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	08/07/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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

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	08/07/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of nine sampled residents (Resident 84) was assessed to determine if the resident was capable of self-administering medications, and the physician ordered to allow the resident to keep medication at the bedside before the facility allowed the resident keep medications at bedside. This deficient practice had the potential for unsafe medication administration and storage for Resident 84 and result in adverse reaction (undesired effect) or receive expired or too much medication that could lead to overdose.During a review of Resident 84's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), bronchiectasis with exacerbation (a worsening of symptoms in individuals with bronchiectasis, a chronic lung condition characterized by abnormal and irreversible widening of the airways), and osteoporosis (a condition where bones become weak and brittle, making them more likely to break). During a review of Resident 84's Initial admission Record dated [DATE] at 5:20 PM, the Initial admission record indicated the resident did not desire to self-administer drugs. The Initial admission Record indicated if the resident wanted to self-administer drugs a Self-administration of Medications Interdisciplinary Team (IDT, a group of professionals who work together to achieve a common goal, typically involving the care of an individual with complex needs) Determination Evaluation would be triggered. During a review of Resident 84's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated [DATE], 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 the resident's active diagnoses included COPD. During a review of Resident 84's Self-Administration of Medication - Xopenex (rescue inhaler that provided quick relief for breathing difficulties) Care Plan dated [DATE], the Care Plan indicated a goal for Resident 84 to safely self-administer medication. The Care Plan interventions indicated to ensure medication was safe and appropriate for self-administration, evaluate the resident's ability to ensure the medication was stored safely and securely, and determine the resident's comprehension of instructions for the medication they were taking, including the dose, timing, and signs of side effects and when to report to facility staff. During a review of Resident 84's Physician's Order dated [DATE] at 10:59 PM, the Physician's Order indicated Xopenex Hydrofluoroalkane (HFA, propellant used in pressurized metered-dose inhalers) aerosol 45 micrograms per actuation (mcg, unit of mass/act), two puff inhale orally every four hours as needed for wheezing, shortness of breath, coughing, for two weeks unsupervised, self-administration, physician gave okay to leave at bedside / family supplies. During a review of Resident 84's Medication Administration Record (MAR) dated [DATE] to [DATE], the MAR indicated Xopenex HFA aerosol 45 mcg/act was documented from [DATE] to [DATE]. The MAR documentation used the code U-SA during each of those days. The MAR chart code indicated U the code for Unknown and there was no indication of SA. During an observation and interview in Resident 84's room on [DATE] at 10:05 AM, Resident 84 was sitting on the edge of the bed and a medication - Xopenex HFA aerosol box was observed to the left side of the resident. Resident 84 stated I've been using this for 40 years; it helps me with my breathing. Resident 84 stated the facility was aware of the medication and her physician allowed her to have the medication at the bedside. During an interview on [DATE] at 10:30 AM, the Licensed Vocational Nurse (LVN) 2 stated there was no assessment done to identify if Resident 84 was capable of using the medication - Xopenex HFA aerosol and IDT did not assess the resident's ability or cognitive status to ensure Resident 84 was able to use the medication. LVN 2 stated the medication should have been renewed otherwise Resident 84 would be self-administering medications that were not ordered that could result in possible side effects of the medication could cause a change in condition in the resident. During an interview on [DATE] at 12:25 PM, the Director of Nursing (DON) stated a self-administration assessment was not done on Resident 84 but should have been done. The DON stated the medication - Xopenex HFA aerosol was not an active order but should have been since the medication was still at the resident's bedside. The DON stated if there was no active order or assessment done Resident 84 could potentially self administer the medication, and the facility would have to renew the order with the physician. During a concurrent interview and record review of the MAR dated [DATE] to [DATE] on [DATE] at 12:40 PM, the DON stated there was no documentation of the medication being used but there should have been. The DON stated if there was no documentation of

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	08/07/2025

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 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. (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	08/07/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to report multiple, consecutive Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) treatments that was refused by one of seven sampled residents (Resident 43) to the physician. These failures resulted in Resident 43 not receiving services and interventions to improve ROM and address reasons for refusals, prevent contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to joint stiffness), and improve overall mobility and physical functioning. Findings: During a review of Resident 43's admission Record, the admission Record indicated the facility originally admitted Resident 43 on 2/18/2020 and re-admitted Resident 43 on 3/14/2025 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), left hand contracture (loss of motion of a joint associated with stiffness and joint deformity), and left above knee amputation (surgical removal of a limb above the level of knee). During a review of Resident 43's Order Summary Report, the Order Summary Report indicated physician's orders, dated 5/20/2025, for RNA to apply a left hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint), five times a week for six hours or as tolerated and for RNA to provide gentle passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 43's left arm, five times a week. During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 43 required set-up or clean up assistance for eating, oral hygiene, and upper body dressing and supervision/touching assistance for rolling to both sides, transfers, toileting hygiene, lower body dressing, and bathing. During an observation and interview on 8/5/2025 at 9:18 am, in Resident 43's room, Resident 43 was lying in bed. Resident 43 stated he was unable to move his left arm on his own because his arm was paralyzed (unable to move). Resident 43 had a left leg AKA (above knee amputation) and was able to raise his left thigh minimally. Resident 43 stated staff assisted with left arm and left leg exercises sometimes but stated he refused to participate most of the time because he preferred to do the exercises on his own since he only trusted particular staff members assisting with ROM exercises. During a concurrent observation and interview on 8/6/2025 at 10:39 am, Restorative Nursing Aide 2 (RNA 2) entered Resident 43's room to attempt an RNA session. Resident 43 looked at RNA 2 and yelled, no! before RNA was able to speak. RNA 2 attempted to explain the importance of exercises and Resident 43 interrupted and adamantly refused to participate. RNA 2 left Resident 43's room and stated Resident 43 had been refusing RNA consistently, multiple times a day, for many months for unknown reasons. RNA 2 stated Resident 43 refused RNA services so often that she stopped documenting Resident 43's RNA refusals in the RNA daily and weekly documentation reports. During a concurrent record review and interview on 8/7/2025 at 9:46 am, RNA 2 stated RNA attempted RNA sessions with each resident on the RNA program at least three times a day before documenting refusals in the medical record. RNA 2 stated if a resident refused to participate in RNA after the third time, the RNAs were supposed to document the resident's refusal on the RNA daily flowsheet and weekly summaries, report the refusal to the charge nurse, and report the refusals in the weekly RNA meetings. RNA 2 stated Resident 43 refused RNA services at least one to two times, every day, for months but stopped documenting any refusals because he refused RNA so frequently. RNA 2 stated she informed the charge nurse of Resident 43's multiple refusals sometimes, but did not document it. During a concurrent interview and record review on 8/7/2025 at 10:30 AM, Restorative Nursing Aide 3 (RNA 3) stated Resident 43 refused RNA at least one to two times a day, five times a week, for many months. RNA 3 stated the RNAs were expected to attempt RNA sessions at least three times a day. RNA 3 stated RNA weekly summaries were written to communicate how a resident tolerated the RNA program throughout the week. RNA 3 stated she worked with Resident 43 consistently since he was admitted to the facility and stated Resident 43 used to consistently participate RNA services up until about four months ago. RNA 3 stated Resident 43's attitude toward staff and participation level in RNA services changed ever since he had his left leg AKA surgery within the past year. RNA 3 stated she did not always inform the charge nurse of Resident 43's refusals and stopped documenting Resident 43's refusals on the daily flowsheets and weekly summaries because the refusals occurred so frequently and

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	08/07/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure and accurate Minimum Data Set (MDS, a resident assessment tool) assessment for three (3) of 3 sampled residents (Residents 43, 81, and 7) by failing to ensure: 1. The functional limitations (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in range of motion (ROM, full movement potential of a joint) was accurate assessed for Resident 43's left arm. 2. The functional limitations in ROM was accurately assessed for Resident 81's both legs. This deficient practice had the potential to result in delayed or missed identification of joint ROM changes, inaccurate care planning, and inadequate provision of services and treatments for Residents 43 and 81. 3. Resident 7's diagnosis of dementia (a progressive brain disorder that affects memory and thought process) and use on antipsychotic medication (medication that affects mood and behavior) was reflected on the MDS. This deficient practice had the potential for Residents 43, 81, and 7 not to receive the necessary care to address resident's needs and the individualized plan of care. Findings: 1.During a review of Resident 43’s admission Record, the admission Record indicated the facility originally admitted Resident 43 on 2/18/2020 and re-admitted Resident 43 on 3/14/2025 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), left hand contracture (loss of motion of a joint associated with stiffness and joint deformity), and amputation (surgical removal of a limb) of the left leg above the level of the knee. During a review of Resident 43’s MDS, dated [DATE], the MDS indicated Resident 43 had moderate impairment with cognitive (ability to think, understand, learn, and remember) skills for daily decision making. The MDS indicated Resident 43 required set-up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, oral hygiene, and upper body dressing and supervision/touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for rolling to both sides, transfers, toileting hygiene, lower body dressing, and bathing. Resident 43’s MDS for functional limitations in ROM was coded “zero” which indicated Resident 43 had no ROM limitations in both arms. During a review of Resident 43’s Quarterly Joint Mobility Evaluation (JME, a brief assessment of a resident's ROM in both arms and both legs), dated 6/5/2025, the JME indicated Resident 43 had minimal (75% to 100% of ROM intact) ROM limitations of the left elbow, maximal (25% to 50% of ROM intact) ROM limitations of the left fingers, and moderate (50% to 75% of ROM intact) ROM limitations of left shoulder. (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	08/07/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 8/5/2025 at 9:18 am, in Resident 43’s room, Resident 43 was lying in bed wearing a splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) to the left hand. Resident 43 stated he wore the splint to the left hand for many hours a day to absorb sweat and to keep the hand open since his left hand automatically closed into a fist if the splint was not worn. Resident 43 stated he was unable to move his left arm on his own because his arm was paralyzed. During a concurrent interview and record review on 8/6/2025 at 4:33 pm, MDS Nurse 1 (MDSN 1) stated the MDS was an assessment tool completed upon admission, quarterly, and upon a significant change of condition to identify the needs of the residents in the facility. MDSN 1 stated the facility monitored for changes in joint ROM by the MDS, JMEs performed by the Rehabilitation Department (Rehab), and weekly RNA meetings. MDSN 1 stated the MDS would indicate if a resident had functional ROM limitations in both arms. MDSN 1 stated she observed a resident actively move his or her arms and legs to perform ADLs, physically moved a resident’s arms and legs through ROM, and gathered information from Rehab which included reviewing the results of the resident’s JME when coding the functional abilities in the MDS. MDSN 1 reviewed Resident 43’s MDS assessment, dated 6/3/2025, and confirmed the MDS functional abilities assessment was coded a “zero” which meant Resident 43 had no ROM limitations in both arms. MDSN 1 reviewed Resident 43’s JME, dated 6/5/2025, and confirmed the JME indicated Resident 43 had minimal ROM limitations of the left elbow, maximal ROM limitations of the left fingers, and moderate ROM limitations of left shoulder. MDSN 1 stated the MDS functional abilities assessment, dated 6/3/2025, was coded incorrectly and should have been coded a “one” since Resident 43 had ROM limitations in the left arm because he was paralyzed and was unable to use the left arm functionally. MDSN 1 stated it was important the MDS was coded accurately to ensure the facility provided the residents with the appropriate care and services. 2. During a review of Resident 81’s admission Record, the admission Record indicated the facility admitted Resident 81 on 12/9/2014 with diagnoses including right-sided hemiplegia and hemiparesis following an unspecified cerebrovascular disease (group of conditions that impact the brain’s blood vessels and blood flow) and apraxia (disorder of the brain and nervous system in which a person is unable to carry out purposeful movements and gestures). During a review of Resident 81’s Quarterly JME, dated 6/5/2025, the JME indicated Resident 81 had moderate ROM limitations in the right hip, right knee, and right ankle and minimal ROM limitations in the left knee. During a review of Resident 81’s MDS, dated [DATE], the MDS indicated Resident 81 had severe impairment with cognitive skills for daily decision making. The MDS indicated Resident 81 required set-up or clean up assistance for eating, supervision/touching assistance for oral hygiene, partial/moderate assistance for upper body dressing and personal hygiene, and substantial/maximal assistance for toilet hygiene, bathing, lower body dressing, and rolling to both sides. Resident 81’s MDS for functional limitations in ROM was coded “zero” which indicated Resident 81 had no ROM limitations in both legs. (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	08/07/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/5/2025 at 10:10 am, in Resident 81’s room, Resident 81 was lying in bed with blankets covering both legs. MDS Nurse 2 (MDSN 2) entered the room and removed the blankets from Resident 81’s legs. Resident 81’s both legs were bent slightly at the knees and the toes of the left foot were bent with the big toe bent inwards to the left, overlapping the second toe. MDSN 2 stated Resident 81 was cognitively impaired and was unable to actively move both legs on her own. During a concurrent interview and record review on 8/6/2025 at 4:33 pm, MDSN 1 stated the MDS was an assessment tool completed upon admission, quarterly, and upon a significant change of condition to identify the needs of the residents in the facility. MDSN 1 stated the facility monitored for changes in joint ROM by the MDS, JMEs performed by Rehab, and weekly RNA meetings. MDSN 1 stated the MDS would indicate if a resident had functional ROM limitations in both arms. MDSN 1 stated she observed a resident actively move his or her arms and legs to perform ADLs, physically moved a resident’s arms and legs through ROM, and gathered information from Rehab which included reviewing the results of the resident’s JME when coding the functional abilities in the MDS. MDSN 1 reviewed Resident 81’s MDS assessment, dated 7/8/2025, and confirmed the functional abilities on the MDS assessment was coded a “zero” which meant Resident 81 had no ROM limitations in both legs. MDSN 1 reviewed Resident 81’s JME, dated 6/5/2025, and confirmed the JME indicated Resident 81 had moderate ROM limitations in the right hip, right knee, and right ankle and minimal ROM limitations in the left knee. MDSN 1 stated the function abilities of the MDS assessment, dated 7/8/2025, was coded incorrectly and should have been coded a “two” since Resident 81 had ROM limitations in both legs since she was unable to actively move both legs functionally. MDSN 1 stated it was important the MDS was coded accurately to ensure the facility provided the residents with the appropriate care and services. During an interview on 8/7/2025 at 2:28 pm, the Director of Nursing (DON) stated it was important the MDS was coded accurately to ensure the facility was able to assess if the care provided was appropriate for the residents’ needs. The DON stated incorrect coding of the MDS could potentially result in an inaccurate assessment of the resident which could negatively impact the care and services he or she received. During a review of the facility’s Policy and Procedures (P/P) titled, “Resident Assessment and Associated Processes,” revised April 2025, the P/P indicated comprehensive, accurate, standardized reproducible assessments of each resident would be conducted initially and periodically as part of an ongoing process through which each resident’s preferences and goals of care, functional and health status, and strengths and needs would be identified. The P/P indicated each person who completed a portion of the resident assessment would sign and certify the accuracy of that portion of the assessment. 3. During a review of Resident 7’s admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included dementia, major depressive disorder (a mood disorder that caused persistent feeling of sadness and loss of interest), and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 7’s MDS, dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated Resident 7 did not have a diagnoses of dementia and was not receiving an antipsychotic medication. (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	08/07/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7’s History and Physical (H&P), dated 6/5/2025, the H&P indicated the resident did not have capacity to understand and make decisions. During a review of Resident 7’s Physician’s Order dated 7/20/2025 at 12:19 PM, the Physician’s Order indicated Seroquel (a group of medications called atypical antipsychotics used to treat serious mental health conditions) oral tablet, give 75 milligram (mg, unit of measurement) by mouth one time a day for psychosis (mental health condition characterized by a loss of touch with reality) manifested by distrust in others causing angry outbursts. During a review of Resident 7’s Medication Administration Record (MAR) dated 7/1/2025 to 7/31/2025, the MAR indicated the resident received Seroquel oral tablet 75 mg from 7/21/2025 to 7/31/2025. During a review of Resident 7’s MAR dated 8/1/2025 to 8/31/2025, the MAR indicated the resident received Seroquel oral tablet 75 mg from 8/1/2025 to 8/6/2025. During a concurrent interview and record review of Resident 7’s MDS dated [DATE] on 8/7/2025 at 3:37 PM, the MDS Nurse (MDSN) stated the MDS did not have the resident’s dementia diagnoses listed but should have been. The MDSN stated if the resident’s dementia diagnoses do not include in the MDS, the facility would not be able to take care of the resident and create a plan of care that was specifically appropriate for Resident 7 and that could affect the resident’s quality of life. During a concurrent interview and record review of Resident 7’s MDS dated [DATE] on 8/7/2025 at 3:41 PM, the MDSN stated the MDS did not indicate the resident was on an antipsychotic medication and Resident 7’s Seroquel was not coded under the antipsychotic portion. The MDSN stated if the Seroquel was not coded then the MDS was not accurate, and the facility was not providing the appropriate care and Resident 7’s quality of life could be affected or be at risk. During a concurrent interview and record review of Resident 7’s MDS date 6/9/2025 on 8/7/2025 at 12:04 PM, the Director of Nursing (DON) stated the resident had a diagnosis of dementia, that did not reflect in the MDS but should have been. The DON the MDS assessment did not capture the resident’s condition during the assessment. During a concurrent interview and record review of Resident 7’s MDS date 6/9/2025 on 8/7/2025 at 12:08 PM, the DON stated the resident’s antipsychotic medication use should have been documented in the MDS otherwise the facility was not capturing the antipsychotic use correctly and the MDS would not be accurate. (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	08/07/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy and procedure (P&P) titled, “Resident Assessment and Associated Processes, dated April 2025, the P&P indicated, “It is the policy of this facility that resident will be assessed and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident’s preferences and goals of care, functional and health status, and strengths and needs will be identified.” The P&P indicated, “An accurate Comprehensive Assessment will be made of the resident’s needs, strengths, goals, life history and preferences, using the RAI (Resident Assessment Instrument) and will include at least the following: cognitive patterns, psychological well-being, disease diagnoses and health conditions, and medications.” The P&P indicated, “The assessment process will include direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. Assessment information will be used to develop, review, and revise the resident’s comprehensive care plan. When applicable, recommendations from the pre-admission screening and resident review (PASARR) evaluation report will be incorporated into the resident’s assessment, care planning, and transitions of care.”

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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) for four of nine residents (Resident 43, 63, 7, and 142) by failing to: 1.Develop Resident 63's care plan related to behavior related to dementia (a progressive brain disorder that results in memory loss, change in personality and thought process that affects the activities of daily living) was developed to address how to supervise and monitor the resident. 2. Develop Resident 7's care plan that addressed how the resident will be monitored while receiving Escitalopram Oxalate (a medication primarily used to treat depression). These deficient practices had the potential for Resident 63 and Resident 7 not to receive necessary care and intervention to manage their behaviors and psychosocial needs related to their disease process and medication therapy. 3. Develop a plan of care for Resident 142 who had recent history of UTI (infection of the bladder, urethra, ureter and kidney) to address intervention and how the resident will be assessed and monitor signs and symptoms (S/S) to prevent recurrence of UTI This deficient practice could result in the Resident 142 not to receive care necessary to prevent recurrent UTI. 4. Develop and implement a comprehensive care plan and conduct interdisciplinary team (IDT, team of health care professionals that work together with the resident and or resident's representative to prioritize the resident 's needs and goals) care conferences to address multiple, consecutive RNA (Restorative Nurse Assistant-facility staff that assist residents with exercises and mobility) refusals for Resident 43 who was identified as having range of motion (ROM, full movement potential of a joint) and mobility concerns. This deficient practice had the potential to negatively affect the delivery of necessary care and services for Resident 43 that could lead to contracture (loss of motion of a joint associated with stiffness and joint deformity) development and a decline in overall physical functioning and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings: 1. During a review of Resident 63’s admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included dementia, schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior, and major depressive disorder (a mood disorder that caused persistent feeling of sadness and loss of interest). During a review of Resident 63’s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/24/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person’s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 63’s Active Diagnoses included dementia, depression, and schizoaffective disorders. The MDS indicated Resident 63 was receiving antipsychotic and antidepressant medications. During a review of Resident 63’s Comprehensive Care Plan, the Care Plan did not include a focused care plan with specific behaviors to monitor or supervise related to Resident 63’s triggered behavior associated with Dementia. (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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 63’s Comprehensive Care Plan on 8/6/2025 at 2:20 PM, the Licensed Vocational Nurse (LVN) 2 stated Resident 63 did not have a care plan for Dementia but should have had one. LVN 2 stated Resident 63’s behaviors related to dementia should have been included as part of the care plan’s interventions and should have been resident specific. LVN 2 stated if the care plan was not resident specific the facility could miss cues or opportunities to help the resident to be less agitated which could lead to her becoming more agitated and affect her sleeping pattern or schedule and develop changes. During a concurrent interview and record review of Resident 63’s Comprehensive Care Plan on 8/6/2025 at 2:46 PM, Minimum Data Set Nurse (MDSN) 2 stated the resident did not have an active dementia care plan but should have had one because the resident’s active diagnoses included dementia. MDSN 2 stated if Resident 63 did not have an active dementia care plan there was a possibility that the facility would not provide proper care because the care plan reflected how the facility takes care of residents. During a concurrent interview and record review of Resident 63’s Comprehensive Care Plan on 8/7/2025 at 11:45 AM, the Director of Nursing (DON) stated the resident should have had an actual dementia care plan. The DON stated the facility did not combine care plan’s usually and the facility would have to find the information “somewhere else” but having all the information regarding the resident’s dementia in one place “would be ideal to have it all together.” 2. During a review of Resident 7’s AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included dementia, major depressive disorder, and type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 7’s MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. The MDS indicated the resident was receiving an antidepressant medication. During a review of Resident 7’s History and Physical (H&P) dated 6/5/2025, the H&P indicated the resident did not have capacity to understand and make decisions. During a review of Resident 7’s Physician’s Order dated 7/9/2025 at 7:50 AM, the Physician’s Order indicated escitalopram oxalate tablet 20 milligram (mg, unit of measurement), give one tablet by mouth one time a day for depression manifested by verbalized feelings of sadness related to major depressive disorder. During a review of Resident 7’s Comprehensive Care Plan, the Care Plan did not include a focused care plan to address on how the resident will be monitored and supervised while receiving Escitalopram Oxalate tablet. During a review of Resident 7’s Medication Administration Record (MAR) dated 7/1/2025 to 7/31/2025, the MAR indicated the resident received Escitalopram Oxalate tablet 20 mg from 7/9/2025 to 7/31/2025. During a review of Resident 7’s MAR dated 8/1/2025 to 8/31/2025, the MAR indicated the resident received Escitalopram Oxalate tablet 20 mg from 8/1/2025 to 8/6/2025. (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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review of Resident 7’s Comprehensive Care Plan on 8/7/2025 at 10:17 AM, Licensed Vocational Nurse (LVN) 2 stated Resident 7 did not have a care plan for Escitalopram Oxalate but should have had one. LVN 2 stated the facility would not be able to monitor any side effects from the medication which could affect Resident 7’s behavior like number of episodes of being sad or agitated. During a concurrent interview and record review of Resident 7’s Comprehensive Care Plan on 8/7/2025 at 12:15 PM, the Director of Nursing (DON) stated the care plan was used to direct the facility on the care of the resident and Resident 7 did not have Escitalopram Oxalate as a “problem” and only included interventions but should have had a care plan for the medication. During a review of the facility’s policy and procedure (P&P) titled, “Comprehensive Person-Centered Care Planning” dated April 2025, the P&P indicated “It is the policy of this facility that the interdisciplinary team (IDT, a group of professionals who work together to achieve a common goal, typically involving the care of an individual with complex needs) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated a definition of “Interventions – are actions, treatments, procedures, or activities designed to meet an objective,” and “Person-centered care – means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.” The P&P indicated “The resident’s comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments.” 3. During a review of Resident 142’s admission Record (AR), the AR indicated that the facility originally admitted Resident 142 on 6/17/2025 and readmitted her on 7/8/2025 with diagnoses including atherosclerosis (hardening of arteries) of coronary artery bypass graft(s) (known as bypass surgery-- a medical procedure to improve blood flow to the heart), UTI, and sepsis (a life-threatening blood infection). During a review of Resident 142’s Minimum Data Set (MDS – a resident assessment tool) dated 7/13/2025, the MDS indicated that Resident 142 was moderately cognitively impaired (decisions poor; cues/supervision required). The MDS indicated that Resident 142 was incontinent in bladder. also indicated that Resident 142 was dependent (helper does all the effort) on toilet hygiene, shower/bathe self, and lower body dressing. During a review of Resident 142’s Urinalysis (UA- a set of tests that looks at the appearance of urine) Final Report date ordered on 6/27/2025, and (result) approved on 7/2/2025, the UA report indicated multiple substances were detected: leukocytes esterase (an enzyme present in white blood cells), protein, glucose, ketones (acids that a human body releases when it burns fat), blood, bilirubin (substance produced by the breakdown of red blood cells), WBC (white blood cells), RBC (red blood cells), bacteria, yeast (fungus). During a review of Resident 142’s Nursing Progress Notes (NPN) dated 7/8/2025, the NPN indicated that Resident 142 was readmitted with diagnoses including UTI and sepsis. (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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 142’s Care Plan, there was no comprehensive care plan developed that indicated to monitor signs and symptoms (S/S) and prevention of UTI. During a concurrent interview and record review on 8/7/2025 at 11 AM with licensed vocational nurse (LVN) 3, LVN 3 stated Resident 142 did not have a care plan developed for UTI. LVN 3 stated Resident 142 developed symptoms of UTI but was treated at the hospital. LVN 3 stated that there should have been care plan to monitor for Resident 142 for S/S of UTI, and there should have been interventions for prevention from recurring. During an interview on 8/7/2025 at 2:29 PM with the Director of Nursing (DON), DON stated Resident 142 developed S/S of UTI and was transferred to the General Acute Care Hospital (GACH) 1 for evaluation and treatment. DON stated that the licensed nursing staffs were responsible for developing a comprehensive care plan upon Resident 142’s readmission to the facility on 7/8/2025, and all nursing staffs were responsible for monitoring and implementing interventions. DON also stated that by not having a comprehensive care plan, nursing staffs could not provide person-centered care to Resident 142 or evaluate the effectiveness of their interventions provided. During a review of the facility’s Policy and Procedures (P&P) titled “Comprehensive Person-Centered Care Planning” revised 4/2025, the P&P indicated that the interdisciplinary team (IDT-)shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. 4. During a review of Resident 43’s admission Record, the admission Record indicated the facility originally admitted Resident 43 on 2/18/2020 and re-admitted Resident 43 on 3/14/2025 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), left hand contracture (loss of motion of a joint associated with stiffness and joint deformity), and left above knee amputation (surgical removal of a limb above the level of knee). During a review of Resident 43’s Order Summary Report, the Order Summary Report indicated physician’s orders, dated 5/20/2025, for RNA to apply a left hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint), five times a week for six hours or as tolerated and for RNA to provide gentle passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 43’s left arm, five times a week. During a review of Resident 43’s MDS, dated [DATE], the MDS indicated Resident 43 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 43 required set-up or clean up assistance for eating, oral hygiene, and upper body dressing and supervision/touching assistance for rolling to both sides, transfers, toileting hygiene, lower body dressing, and bathing. (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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 43’s Quarterly Joint Mobility Evaluation (JME, a brief assessment of a resident's ROM in both arms and both legs), dated 6/5/2025, the JME indicated Resident 43 had minimal (75% to 100% of ROM intact) ROM limitations of the left elbow and left hip, maximal (25% to 50% of ROM intact) ROM limitations of the left fingers, and moderate (50% to 75% of ROM intact) ROM limitations of left shoulder. During an observation and interview on 8/5/2025 at 9:18 am, in Resident 43’s room, Resident 43 was observed lying in bed. Resident 43 stated he was unable to move his left arm on his own because his arm was paralyzed (unable to move). Resident 43 had a left leg AKA (above knee amputation) and was able to raise his left thigh minimally. Resident 43 stated staff assisted with left arm and left leg exercises sometimes but stated he refused to participate most of the time because he preferred to do the exercises on his own since he only trusted particular staff members assisting with ROM exercises. During a concurrent observation and interview on 8/6/2025 at 10:39 am, Restorative Nursing Aide 2 (RNA 2) entered Resident 43’s room to attempt an RNA session. Resident 43 looked at RNA 2 and yelled, “no!” before RNA was able to speak. RNA 2 attempted to explain the importance of exercises and Resident 43 interrupted and adamantly refused to participate. RNA 2 left Resident 43’s room and stated Resident 43 had been refusing RNA consistently, multiple times a day, for many months for unknown reasons. RNA 2 stated Resident 43 refused RNA services so often that she stopped documenting Resident 43’s RNA refusals in the RNA daily and weekly documentation reports. During an interview on 8/7/2025 at 10:30 AM, Restorative Nursing Aide 3 (RNA 3) stated Resident 43 refused RNA at least one to two times a day, five times a week for many months. RNA 3 stated the RNAs were expected to attempt RNA sessions at least three times a day. RNA 3 stated she worked with Resident 43 consistently since he was admitted to the facility and stated Resident 43 used to consistently participate RNA services up until about four months ago. RNA 3 stated Resident 43’s refusals were a known issue amongst staff, including the Director of Staff Development (DSD) who supervised the RNAs, since Resident 43’s RNA refusals had been an ongoing issue for many months. RNA 3 stated Resident 43’s attitude toward staff and participation level in RNA services changed ever since he had his left leg AKA surgery. During an interview on 8/7/2025 at 11:00 am, the DSD stated she supervised the RNAs. The DSD stated the RNAs attempted RNA sessions for each resident on the RNA program at least three times a day. The DSD stated if a resident continued to refuse after the third attempt or if the resident demonstrated a pattern of refusals, RNA should document the resident’s refusal on the daily and weekly record and report the refusal to the charge nurse and in the weekly RNA meetings. The DSD stated facility staff should investigate the reason for refusal, notify the physician, conduct an IDT meeting, and update the care plan. The DSD stated she was aware of Resident 43’s consistent refusals of RNA services for many months. The DSD confirmed the facility staff did not notify the physician, did not investigate the reason for Resident 43’s recurring refusals, and did not conduct an IDT meeting to address Resident 43’s multiple and consistent refusals. The DSD stated it was important the facility created a care plan and conducted an IDT meeting when Resident 43’s demonstrated patterns of refusals for RNA to ensure Resident 43 received the appropriate care and areas of concern were addressed. (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	08/07/2025

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/7/2025 at 11:46 am, the Minimum Data Set Nurse 1 (MDSN 1) stated a care plan was developed and used as a guideline to ensure proper care was provided for each resident. MDSN 1 stated IDT conferences were conducted upon admission, quarterly, and as needed if any area of concern requiring a formal, interdisciplinary discussion was warranted. MDSN 1 stated IDT conferences were important to ensure the root cause of the issue was investigated and appropriate interventions were implemented. MDSN 1 stated multiple and consistent RNA refusals should be reported by the RNA to the charge nurse, the physician should be notified, an IDT conference should be conducted to investigate the issue, and a care plan should be developed or updated to address the RNA refusals. MDSN 1 stated she was aware of Resident 43’s multiple RNA refusals. MDSN 1 reviewed Resident 43’s clinical record and confirmed the facility did not investigate the reason for Resident 43’s RNAs refusals, did not create a care plan, and did not conduct an IDT meeting to address Resident 43’s multiple and consistent refusals. MDSN 1 stated it was important for the facility to create a care plan and conduct an IDT meeting when Resident 43 demonstrated patterns of RNA refusals to ensure Resident 43 received the appropriate care and services and the reason for refusal was properly investigated. During a concurrent interview and record review on 8/7/2025 at 12:25 pm, the Social Services Director (SSD) stated an IDT conference should be conducted if a resident consistently refused to participate in RNA services. The SSD stated an IDT conference to address continuous RNA refusals was important to ensure the facility worked as a team to discuss, develop, and implement a plan of care to ensure the appropriate care and services were provided and the root cause of the refusals was investigated. The SSD reviewed Resident 43’s clinical record and confirmed no IDT conferences were conducted to address Resident 43’s continuous RNA refusals and should have been done as soon as Resident 43’s began to consistently refuse RNA services. During an interview on 8/7/2025 at 2:28 pm, the Director of Nursing (DON) stated comprehensive care plans were used as a guide to ensure the appropriate care and services were provided for each resident. The DON stated care plans should be developed, and an IDT conference should be conducted if a resident refused RNA consistently to ensure the reason for refusal was investigated, areas of concern were identified, goals were created, and interventions were established to address the resident’s needs. The DON stated if a care plan was not developed and an IDT conference was not done for residents who consistently refused to participate in an RNA program, staff may not investigate the reason for refusal and the resident may not receive the appropriate care and services. During a review of the facility’s Policy and Procedure (P&P) titled, “Comprehensive Person-Centered Care Planning,” revised 4/2025, the P&P indicated the IDT shall develop a comprehensive, person-centered care plan that included measurable objectives and timeframes to meet a resident’s medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The P/P indicated in the event a resident refused treatment, the comprehensive care plan would identify care or service declined, the associated risks, IDT’s effort to educate the resident and resident representative and any alternative means to address the risk.

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	08/07/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a communication tool or device that translate to a language the resident could understand for one of three residents (Resident 94) who does not speak the formal language in the facility. This deficient practice prevented Resident 94 from communicating the necessary needs with facility staff that could delay in the resident receiving appropriate care/treatment. A review of Resident 94's admission Record [AR] indicated Resident 94 was admitted to the facility on [DATE], with diagnoses that included prostate cancer (uncontrolled growth and spread of abnormal cells that can invade and damage healthy tissues) and anemia (lower-than-normal number of red blood cells). The AR indicated that Resident 94 primary language was Spanish. A review of Resident 94's History and Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the Patient's health status) signed by the attending physician on 7/3/2025, the HPE indicated Resident 94 does not have the capacity to understand and make decisions. A review of Resident 94's Minimum Data Set (MDS, a resident assessment tool) dated 7/6/2025, the MDS indicated that Resident 94 had a moderately impaired cognition (thought process). During an observation on 8/4/2025 at 9:42AM, Resident 94's room did not have any communication tool or device, or translation material posted around his living area. During a concurrent resident room observation and interview on 8/7/2025 at 9:00AM, Certified Nursing Assistant (CNA 2) stated that she did not see any translation or communication tool or device and material in Resident 94 living area. CNA 1 stated that Resident 94 does not speak English. CNA 2 stated it was important to have translation material at bedside for residents that did not speak English so the resident will be able to communicate their needs for any type of assistance and while providing ADL care. During an interview on 8/7/2025 at 9:18AM, Director of Nursing (DON) stated that every resident room should have a communication board posted to assist in resident's expressing their needs. The DON stated by Resident 94 not having the communication board, it could negatively impact on the delivery of care such as the resident requesting assistance to the bathroom. A review of the facility's policy and procedure (P&P) titled Communication Tool, revised 10/2019 indicated the facility will supply residents and/or family members with the use of a communication board that has universally known drawings. The P&P indicated the communication tool will be kept at the resident's bedside for use.

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	08/07/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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	08/07/2025

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 - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 81) who was assessed as being at risk for pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) was provided a pressure relieving barrier to be placed between Resident 81's overlapping, contracted (loss of motion of a joint associated with stiffness and joint deformity) toes of the left foot as indicated on the facility policy. This deficient practice had the potential to result in Resident 81 developing pressure ulcers on the left foot. Findings: During a review of Resident 81's admission Record, the admission Record indicated the facility admitted Resident 81 on 12/9/2014 with diagnoses including right-sided hemiplegia and hemiparesis following an unspecified cerebrovascular disease (group of conditions that impact the brain's blood vessels and blood flow) and apraxia (disorder of the brain and nervous system in which a person is unable to carry out purposeful movements and gestures). During a review of Resident 81's Minimum Data Set (MDS, resident assessment tool), dated 7/8/2025, the MDS indicated Resident 81 had severe impairment with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 81 required set-up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating, supervision/touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) for oral hygiene, partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for upper body dressing and personal hygiene, and substantial/maximal assistance (Helper does more than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides more than half the effort) for toilet hygiene, bathing, lower body dressing, and rolling to both sides. The MDS indicated Resident 81 was at risk for pressure ulcer development. During a review of Resident 81's Braden Scale (pressure ulcer risk assessment tool), dated 7/18/2025, the Braden Scale indicated Resident 81 was at moderate risk for pressure ulcer development due to slightly limited sensory perception (unable to communicate discomfort, needs to be turned, or had limited ability to feel paid or discomfort in one or two arms or legs), very moist skin, and very limited mobility (ability to move). During a review of Resident 81's care plan, the care plan indicated Resident 81 had potential for pressure ulcer development. The care plan indicated a goal for Resident 81 to have intact skin, free of redness, blisters or discoloration with an intervention which included to follow facility policy and protocols for the prevention and treatment of skin breakdown (tissue damage caused by friction, shear, moisture, or pressure). During a concurrent observation and interview on 8/5/2025 at 10:10 am, in Resident 81's room, Resident 81 was lying in bed with blankets covering both legs. MDS Nurse 2 (MDSN 2) entered the room and removed the blankets from Resident 81's legs. Resident 81's both legs were bent slightly at the knees and the toes of the left foot were bent with the big toe bent inwards to the left, overlapping the second toe. MDSN 2 stated Resident 81 was cognitively impaired and was unable to actively move both legs on her own. During a concurrent observation and interview on 8/6/2025 at 9:39 am, Licensed Vocational Nurse 2 (LVN 2) confirmed Resident 81 had contractures of the left foot causing the left big toe and second toe to overlap. LVN 2 separated Resident 81's left big toe and second toe and confirmed there were areas of pressure on the skin where the toes overlapped. LVN 2 stated Resident 81 should have a barrier (something that blocks, restricts or separates) to offload the pressure between the toes of the left foot but did not. LVN 2 stated Resident 81 was at risk for developing pressure ulcers and fungus (organism that lives by feeding on living tissues) on the left foot because Resident 81's toes were overlapping with constant areas of pressure on the skin with no barrier in-between to separate the toes. During a concurrent observation and interview on 8/6/2025 at 9:48 am, LVN 9 confirmed Resident 81 had contractures of the left foot causing the left big toe and second toe to overlap. LVN 9 separated Resident 81's left big toe and second toe and confirmed there were areas of pressure on the skin where the toes overlapped. LVN 9 stated Resident 81 should have a barrier between Resident 81's left big toe and second toe to offload the pressure but did not. LVN 9 stated Resident 81 was at risk for developing skin breakdown and pressure sores because Resident 81's left toes were contracted, there were areas of constant pressure between the overlapping left big toe and second toe with no barrier, and Resident 81 required total care for mobility and was unable to move on her own. During an interview on 8/7/2025 at 2:28 pm, the Director of Nursing (DON) stated the lack of repositioning

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	08/07/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (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	08/07/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to provide care and services to one of three sampled residents (Resident 142) who was incontinent of bladder (loss of bladder control) and had recent history of urinary tract infection (UTI- an infection in the bladder/urinary tract) was not kept clean and dry. Resident 142's incontinent brief was soaked with urine when observed at 10:35 AM. Certified Nursing Assistant (CNA) 2 stated she changed Resident 142's incontinent brief around 7:45 AM and she was going to check if the resident need to be changed at 11:30 AM. This deficient practice had the potential to result Resident 142 to be at risk for recurrent UTI and skin breakdown. Findings: During a review of Resident 142's admission Record (AR), the AR indicated that the facility originally admitted Resident 142 on 6/17/2025 and readmitted her on 7/8/2025 with diagnoses including atherosclerosis (hardening of arteries) of coronary artery bypass graft(s) (known as bypass surgery-- a medical procedure to improve blood flow to the heart), UTI, and sepsis (a life-threatening blood infection). During a review of Resident 142's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/13/2025, the MDS indicated that Resident 142 had moderately impaired cognition (decisions poor; cues/supervision required). The MDS indicated that Resident 142 was always incontinent of bladder. The MDS also indicated that Resident 142 was dependent (helper does all the effort) on toilet hygiene, shower/bathe self, and lower body dressing. During a review of Resident 142's Urinalysis (UA- a set of tests that looks at the appearance of urine) Final Report dated 7/2/2025, indicated Resident 142 urine had leukocytes esterase (an enzyme present in white blood cells), protein, glucose, ketones (acids that a human body releases when it burns fat), blood, bilirubin (substance produced by the breakdown of red blood cells), WBC (white blood cells) , RBC (red blood cells) with bacteria, yeast (fungus). The result indicated presence of infection. During a review of Resident 142's Tasks Documentation Survey Report (TDSR) dated from 7/2025 to 8/2025, the TDSR indicated that Resident 142 was dependent (helper does all of the effort) on toilet hygiene. The DSR indicated that Resident 142 was assisted with toilet hygiene one or two shifts of total three shifts per day. The TDSR did not specifically indicate how many times Resident 142 was assisted per shift or per day for toilet hygiene. During a concurrent observation and an interview at 8/6/2025 at 10:35 AM with CNA 2, CNA 2 stated she changed Resident 142's diaper around 7:45 AM and she plans to change the resident's diaper again at 11:30 AM. CNA 2 stated she just asked, and Resident 142 responded to her that she was dry but did not specify what time she asked the resident. CNA 2 walked to Resident 142 and checked the diaper upon request, Resident 142's diaper was observed soaked and wet when opened. During a concurrent interview and record review on 8/7/2025 at 11 AM with licensed vocational nurse (LVN) 3, LVN 3 stated Resident 142 did not have a care plan developed for UTI. LVN 3 stated Resident 142 developed symptoms of UTI but was treated at the hospital. LVN 3 stated that there should have been care plan to monitor for Resident 142 for S/S of UTI, and there should have been interventions for prevention from recurring. During an interview on 8/6/2025 at 11:10 AM with the Licensed Vocational Nurse (LVN) 8, LVN 8 stated CNA 2 should be checking diaper every 2 hour During an interview on 8/7/2025 at 2:29 PM with the Director of Nursing (DON), DON stated Resident 142 developed S/S of UTI and was transferred to the General Acute Care Hospital (GACH) 1 for evaluation and treatment. DON stated that the licensed nursing staffs were responsible for developing a comprehensive care plan upon Resident 142's readmission to the facility on 7/8/2025 but the care plan was not developed, DON stated all nursing staffs were responsible for monitoring and implementing interventions. DON also stated that by not having a comprehensive care plan, nursing staffs could not provide person-centered care to Resident 142 or evaluate the effectiveness of their interventions provided. DON stated CNA 3 should have not assumed Resident 142's incontinent brief was dry without checking. During an interview on 8/7/2025 at 3:50 PM with the Medical Record Director (MRD), MRD stated that the facility did not have policy and procedures for incontinence care or one related to prevention measurement of UTI.

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	08/07/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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	08/07/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's policy and procedure for Nutrition Status Management to weigh one of four sampled residents (Resident 142) upon readmission for nutrition evaluation and management. Resident 142 was weighed six days after readmitted to the facility on [DATE]. The nutrition evaluation by the Registered Dietitian (RD- professionals who are experts in food and nutrition) review was not conducted and did not identify Resident 142's weight loss until six days later. This deficient practice had resulted in the delayed implementation of the intervention for Resident 142's weight maintenance and nutrition management to prevent further weight loss.Findings: During a review of Resident 142's admission Record (AR), the AR indicated that the facility originally admitted Resident 142 on 6/17/2025 and readmitted her on 7/8/2025 with diagnoses including atherosclerosis (hardening of arteries) of coronary artery bypass graft(s) (known as bypass surgery-- a medical procedure to improve blood flow to the heart), UTI, and sepsis (a life-threatening blood infection). During a review of Resident 142's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 7/13/2025, the MDS indicated that Resident 142 was moderately cognitively impaired (decisions poor; cues/supervision required). The MDS indicated that Resident 142 complained of difficulty or pain with swallowing. The MDS also indicated that Resident 142 was dependent (helper does all the effort) on toilet hygiene, shower/bathe self, and lower body dressing. During a review of Resident 142's Physician's Orders dated 7/8/2025, the Physician's Orders indicated to weigh Resident 142 weekly weight for four weeks then monthly. During a review of Resident 142's Physician's Orders dated 7/14/2025, the Physician's Orders indicated to provide Glucerna two times daily for supplement. During a review of Resident 142's Nutrition Evaluation and RDN (Registered Dietitian Nutritionist- also known as RD) Review (NERR) dated 7/14/2025, the NERR indicated the RDN reviewed most recent weight 135.2 pounds (lbs.) measured on 7/1/2025. The NERR also indicated that RDN reviewed and compared weight of Resident 142 which measured 140.6 on 6/18/2025 with weight measured 127.5 on 7/14/2025. During a review of Resident 142's Physician's Orders dated 7/29/2025, the Physician's Orders indicated CCHO (controlled carbohydrate) NAS (no added salt) diet mechanical soft (foods that are soft and easy to chew)- chopped texture, thin liquid consistency, fortified (a food that has extra nutrients added to it). During a review of Resident 142's Weights and Vitals Summary (WVS) dated from 7/1/2025 to 8/4/2025, the WVS indicated that Resident 142 weights on the following dates: 7/1/2025-135.2 lbs. 7/14/2025-127.5lbs 7/22/2025-124.5 lbs. 7/28/2025-124.5 lbs. 8/4/2025-124.2 lbs. During an observation and concurrent interview on 8/6/2025 at 12:45 PM with Resident 142 at lunch time, Resident 142 was observed putting down utensils after eating several spoons full of different items on the tray. Resident 142 stated she just did not have any appetite to eat her current meal and she felt she has lost some weight. Resident 142 stated that the doctor ordered supplemental drinks for her since last month and that's what she has been given in between three meals. During a concurrent record review and an interview on 8/6/2025 at 1:15 PM with the Licensed Vocational Nurse (LVN) 8, Resident 142's WVS and NERR were reviewed. LVN 8 stated Resident 8 was not weigh on July 8, 2025, upon readmission to the facility and she focused on the weight loss from one month apart. LVN 8 stated the nurse who admitted the resident should have weighed the resident and documented it in the EHR (electronic health record- a digital collection of a patient's medical history and health information). During a concurrent record review and an interview on 8/6/2025 at 3:50 PM with the Registered Dietitian (RD), WVS and Nutrition Evaluation and RDN Review were reviewed. RD stated she evaluated Resident 142's nutritional status and initiated oral supplement when she noticed the weight loss on 7/14/2025 compared to previous weight measured on 7/1/202. RD stated she did not know why Resident 142 was not weighed upon readmission on [DATE]. RD stated evaluation and interventions could have been done earlier if the weight loss was identified earlier. During an interview on 8/7/2025 at 2:55 PM with the Director of Nursing (DON), DON stated there was no weight measurement documented for Resident 142 when the resident was admitted on [DATE], the missing weight measurement should have been documented in the EHR. DON stated Resident 142's nutrition status negatively impacted the weight evaluation conducted by IDT that identified resident's weight loss six days later. During a review of the facility's Policy and Procedures (P&P) titled Nutrition Status Management revised in 4/2025, the P&P indicated that each resident's nutritional status is assessed on admission and at least quarterly thereafter. The P&P also indicated that each resident is to be weighed upon admission. The weight will be entered directly into the

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	08/07/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (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	08/07/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services to one of five sampled residents (Resident 157) as evidenced by: 1. Failing to administer Entresto (a medication to treat heart failure [a chronic condition in which the heart does not pump blood as well as it should]) to Resident 157 on 6/29/2025 at 9 AM, 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM. 2. Failing to document the reason why Entresto was not administered on 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM. 3. Failing to notify the physician and obtain an order when Resident 157 did not receive Entresto on 6/29/2025 at 9 AM, 6/30/2025 at 5 PM, 7/1/2025 at 5 PM, and 7/16/2025 at 5 PM due to unavailability of the medication at the scheduled time for administration. These deficient practices placed Resident 157 at risk for worsening of her heart condition and hypertension (high blood pressure). During a review of Resident 157's admission Record (AR), the AR indicated the facility originally admitted Resident 157 on 5/26/2019 and readmitted on [DATE] with diagnoses that included heart failure and hypertension (high blood pressure). During a review of Resident 157's Minimum Data Set (MDS, a resident assessment tool), dated 5/7/2025, the MDS indicated Resident 157 had intact memory and cognition (ability to think and reasonably). The MDS indicated Resident 157 required setup and clean-up assistance with eating and oral hygiene, supervision or touching assistance with personal hygiene, and partial/moderate assistance (helper does less than half the effort) with toileting hygiene and chair/bed-to-chair transfer and shower/bathe self. During a review of Resident 157's Order Summary Report, dated 8/5/2025, the report indicated the physician ordered Entresto Oral Tablet 24-26 milligram (MG, a unit of measurement) two tablets by mouth two times a day for heart failure, starting on 3/27/2025. During a review of Resident 157's Progress Notes (PN), dated 6/29/2025 at 9:39 AM, the PN indicated Entresto was not available. During an interview on 8/5/2025 at 9:10 AM with Resident 157, Resident 157 stated she did not receive her Entresto 24/26mg 2 tabs last week for several days and remembered getting it just one day. Resident 157 stated the nurses told her the medication was not available in the facility. Resident 157 stated this issue has occurred a few times and she went without the medication for 3 days but was unable to recall on what day it occurred. Resident 157 stated she needed Entresto to treat her heart and blood pressure so she was worried her heart condition would get worse without the consistent administration of Entresto. During an interview on 8/5/2025 at 9:30 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated t Resident 157 would miss the Entresto doses occasionally because the medication was not available in the facility. LVN 1 stated if Resident 157 did not receive the scheduled doses of Entresto, the resident's blood pressure would be elevated. During an interview on 8/5/2025 at 10 AM with the Director of Nursing (DON), the DON stated if Resident 157 did not receive the scheduled dose, it could affect the therapeutic level of Entresto in her body and put her at risk for elevated blood pressure. During an interview on 8/5/2025 at 12:54 PM with Registered Nurse (RN) 1, RN 1 stated she was not aware that the nurses had issue of re-ordering refills for Resident 157's Entresto and no nurses reported to her before. During a concurrent interview and record review on 8/5/2025 at 12:55 PM with RN 1, Resident 157's Medication Administration Record (MAR), dated 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM, and Resident 157's PN, dated 6/30/2025 at 6:38 PM, 7/1/2025 at 7:39 PM and 7/16/2025 6:28 PM, were reviewed. The MAR indicated Entresto were documented with 7 (nurse did not administer Entresto at that time and to see PN) on 6/29/2025 at 9 AM, 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM. The PN did not indicate documentation of the reason why the medication was not given on 6/29/2025 at 9 AM, 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM. RN 1 stated according to Resident 157's MAR the licensed nurses did not administer Entresto to Resident 157 on 6/29/2025 at 9 AM, 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM. RN 1 stated the nurse should document the reason why the medication was not administered to Resident 157 in the PN and Resident 157's PN did not indicate documentation of the reason why the medication was not given on 6/29/2025 at 9 AM, 6/30/2025 at 5 PM, 7/1/2025 at 5 PM and 7/16/2025 at 5 PM. RN 1 stated the nurse should also notify the physician about the dose of medication not given to the resident and document the physician's order and instruction to make sure the resident did not experience negative effect from the missing dose of the medication. RN 1 stated it was important to clearly document the information on the resident's medical record to ensure the consistent care was provided to the resident. During an interview on 8/6/2025 at 10:54 AM with LVN 7, LVN 7 stated he did not administer Entresto to Resident 157 on 7/16/2025 at 5 PM because Entresto was not available at the

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	08/07/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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	08/07/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe provisions of pharmaceutical services to provide safe storage of medications as indicated in the facility's policy and procedure by failing to: 1.Ensure Resident 84 assessed and have a physician's order to keep Xopenex (a rescue inhaler that provided quick relief for breathing difficulties) at the bedside. 2. Ensure Medication Cart 1 and Medication Cart 2 did not have loose pills in the drawer that licensed nurses could not identify. These deficient practices had the potential for the resident to self administer multiple dosage of medication and cause overdose and/or lead to unsafe consumptions of medication by other residents who could access the medications. Addition the deficient practice could result in medication loss and misuse. Findings: 1.During a review of Resident 84's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), bronchiectasis with exacerbation (a worsening of symptoms in individuals with bronchiectasis, a chronic lung condition characterized by abnormal and irreversible widening of the airways), and osteoporosis (a condition where bones become weak and brittle, making them more likely to break). During a review of Resident 84's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/18/2025, 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 the resident's active diagnoses included COPD. During a review of Resident 84's care plan titled Self-Administration of Medication - Xopenex Care Plan dated 5/31/2023, the Care Plan indicated a goal for the resident to safely self-administer medication. The Care Plan interventions indicated to ensure medication was safe and appropriate for self-administration, the facility will evaluate the resident's ability to ensure the medication was stored safely and securely, and determine the resident's comprehension of instructions for the medication they were taking, including the dose, timing, and signs of side effects and when to report to facility staff. During a review of Resident 84's Physician's Order dated 3/30/2025 at 10:59 PM, the Physician's Order indicated to administer Xopenex Hydrofluoroalkane (HFA, propellant used in pressurized metered-dose inhalers) aerosol 45 micrograms per actuation (mcg, unit of mass/act), two puff inhale orally every four hours as needed for wheezing, shortness of breath, coughing, for two weeks unsupervised, self-administration, physician gave okay to leave at bedside / family supplies. During an observation and interview in Resident 84's room on 8/4/2025 at 10:05 AM, Resident 84 was sitting on the edge of the bed and a medication - Xopenex HFA aerosol was observed to the left side of the resident on the bed. Resident 84 stated I've been using this for 40 years; it helps me with my breathing. Resident 84 stated the facility was aware of the medication she kept at bedside and her physician stated the resident was able to have the medication at the bedside. During an interview on 8/7/2025 at 10:49 AM, the Licensed Vocational Nurse (LVN) 2 stated because there was not an order for the medication - Xopenex HFA aerosol, the medication should not have been at the bedside. LVN 2 stated the medication should have been kept in the medication cart for safety. LVN 2 stated if the medication was left at bedside there was potential for a medication error and could be harmful for Resident 84 because of side effects. During an interview on 8/7/2025 at 12:45 PM, the Director of Nursing (DON) stated the medication - Xopenex HFA aerosol should not have been at the bedside otherwise Resident 84 could use the medication and the facility would not know how much the resident was using. The DON stated the facility must make sure there was a physician's order if the resident needed the medication. The DON stated the medication should have been stored in the medication cart. During a concurrent interview and record review of the facility's policy and procedure (P&P) titled, Self-Administration of Medications dated May 2019, the P&P indicated If a resident desired to participate in self-administration of medications, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. Residents will be instructed regarding proper administration of medication by the nurse. Nursing will be responsible for recording self-administered doses in the resident's medication administration record (MAR). The P&P indicated, Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage. LVN 2 stated the facility was not following the policy which could turn into a medication error and affect Resident 84's overall health. During a concurrent interview and record review of the facility's P&P titled, Self-Administration of Medications

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	08/07/2025

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. (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	08/07/2025

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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promptly provide dental services for one of nine sampled residents (Resident 79) by failing to follow recommendations from the dentist for an oral surgery referral for bone spurs removal (a surgical procedure to remove a bone spur - small sharp pieces of bone that could sometimes detach after a tooth extraction or other oral surgery). This deficient practice resulted in Resident 79 having pain and resorting to eating oatmeal, soups, and pureed food that can potentially result lt in weight loss. During a review of Resident 79's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), gout (a type of arthritis [a condition that caused pain, swelling, and stiffness in one or more joints] that caused sudden, severe pain, swelling, and stiffness in one or more joints), and gastro-esophageal reflux disease (a condition where stomach acid flows back into the esophagus, causing irritation and discomfort). During a review of Resident 79's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/9/2025, 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 under the oral/dental status, the facility did not check the box indicating the resident had mouth or facial pain, discomfort or difficulty with chewing. During a review of Resident 79's Social Services Progress Notes dated 5/14/2025 at 7:40 AM, the Progress Note indicated the resident was seen by the dentist. During a review of Resident 79's Dental Notes dated 5/14/2025, the Dental Notes indicated the Dentist recommended the resident have an Oral Surgery (OS) referral for bone spurs removal. The Dental Notes indicated the referral was given. During an interview on 8/4/2025 at 10:21 AM, Resident 79 stated the dentures (removable sets of artificial teeth, used to replace missing natural teeth) she received from the facility were hurting, so the resident did not use them. Resident 79 stated about two months ago the doctor recommended the resident get her gums/mouth cleaned and that might help with the dentures, but Resident 79 stated she had not heard anything from the social service designee and the nurses regarding the dentist's recommendation. Resident 79 stated that because she did not wear the dentures, the resident was only able to eat oatmeal, soups, and pureed food. During a concurrent interview and record review of Resident 79's Dental Notes dated 5/14/2025 on 8/7/2025 at 9:15 AM, the Social Service Director (SSD) stated the facility should have followed up with the dentist regarding the recommendations but there was no documented evidence provided the regarding the referral. The SSD could not find documentation indicating the resident was provided with follow up from the recommendations of the dentist from May until now. The SSD stated she was unable to state what could have happened to Resident 79 due to treatment not being provided because her opinions were not professional. During an interview on 8/7/2025 at 10:22 AM, the Licensed Vocational Nurse (LVN) 2 stated Resident 79 had complained about her teeth before, and the facility always had the in-house dentist see the resident. LVN 2 stated Resident 79 complained about her dentures poorly fitting and wanted them adjusted so the facility had the dental consultant come see the resident. During an interview on 8/7/2025 at 12:16 PM, the Director of Nursing (DON) stated the facility did not follow up with dental recommendations for Resident 79 as soon as possible but at least the staffs should have followed up within one month and the interdisciplinary team (IDT, a group of professionals who work together to achieve a common goal, typically involving the care of an individual with complex needs) should have followed up as well. The DON stated Resident 79's dentures were to help with eating and for aesthetic purposes (improve the appearance of the smile and creating natural looking teeth and gums) and although the resident could still eat, her diet would have to be modified regarding texture and the facility would have to provide pureed foods. During a review of the facility's policy and procedure (P&P) titled, Dental Services dated April 2025, the P&P indicated It is the policy of this Facility to ensure that its resident who require dental services on a routine or emergency basis have access to such services without barrier. It is likewise the policy of the Facility to repair or replace the dentures of a resident. The P&P indicated a definition of Emergency dental services - includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by the dentist. The P&P indicated, In the event that a Facility resident requires emergency dental services, for the repair or replacement of dentures or otherwise, the Facility will: assist the resident in making the necessary

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	08/07/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview and record review the facility failed to follow its policy and procedure on food storage, preparation, distribution and serving food in accordance with professional standards for food service safety by failing to ensure that the Dietary Aid (DA) 1 labeled individually packaged four (4) cups of cottage cheese, 12 cups of yogurt, and four (4) cups of puddings in the refrigerator with the date of Use By. This deficient practice had the potential to cause food unlabeled past safe storage time/ period, and place residents who consume this food at risk for foodborne illness (food poisoning or food illness due to pathogens [harmful organisms that cause illness such as bacteria, viruses, or parasites] and toxins that contaminate food). Findings: During an observation and concurrent interview on 8/5/2025 at 11:35 AM, a food tray with a total of 20 individually- wrapped food in dessert cups was observed in the refrigerator which includes four cups of cottage cheese, 12 cups of variety flavors of yogurt, and four cups of pudding. The tray and the 20 individually- wrapped food cups were not labeled with Use by date. DA 1 stated he did not see labels of Use by date on any of the 20 cups and on the tray. DA 1 stated he was the person who individually wrapped the food in dessert cups and put them in the refrigerator, but he did not prepare and labeled the 20 cups with the Use by date. DA 1 stated he should not rush his work and should have made sure all food cups were labeled correctly at the time he put them in the refrigerator for food safety. During an interview on 8/5/2025 at 11:40 AM with the Dietary Supervisor (DS), the DS stated he saw DA 1 wrapping the 20 dessert cups and he believes DA 1 knows the standards of practice to label food when refrigerating it. DS stated if those 20 dessert cups containing perishable food are improperly stored or left unlabeled with Use by date, it can place residents at risk for consuming expired food and cause foodborne illnesses. During a review of the facility's policy and procedures (P&P) titled Labeling and Dating of Foods dated 2023, the P&P indicated the following: The individual opening or preparing food shall be responsible for date marking at the time of processing and/or storage. For foods that are commercially processed, ready to eat and intended to be stored cold greater than 24 hours will be marked with a Use By date. For foods that are prepared by the facility, held greater than 24 hours cold shall be clearly marked to indicate the date by which the food shall be consumed or discarded--- Use by.

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	08/07/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain complete and accurate documentation in the medical records for two of nine sampled residents (Residents 63 and 43) by failing to ensure: 1. Resident 63's use of antipsychotic medication (primarily used to treat psychosis [mental state where a a resident has difficulty distinguishing between what is real and what is not]) and antidepressant medications (a medication used to treat depression) on the resident's Nursing Summary Weekly. This deficient practice had the potential to result in Resident 63's lack of or delay in treatment and interrupt the provision of care/intervention to the resident's psychosocial need. 2. Restorative Nursing Assistant (RNA- nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) treatment that were refused by Resident 43 were accurately documented in the resident's medical records. This deficient practice had the potential to negatively impact the provision of necessary care and services due to the inaccurate reflection of services provided to Resident 43. Findings: 1.During a review of Resident 63’s admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities, schizoaffective disorder (a mental illness that could affect thoughts, mood, and behavior, and major depressive disorder (a mood disorder that caused persistent feeling of sadness and loss of interest). During a review of Resident 63’s Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 5/24/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person’s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 63’s active Diagnoses included dementia, depression, and schizoaffective disorders. The MDS indicated Resident 63 was receiving antipsychotic and antidepressant medications. During a review of Resident 63’s Physician’s Order dated 10/24/2024 at 4:11 PM, the Physician’s Order indicated Seroquel (a medication classified as an atypical antipsychotic to treat mental health conditions like schizophrenia) oral tablet 25 milligrams (mg, unit of measurement), give one tablet by mouth at bedtime related to schizoaffective disorder, manifested by auditory hallucinations (hearing things that were not there). During a review of Resident 63’s Physician’s Order dated 7/24/2027 at 4:33 PM, the Physician’s Order indicated fluoxetine hydrochloride (fluoxetine HCL, type of antidepressant used to treat various mental health conditions including depression) capsule (a type of pill where the medicine was encased in a shell, typically made of gelatin) 20 mg, give one capsule by mouth one time a day related to major depressive disorder, single episode manifested by crying spells for no apparent reason. During a review of Resident 63’s Nursing Summary Weekly dated 6/15/2025 at 12:44 AM, the Nursing Summary Weekly indicated the resident was not using psychoactive medications such as an antidepressant in the last seven days or taking antipsychotic medications. (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	08/07/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63’s Medication Administration Record (MAR) dated 6/1/2025 to 6/30/2025, the MAR indicated the resident received Seroquel oral tablet 25 mg, one tablet by mouth at bedtime every day from 6/1/2025 to 6/30/2025. The MAR indicated Resident 63 received fluoxetine HCL capsule 20 mg, one capsule by mouth one time a day every day from 6/1/2025 to 6/30/2025. During a concurrent interview and record review of Resident 63’s Nursing Summary Weekly dated 6/15/2025 at 12:44 PM on 8/7/2025 at 10:13 AM, Licensed Vocational Nurse (LVN) 2 stated Resident 63 was taking an antipsychotic and antidepressant medication. LVN 2 stated the Nursing Summary Weekly was not accurate and should have indicated the resident was receiving both antipsychotic and antidepressant medications. LVN 2 stated if the Nursing Summary Weekly did not reflect accurate information the facility could miss to monitor the side effects of the medications, or the effectiveness of the medication used and could affect Resident 63’s overall health including an increase or decrease in the resident’s behavior. During a concurrent interview and record review of Resident 63’s Nursing Summary Weekly dated 6/15/2025 at 12:44 PM on 8/7/2025 at 11:12 AM, the Director of Nursing (DON) stated Resident 63 was receiving antipsychotic and antidepressant medications and the Nursing Summary Weekly did not reflect that information but should have. The DON stated if the Nursing Summary Weekly did not reflect accurate information the facility would not have an overall picture of the resident’s care and would not accurately summarize the resident’s information. During an interview on 8/7/2025 at 4:12 PM, the Director of Health Information Management (DHIM) stated the facility did not have a policy on nursing documentation or charting. During a review of the facility’s policy and procedure (P&P) titled, “Resident Assessment and Associated Processes” dated April 2025, the P&P indicated, “It is the policy of this facility that resident will be assessed, and the findings documented in their clinical health record. These will be comprehensive, accurate, standardized reproducible assessment of each resident and will be conducted initially and periodically as part of an ongoing process through which each resident’s preferences and goals of care, functional and health status, and strengths and needs will be identified.” The P&P indicated, “The assessment process will include direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. Assessment information will be used to develop, review, and revise the resident’s comprehensive care plan. When applicable, recommendations from the pre-admission screening and resident review (PASARR) evaluation report will be incorporated into the resident’s assessment, care planning, and transitions of care. ” 2. During a review of Resident 43’s admission Record, the admission Record indicated the facility originally admitted Resident 43 on 2/18/2020 and re-admitted Resident 43 on 3/14/2025 with diagnoses including left-sided hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following a cerebral infarction (stroke, blockage of the flow of blood brain, causing or resulting in brain tissue death), left hand contracture (loss of motion of a joint associated with stiffness and joint deformity), and left above knee amputation (surgical removal of a limb above the level of knee). (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	08/07/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 43’s Order Summary Report, the Order Summary Report indicated physician’s orders, dated 5/20/2025, for RNA to apply a left hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint), five times a week for six hours or as tolerated and for RNA to provide gentle passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 43’s left arm, five times a week. During a review of Resident 43’s MDS, dated [DATE], the MDS indicated Resident 43 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated Resident 43 required set-up or clean up assistance for eating, oral hygiene, and upper body dressing and supervision/touching assistance for rolling to both sides, transfers, toileting hygiene, lower body dressing, and bathing. During a review of Resident 43’s RNA daily documentation flowsheet (RNA flowsheet, daily record of RNA services provided for each month), dated 7/2025, the RNA flowsheet indicated Restorative Nursing Aide 3’s (RNA 3) initials on the following days: 7/1/2025 to 7/4/2025, 7/7/2025, 7/8/2025, 7/16/2025, 7/18/2025, 7/23/2025, 7/25/2025, 7/29/2025, and 7/30/2025. The RNA flowsheet indicated Restorative Nursing Aide 2’s (RNA 2) initials on the following days: 7/9/2025 to 7/11/2025, 7/14/2025, 7/15/2025, 7/17/2025, 7/21/2025, 7/22/2025, 7/24/2025, 7/28/2025, and 7/31/2025. During a review of Resident 43’s RNA Weekly Summary, dated 7/2/2025, the weekly summary indicated Resident 43 was seen five times a week for RNA sessions and had “zero” episodes of RNA refusals. During a review of Resident 43’s RNA Weekly Summary, dated 7/9/2025, the weekly summary indicated Resident 43 was seen five times a week for RNA sessions and had “zero” episodes of RNA refusals. During a review of Resident 43’s RNA Weekly Summary, dated 7/16/2025, the weekly summary indicated Resident 43 was seen five times a week for RNA sessions and had “zero” episodes of RNA refusals. During a review of Resident 43’s RNA Weekly Summary, dated 7/23/2025, the weekly summary indicated Resident 43 was seen five times a week for RNA sessions and had “zero” episodes of RNA refusals. During a review of Resident 43’s RNA Weekly Summary, dated 7/30/2025, the weekly summary indicated Resident 41 was seen five times a week for RNA sessions and had “zero” episodes of RNA refusals. During an observation and interview on 8/5/2025 at 9:18 am, in Resident 43’s room, Resident 43 was lying in bed. Resident 43 stated he was unable to move his left arm on his own because his arm was paralyzed (unable to move). Resident 43 had a left leg AKA and was able to raise his left thigh minimally. Resident 43 stated staff assisted with left arm and left leg exercises sometimes but stated he refused to participate most of the time because he preferred to do the exercises on his own since he only trusted particular staff members assisting with ROM exercises. (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	08/07/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/6/2025 at 10:39 am, Restorative Nursing Aide 2 (RNA 2) entered Resident 43’s room to attempt an RNA session. Resident 43 looked at RNA 2 and yelled, “no!” before RNA was able to speak. RNA 2 attempted to explain the importance of exercises and Resident 43 interrupted and adamantly refused to participate. RNA 2 left Resident 43’s room and stated Resident 43 had been refusing RNA consistently, multiple times a day, for many months for unknown reasons. RNA 2 stated Resident 43 refused RNA services so often that she stopped documenting Resident 43’s RNA refusals in the RNA daily and weekly documentation reports. During a concurrent record review and interview on 8/7/2025 at 9:46 am, RNA 2 stated RNA attempted RNA sessions with each resident on the RNA program at least three times a day before documenting refusals in the medical record. RNA 2 stated if a resident refused to participate in RNA after the third time, the RNAs were supposed to document the resident’s refusal on the RNA daily flowsheet and weekly summaries, report the refusal to the charge nurse, and report the refusals in the weekly RNA meetings. RNA 2 reviewed Resident 43’s July 2025 RNA flowsheet and July 2025 weekly summaries, dated 7/2/2025, 7/9/2025, 7/16/2025, 7/23/2025, and 7/30/2025. RNA 2 confirmed she initialed the following dates 7/9/2025 to 7/11/2025, 7/14/2025, 7/15/2025, 7/17/2025, 7/21/2025, 7/22/2025, 7/24/2025, 7/28/2025, and 7/31/2025 which indicated RNA treatment was provided that day. RNA 2 confirmed the July 2025 RNA weekly summaries indicated Resident 43 was seen five times for treatment each week and refused “zero” times. RNA 2 stated the July 2025 RNA flowsheets and July RNA weekly summaries were inaccurate because Resident 43 refused RNA at least one to two times, every day, but stopped documenting any refusals because he refused RNA so frequently. RNA 2 stated she recalled Resident 43 refused RNA completely and did not receive RNA treatment on some days in July 2025, but could not recall which specific days, did not circle her initials on those days to indicate refusals, and did not document the refusals on the RNA weekly summaries. RNA 2 stated she informed the charge nurse of Resident 43’s multiple refusals “sometimes,” but did not document it. RNA 2 stated refusals should be documented accurately in the resident’s records to ensure the facility was aware of the resident’s refusals, the doctor was notified, and the Rehabilitation Department (Rehab) or nursing could re-assess the resident and adjust the program if needed. During a concurrent interview and record review on 8/7/2025 at 10:30 AM, Restorative Nursing Aide 3 (RNA 3) stated Resident 43 refused RNA at least one to two times a day, five times a week, for many months. RNA 3 stated the RNAs were expected to attempt RNA sessions at least three times a day. RNA 3 stated RNA weekly summaries were written to communicate how a resident tolerated the RNA program throughout the week. RNA 3 stated she worked with Resident 43 consistently since he was admitted to the facility and stated Resident 43 used to consistently participate RNA services up until about four months ago. RNA 3 stated Resident 43’s attitude toward staff and participation level in RNA services changed ever since he had his left leg AKA (above knee amputation) surgery within the past year. RNA 3 reviewed Resident 43’s July 2025 RNA weekly summaries, dated 7/2/2025, 7/9/2025, 7/16/2025, 7/23/2025, and 7/30/2025, and confirmed the weekly summaries indicated Resident 43 was seen five times for treatment each week and refused “zero” times. RNA 3 stated Resident 43’s July 2025 weekly summaries, dated 7/2/2025, 7/9/2025, 7/16/2025, 7/23/2025, and 7/30/2025, were inaccurate because the documents indicated Resident 43 refused RNA “zero” times when Resident 43 consistently refused RNA sessions at least one to two times a day, five times a week, for the entire month. RNA 3 stated she should have indicated the number of refusals in Resident 43’s weekly summaries to ensure staff were aware of Resident 43’s continuous refusals but did not. (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	08/07/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/7/2025 at 11:00 am, the DSD stated she supervised the RNAs. The DSD stated the RNAs attempted RNA sessions for each resident on the RNA program at least three times a day. The DSD stated if a resident continued to refuse after the third attempt or if the resident demonstrated a pattern of refusals, RNA should document the resident’s refusal on the daily and weekly record and report the refusal to the charge nurse and in the weekly RNA meetings with the DSD. The DSD stated facility staff should investigate the reason for the refusal, notify the physician, conduct and IDT meeting, and update the care plan. The DSD stated she was aware of Resident 43’s consistent refusals of RNA services for many months. The DSD reviewed Resident 43’s July 2025 weekly summaries, dated 7/2/2025, 7/9/2025, 7/16/2025, 7/23/2025, and confirmed the weekly summaries indicated Resident 43 refused RNA “zero” times in the month of July 2025 despite knowledge and reports of daily, consistent RNA refusals. The DSD stated inaccurate RNA documentation could potentially result in an inaccurate reflection of a resident’s tolerance to the RNA program and services provided and missed opportunities to investigate reasons for refusals which could negatively affect the care plan. During an interview on 8/7/2025 at 2:28 pm, the Director of Nursing (DON) stated accurate RNA documentation was important to ensure the facility had an accurate assessment of the type and frequency of services provided, the status of the resident’s function, and the resident’s tolerance to the RNA program. During a review of the facility’s Policy and Procedure (P/P) titled, “RNA Services, ROM, and Contracture Prevention,” revised 5/2019, the P/P indicated the facility would ensure the management of a resident’s joint mobility was provided by an interdisciplinary team approach of assessment, care planning, and preventative or rehabilitative measures. The P/P indicated appropriate documentation was completed to address goals of the program and resident tolerance to the program.

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	08/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (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	08/07/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to follow their facility's policies and procedures (P&P) for 1 of 5 sample residents (Resident 3) when Licensed Vocational Nurse (LVN) 6 did not wear personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when administering medication through Resident 3's feeding tube (g-tube, a thin flexible tube used to deliver nutrition, hydration, and medication directly into the stomach when a person is unable to eat or drink on their own). This failure had the potential to result in Resident 6 sustaining an infection from external exposure from other residents, staff, and visitors and the infection could spread throughout the facility. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 3/28/2023 and readmitted Resident 3 on 7/30/2024 with diagnoses that included quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty swallowing). During a review of Resident 3's Minimum Data Set (MDS, resident assessment tool), dated 5/20/2025, the MDS indicated Resident 3 rarely made decisions regarding tasks of daily life. The MDS indicated Resident 3 was dependent (helper does all the effort) for his activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) such as toileting hygiene, bathing, and dressing himself. The MDS indicated Resident 3 required maximal assistance (helper does more than half the effort) when turning side to side in bed, moving from a sitting to a lying position, and transferring from chair/bed to chair. The MDS indicated Resident 3 had a feeding tube. During a review of Resident 3's care plan, revised on 6/10/2025, the care plan's interventions included to use enhanced barrier precautions (EBP, a set of infection control interventions designed to reduce the transmission of multidrug-resistant [MDRO] organisms) and to provide local care at g-tube site, and to monitor for signs and symptoms of infection. During a review of Resident 3's Order Summary Report, order date 9/11/2024, the order indicated Resident 3 was placed on enhanced barrier precautions: PPE required for high resident contact care activities. The order indicated Resident 3 had an indwelling medical device, g-tube. During an observation on 8/6/2025 at 4:02 PM outside Resident 3's room, there was an Enhanced Barrier Precaution signage posted by the doorway. During an observation on 8/6/2025 at 4:05 PM inside Resident 3's room, Licensed Vocational Nurse (LVN) 6 was observed not wearing a gown, wearing only gloves, when checking Resident 3's blood pressure. During another observation on 8/6/2025 at 4:20 PM inside Resident 3's room, LVN 6 was observed not wearing a gown, wearing only gloves, when flushing and administering Resident 3's medication through his g-tube. During an interview on 8/6/2025 at 5 PM with LVN 6, LVN 6 stated she did not wear her PPE when handling Resident 3's g-tube, which was an indwelling medical device. LVN 6 stated, she should have worn a gown when in contact or when handing the resident's g-tube to prevent the spread of infection when accessing the medical device. During an interview on 8/7/2025 at 2:30 PM with the Director of Nursing (DON), the DON stated, EBP residents included residents who have wounds or indwelling medical devices. The DON stated it was important to wear PPE for infection control. The DON stated, EBP residents were considered high risk residents, and it was important for the nursing staff to wear PPE to prevent exposing any bacteria or germs on their clothes to these residents. During a review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions, dated 3/2024, the P&P indicated, it is the policy of this facility to implement infection control measures to prevent the spread of communicable disease and conditions. During a review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions, dated 3/2024, the P&P indicated standard precautions are infection prevention practices that apply to the care of all residents, and are based on the principle that all blood, body fluids, secretions, and excretions (except sweat) may contain transmissible infectious agents. During a review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions, dated 3/2024, the P&P indicated standard precautions included: proper selection and use of PPE, such as gowns, gloves, facemasks, respirators, and eye protection. During a review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions, dated 3/2024, the P&P indicated Enhanced Barrier Protection (EBP) expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDRO to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. The P&P indicated, residents with wounds or indwelling medical devices are at especially high risk for both acquisition and of colonization with MDROs. During a review of

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	08/07/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (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	08/07/2025

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe and hazard free environment for three of five sampled residents (Resident 22, 144, and 159) as evidenced by multiple power strips were plugged in another power strip around Resident 22, 144 and 159's bed. The deficient practice had the potential to lead to power overload, overheat that could lead to fire at the facility that threatens the lives of residents, staffs and visitors and/or put them at risk for injury and harm. Findings: 1. During a review of Resident 159's admission Record (AR), the AR indicated the facility originally admitted Resident 159 on 10/23/2014 and readmitted on [DATE] with diagnoses that included anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and difficulty in walking. During a review of Resident 159's Minimum Data Set (MDS, a resident assessment tool), dated 7/7/2025, the MDS indicated Resident 159 had intact memory and cognition (ability to think and reasonably). The MDS indicated Resident 159 required setup and clean-up assistance with eating and oral hygiene, supervision or touching assistance with personal hygiene, and partial/moderate assistance with toileting hygiene and chair/bed-to-chair transfer and shower/bathe self. During a concurrent observation and interview on 8/4/2025 at 9:04 AM with Resident 159, Power Strip 1 was mounted to the wall on the right side of the head of Resident 159's bed, with another Power Strip 2 plugged into it. Power Strip 3 was also plugged into Power Strip 2. A total of 3 Power Strips were plugged into one wall electrical outlet. Resident 159 stated she had stayed in this room for almost a year, and the three power strips were there when she moved in. Resident 159 stated the staff knew about the three power strips being plugged in one wall electrical outlet, but no one removed them. Resident 159 stated she was concerned about the safety because of these electrical wires and power strips that could lead to power overload and fire. 2. During a review of Resident 22's AR, the AR indicated the facility originally admitted Resident 22 on 2/25/2015 and readmitted on [DATE] with diagnoses that included diabetes mellitus (a group of diseases that result in too much sugar in the blood) and difficulty in walking. During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 had severely impaired memory and cognition. The MDS indicated Resident 22 required setup and clean-up assistance with eating, partial/moderate assistance with personal hygiene, substantial/maximal assistance with oral hygiene, and was dependent on toileting hygiene and chair/bed-to-chair transfer. 3. During a review of Resident 144's AR, the AR indicated the facility originally admitted Resident 144 on 7/19/2024 and readmitted on [DATE] with diagnoses that included hemiplegia (a condition characterized by weakness or paralysis [the affected side has limited or no ability to move] on one side of the body) and muscle weakness. During a review of Resident 144's MDS, dated [DATE], the MDS indicated Resident 144 had severely impaired memory and cognition. The MDS indicated Resident 144 required setup and clean-up assistance with eating, supervision or touching assistance with oral hygiene, partial/moderate assistance with personal hygiene, substantial/maximal assistance with toileting hygiene and chair/bed-to-chair transfer. During a concurrent observation and interview on 8/4/2025 at 10:56 AM with Resident 22, Power Strip 4 was mounted to the wall at foot side of Resident 144's bed, with Power Strip 5 plugged into it. Power strip 5 was mounted to the wall next to Power Strip 4. Resident 22's hospital bed and her TV plugged into Power Strip 5. Resident 22 and Resident 144's curtains were draped close to the two power strips near the oxygen concentrator that Resident 22 used when she was short of breath. Resident 22 stated her TV on the nightstand was always at the foot of her bed and she did not know when and how the electrical plugs were arranged. During a concurrent observation and interview on 8/4/2025 at 12:07 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated Power Strip 4, which was plugged into the electric wall outlet next to Resident 144's bed, was mounted to the wall at the foot of Resident 144's bed. CNA 1 stated Power Strip 5 was plugged into Power Strip 4, and Resident 22's hospital bed and TV were plugged into Power Strip 5. CNA 1 stated she did not know how long Power Strip 5 was plugged into Power Strip 4 and who plugged it like this. CNA 1 stated she did not know if it was safe to connect the power strips to each other. During a concurrent observation and interview on 8/4/2025 at 12:14 PM with the Maintenance Director (MD), the MD stated Power Strip 2 was plugged into Power Strip 1, and Power Strip 3 was plugged into Power Strip 2 around Resident 159's bed. The MD stated the staff should not connect the power strips to each other because it could cause fire and put the residents at risk for fire hazards. The MD stated he did not know who connected the power strips to each other in Resident 22, 144, and 159's rooms and did not know