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	03/11/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on observation, interviews and record review, the facility failed to implement facility's policy and procedure titled, Abuse: Prevention and Prohibition Against Suspicion of Crime, during the provision of care and services for one of one sampled residents (Resident 1) by failing to: Prevent mental abuse by a male therapist, who made Resident 1 feel uncomfortable.Identify mental abuse.Investigate an allegation of Resident 1 feeling uncomfortable with the male therapist and the way he moved when he was doing the therapy.Report allegation of mental abuse outside of facility and to the appropriate State of Federal agencies in the applicable timeframes. These deficient practices placed residents at risk of further abuse, feeling of intimidation and neglect. Cross referenced to F607Findings: During a review of Resident 1's admission Record (AR), the AR indicated an admission to the facility on 2/11/2026 with diagnoses that included metabolic encephalopathy (syndrome of brain dysfunction caused by systemic illness, organ failure, toxin accumulation, affecting consciousness, cognition, and motor function), abnormalities of gait and mobility, and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screen tool) dated 2/16/2026 indicated Resident 1 had severely impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience and the senses). The MDS described Resident 1's ability to understand others as usually understands which indicated the resident would miss some part/intent of message but comprehends most conversation. During a review of Resident 1's Physical Therapy Treatment Encounter Note(s) dated 2/23/2026 to 3/10/2026, the Note indicated the following male therapists that provided Physical and Occupational Therapy to Resident 1: Physical Therapist (PT) 1 provided Physical Therapy to Resident 1 on 2/23/2026 and 3/5/2026 Physical Therapist Assistant (PTA) 1 provided Physical Therapy to Resident 1 on 2/24/2026. PTA 2 provided Physical Therapy to Resident 1 from 2/25/2026 to 2/27/2026. During a review of Resident 1's Occupational Therapy Treatment Encounter Note(s) dated 2/23/2026 to 3/10/2026 indicated the following male therapists provided Occupational Therapy to Resident 1: Occupational Therapy Assistant (OTA) 1 provided Occupational Therapy to Resident 1 on 2/23/2026 and 3/4/2026. OTA 2 provided Occupational Therapy to Resident 1 on 2/24/2026, 2/25/2026, and 3/2/2026. During an interview in Resident 1's room on 3/11/2026 at 11:15 AM, Resident 1 stated a male staff from the rehabilitation department touched her inappropriately about two weeks ago or less from this day and unable to recall the exact date. Resident 1 stated she could not recall the name of the staff, just that he was a male therapist. Resident 1 stated while she was lying in bed, the male therapist was holding her left leg and moving it from side to side and not counting the repetitions. Resident 1 stated the male therapist was making a certain movement and it was like he was having an erection, and it seemed sexual. Resident 1 stated I don't understand why I'm feeling this way, when I'm an older woman, it makes me nervous, and I'm scared. Resident 1 stated she informed the Social Services Director (SSD) two weeks ago which was the last time she saw the male therapist. Resident 1 stated the SSD told the rehabilitation department staff not to have a male therapist come over to Resident 1's room. Resident 1 stated she had communicated this incident to three or four people that works at the facility but could not recall who the other staff were. During an interview on 3/11/2026 at 11:36 AM, the Director of Staff Development (DSD) stated (continued on next page)

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's family member (FM) 1 told her about the allegation last week (could not recall exact day) when she was making resident rounds. The DSD stated Resident 1 said she felt uncomfortable with a male therapist and the way he moved when he was doing the therapy in her room. The DSD stated Resident 1 told her she would rather have another therapist. The DSD stated she was not sure of who the male therapist was but told the staff scheduler in the Rehabilitation Department not to assign the male therapist that was previously assigned to Resident 1. The DSD stated FM 1 just wanted to make sure Resident 1 did not have a male therapist. The DSD stated she brought the incident up to the facility's administration. The DSD stated she did not ask Resident 1 for additional specific details about the incident or investigate the identity of the therapist during Resident 1's report. During an interview on 3/11/2026 at 11:46 AM, the SSD stated she could not recall the exact date, but the previous week (3/2/26 to 3/6/26), Resident 1 mentioned the incident with regards to the male therapist. The SSD stated Resident 1 could not recall the name of the male therapist. The SSD stated Resident 1 said she felt uncomfortable. The SSD stated she did not clarify or asked Resident 1 about the incident the resident mentioned about an unidentified male therapist. The SSD stated Resident 1 told her she did not want any male therapist, with the exception of one male therapist, OTA 1. The SSD stated she spoke with OTA 1 from the Rehabilitation Department about Resident 1's request the male therapist that Resident 1 mentioned and not to assign any male therapists to Resident 1 because she felt uncomfortable. The SSD stated she did not ask Resident 1 why she felt uncomfortable and did not investigate when Resident 1 mentioned the incident with the unidentified male therapist on a date the SSD could not recall. During an interview on 3/11/2026 at 12:05 PM, the Director of Rehabilitation (DOR) stated he had been informed that Resident 1 felt uncomfortable but did not know which male therapist was involved. The DOR explained that the rehabilitation department decided to adjust the assignment so that only female therapists would work with Resident 1. The DOR stated he could not recall the exact date this was brought to his attention, only that it was mentioned to him last week. During a concurrent review of the Rehabilitation Department's therapist roster, the DOR acknowledged that there were several male therapists on staff. The DOR stated he did not know who the therapist could have been, saying, it could be anybody. The DOR also stated that he did not conduct an investigation to identify the therapist, adding that the assignment was just changed. During a concurrent interview and record review of List of Therapist worked with Resident 1 on 3/11/2026 at 12:15 PM, the DOR stated the checkmark next to therapist's name indicated they were male. The DOR stated the therapy notes would indicate who was assigned to Resident 1 on a specific day. During an interview on 3/11/2026 at 12:30 PM, PTA 1 stated he worked with Resident 1 at least 1to 2 times in the gym. PTA 1 stated he did not provide therapy in Resident 1's room at all. PTA 1 stated he did not have any issues with Resident 1 and she did not complain of any discomfort. During an interview on 3/11/2026 at 12:40 PM, PTA 2 stated he had worked with Resident 1, 3 to 4 times inside her room. PTA 2 stated the last time he worked with Resident 1 was in February 2026. PTA 2 stated he would do several exercises like side legs, quad sets, and ankle pumps which were done mostly in bed. PTA 2 stated Resident 1 wanted a more extensive and harder exercise. PTA 2 stated Resident 1 told him, I like male therapist because they do more. PTA 2 stated during two of their therapy sessions, Resident 1's family was in the room. PTA 2 stated he did not inappropriately touch Resident 1 or make sounds, during any of the sessions. PTA 2 stated there was very minimal talking with Resident 1 and there were no times when Resident 1 told him to stop. During an interview on 3/11/2026 at 1:43 PM, PT 1 stated he did not remember working with Resident 1 at all. PT 1 stated he might have worked with the resident but could not recall. During another interview on 3/11/2026 at 1:46 PM, the DOR stated that when the rehabilitation department receives a request for a male or female therapist, the department follows the request. The DOR stated if the request was regarding a specific therapist he would find out who, if they (resident) say they do not want a male therapist, I don't find out why. The DOR stated if he knew the situation about a specific male therapist and had more information presented to him, he would do something about it. The DOR stated he just thought (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 feeling uncomfortable with male therapist was a preference, not a problem. The DOR stated had he known more details he would have investigated the incident. The DOR stated he probably would have asked further what the problem was. The DOR stated he did not interview Resident 1 to ask about the request because he perceived it as a resident's preference. The DOR stated, no one was suspended (in the Rehabilitation Department) because it was a preference. During an interview in Resident 1's room on 3/11/2026 at 1:54 PM, Resident 1 stated she was wearing a gown and diapers during the incident with the unidentified male therapist that happened about two weeks ago. Resident 1 stated the privacy curtains were left open. During an interview on 3/11/2026 at 2:03 PM, the DSD stated she did not investigate or ask Resident 1 or FM 1 specific details about the male therapist because Resident 1 and FM 1 were talking about other things on the day (which she could not recall) Resident 1 and FM 1 informed her about the male therapist. The DSD stated Resident 1 told her the male therapist made me feel uncomfortable because of the way he was moving. The DSD stated she did not think the information brought up by Resident 1 to her attention as an allegation of abuse but thought of the conversation more of a preference for the gender of the therapists. During an interview on 3/11/2026 at 2:12 PM, the SSD stated last week (could not recall date) she asked Resident 1 why she felt uncomfortable with the male therapist. The SSD stated Resident 1 said I did not like that he did not do anything to me, therapy wise. The SSD stated Resident 1 could not tell her what happened, just that normally the therapist would count and at that moment he did not count. The SSD stated Resident 1 did not mention what part of her body was moving. The SSD stated if it was an allegation of abuse she would go to the abuse coordinator, make a report and do a more thorough investigation. The SSD stated it was not reported as abuse, Resident 1 just said she was uncomfortable. SSD stated she did not document anything regarding Resident 1' reported incident with an unidentified male therapist. SSD stated she did not investigate Resident 1's report. During an interview on 3/11/2026 at 2:32 PM, the Administrator (ADM) stated the incident was not reported because the details given from the DSD and SSD were just that Resident 1 was uncomfortable and preferred a certain therapist.The ADM stated that Resident 1 expressing being uncomfortable around male staff did not, on its own, constitute an allegation. The ADM explained that no formal allegation was received because no specific details were provided by facility staff beyond the resident's verbalization of being uncomfortable. The ADM stated had they known more details, they would have reported and completed an investigation. During a telephone interview on 3/23/2026 at 4:24 PM, Resident 1's Family Member (FM 1) stated she could not recall when the incident with the unidentified male therapist occurred. FM 1 reported that when Resident 1 told her about the male therapist, it had already been about five days since the incident. FM 1 stated she was not present during the incident or the physical therapy session. She also stated she did not record the date or time when Resident 1 informed her of the incident. FM 1 reported that after Resident 1 told her about the male therapist, she immediately notified the SSD and informed the SSD of what Resident 1 had shared. FM 1 stated she told the SSD that a male physical therapist had been at Resident 1's bedside, grabbed Resident 1 by the ankle/heel, and began pushing her legs up and down, performing that movement repeatedly. FM 1 stated Resident 1 told her the male therapist was making a weird movement in a circular way and was not counting during the exercise. FM 1 stated Resident 1 told her she felt very nervous and scared and did not want to see or be near him. FM 1 clarified that Resident 1 was not refusing therapy; she only did not want to work with that specific male therapist. During a review of the facility's policy and procedure (P&P) titled Abuse: Prevention and Prohibition Against Suspicion of Crime, dated 6/2018, the P&P indicated all personnel, residents, visitors, etc. are encouraged to report incidents and grievances without the fear of retribution. The P&P indicated the facility will assist staff in identifying abuse, neglect, and exploitation of residents, and misappropriation of resident property which includes identifying the different types of abuse-mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. The P&P indicated some cases of abuse are not directly observed, understanding (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident outcomes of abuse can assist in identifying whether abuse isoccurring or has occurred. The P&P indicated possible indicators of abuse include: sudden or unexplained changes in behaviors or activities (fear of a person or place, feelings of guilt or shame, etc.). The P&P indicated after receiving the allegation, and during and after the investigation, the Administrator will ensure that all residents are protected from physical and psychosocial harm. The P&P indicated all allegation of abuse will be promptly and thoroughly investigated by the Administrator or his/her designee. The P&P indicated all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator. The P&P indicated allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per facility policy and applicable regulations.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to immediately report an allegation of potential abuse for 1 of 1 residents reviewed (Resident 1), when multiple facility staff-including the SSD, DSD, and DOR-failed to report Resident 1's allegation of potential abuse to the State Agency and other required agencies, resulting in a delay in required reporting and placing Resident 1 and other residents at potential risk. This failure resulted in a delay in reporting a potential allegation of abuse and had the potential to place Resident 1 and other residents at risk. Cross referenced to F607Findings: During a review of Resident 1's admission Record (AR), the AR indicated an admission to the facility on 2/11/2026 with diagnoses that included metabolic encephalopathy, abnormalities of gait and mobility, and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 1 had severely impaired cognition. The MDS described Resident 1's ability to understand others as usually understands. During an interview in Resident 1's room on 3/11/2026 at 11:15 AM, Resident 1 stated a male staff from the rehabilitation department touched her inappropriately about two weeks ago or less from this day and was unable to recall the exact date. Resident 1 stated she informed the Social Services Director (SSD) two weeks ago, which was the last time she saw the male therapist. Resident 1 stated she had communicated this incident to three or four people that worked at the facility but could not recall who the other staff were. During an interview on 3/11/2026 at 11:36 AM, the Director of Staff Development (DSD) stated Resident 1's family member (FM 1) told her about the allegation last week when she was making resident rounds. The DSD stated she did not ask Resident 1 for additional specific details about the incident or investigate the identity of the therapist during Resident 1's report. The DSD did not report Resident 1's allegation to the State Agency. During an interview on 3/11/2026 at 11:46 AM, the SSD stated Resident 1 mentioned the incident with regards to the male therapist last week but could not recall the name of the male therapist. The SSD stated she did not clarify or ask Resident 1 about the incident. The SSD stated she did not ask Resident 1 why she felt uncomfortable and did not investigate when Resident 1 mentioned the incident with the unidentified male therapist. The SSD did not report Resident 1's allegation to the State Agency. During an interview on 3/11/2026 at 12:05 PM, the Director of Rehabilitation (DOR) stated he had been informed that Resident 1 felt uncomfortable but did not know which male therapist was involved. The DOR stated the assignment was just changed and confirmed he did not conduct an investigation to identify the therapist. The DOR did not report Resident 1's allegation to the State Agency. During an interview on 3/11/2026 at 2:03 PM, the DSD stated she did not investigate or ask Resident 1 or FM 1 specific details about the male therapist. The DSD stated she did not think the information brought up by Resident 1 to her attention was an allegation of abuse. The DSD did not report the allegation to State Agency. During an interview on 3/11/2026 at 2:12 PM, the SSD stated Resident 1 could not tell her what happened, and that if it was an allegation of abuse she would have gone to the abuse coordinator, made a report, and done a more thorough investigation. The SSD stated it was not reported as abuse and she did not document anything or investigate Resident 1's report. During an interview on 3/11/2026 at 2:32 PM, the Administrator (ADM) stated the incident was not reported because the details given from the DSD and SSD were just that Resident 1 was uncomfortable and preferred a certain therapist. The ADM stated no formal allegation was received and confirmed the facility did not report the incident. During a telephone interview on 3/23/2026 at 4:24 PM, Resident 1's Family Member (FM 1) stated she could not recall when the incident with the unidentified male therapist occurred. FM 1 stated that when Resident 1 told her about the male therapist, it had been about five days after the actual incident. FM 1 stated she was not present during the incident or the physical therapy session and did not mark the day or time Resident 1 told her about the incident. FM 1 reported that after Resident 1 told her about (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the male therapist, she immediately spoke to the SSD and informed the SSD of what Resident 1 had told her. FM 1 stated she told the SSD that a male physical therapist was at Resident 1's bedside and began doing that movement (up and down). FM 1 stated Resident 1 told her the male therapist was making a weird movement in a circular way and was not counting. FM 1 stated Resident 1 told her she felt very nervous and scared and did not want to see or be near him. FM 1 stated Resident 1 was not refusing therapy; she just did not want to see this specific male therapist. A review of the facility's policy and procedure titled Abuse: Prevention and Prohibition Against Suspicion, revision dated 6/2018, indicated all personnel, residents, visitors, etc., are encouraged to report incidents and grievances without fear of retribution. The P&P indicated all allegations of abuse, neglect, misappropriation of resident property, or exploitation should be reported immediately to the Administrator and reported to the appropriate State or Federal agencies within required timeframes. The facility did not follow its policy.