there were changes and the resident could get more injured. During an interview on 11/19/2025 at 3:15 PM, the Director of Nursing (DON) stated Resident 1's fracture could have been from the fall at the facility or due to the resident's osteoporosis. The DON stated if an observation was done that Resident 1 had bruising, the facility staff should have documented the observation and what intervention was done due to the finding. The DON stated that when a problem was identified, the facility staff would do a change in condition to identify the issue and for Resident 1, because she had multiple comorbidities that could exacerbate the resident's fracture. The DON stated there was no documentation or change in condition that was done for Resident 1's bruising observed by the PT. During an interview on 11/19/2025 at 3:25 PM, the Treatment Nurse (TN) stated she had not seen bruising on Resident 1 and no other facility staff member ever informed her of bruising to the resident's leg. During an interview on 11/19/2025 at 3:57 PM, the Licensed Vocational Nurse (LVN) 1 stated she was familiar with Resident 1 because Resident 1's room was always assigned to her station so LVN 1 was the assigned nurse to the resident. LVN 1 stated during the times she was assigned to Resident 1; the resident complained of pain to her (Resident 1) leg but was never informed of any bruising to the resident's leg from another staff member. During an interview on 11/19/2025 at 4:20 PM, the TN stated on 10/2/2025 she noticed swelling to Resident 1's left leg while providing treatment. The TN stated another facility staff member initiated the change in condition but must have forgotten to indicate there was swelling. The TN stated she should have documented the swelling because the swelling was a change of condition for Resident 1 and if there was no documentation that could harm the resident. During a review of the facility's policy and procedure (P&P) titled Change in Condition dated April 2025, the P&P indicated It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The P&P indicated The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055706	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER The Orchard - Post Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's provider using SBAR (situation, background, assessment, and recommendation - a communication framework for providing concise, essential information, especially in critical situations) or similar process to obtain new orders or interventions. The P&P indicated, The nurse will communicate the change to other departments as appropriate and updated communications will be available during morning report. Each department notified will perform their own evaluation and assessment to determine if change requires further intervention and implement actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR).		