

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2024
NAME OF PROVIDER OR SUPPLIER Orchard Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 4840 E.Tulare Avenue Fresno, CA 93727	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45938</p> <p>Based on observation, interview and record review, the facility failed to follow professional standards of quality for one of three sampled residents (Resident 1) when Resident 1 was admitted to the facility on [DATE] and was readmitted on [DATE] and 10/28/24 and no inventory of personal belongings was completed, and the facility did not follow their policy and procedure (P&P) titled Personal Property.</p> <p>These failures resulted in Resident 1's personal belongings not being inventoried and the risk for Residents 1's wallet, checkbook and bankcard getting lost.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 11/5/24 at 12:47 p.m. in Resident 1's room, Resident 1 was lying down in bed awake. Resident 1 stated, he was admitted to the facility about three months ago. Resident 1 stated, when he was admitted, he came to the facility with his checkbook, wallet and bank card. Resident 1 stated, he believed his checkbook, wallet and bankcard was in his bedside cabinet.</p> <p>During a review of Resident 1's Face Sheet (FS-include the patient's name, address, date of birth, insurance information, and emergency contact information.) dated 11/6/24, the FS indicated, Resident 1 was initially admitted to the facility on [DATE] with primary diagnosis of Polyneuropathy (several nerves that malfunction at the same time) and Muscle Weakness. Resident 1's FS indicated he was his own Responsible Party (RP- the person in charge of and responsible for making decisions).</p> <p>During a review of Resident 1's Minimum Data Set [MDS- a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment], dated 11/1/24, the MDS section C indicated, Resident 1 had a BIMS (Brief Interview for Mental Status) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) which indicated Resident 1 was cognitively intact.</p> <p>During an interview on 11/5/24 at 12:51 p.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated, the process at the facility was when residents were admitted to the facility, the CNA took inventory of the belongings on paper and gave the belongings and the paper to the Licensed Vocational Nurse (LVN).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 11/5/24 at 1:10 p.m. with Medical Records (MR), Resident 1 Electronic Medical Record (EMR) was reviewed. The EMR indicated, Resident 1 was admitted to the facility on [DATE], and was readmitted to the facility on [DATE] and on 10/28/24. MR stated, Resident 1 was admitted to the facility on [DATE]. MR stated, there was no inventory list completed for Resident 1 when he was admitted on [DATE]. MR stated, there was no inventory list in the EMR for the re-admissions on 10/4/24 and 10/28/24. MR stated, Resident 1 should have had an inventory list completed for each admission. MR stated, the CNA was responsible for filling out the inventory paper form, and the LVN was responsible to input the items from the inventory form into the computer and get a signature of the resident or the Residents RP.</p> <p>During a concurrent observation and interview on 11/5/24 at 1:21 p.m. with CNA 1 in Resident 1's room, CNA 1 went through Resident 1's bedside cabinet and was unable to find his wallet, checkbook or bank card. CNA 1 went through Resident 1's pants and jackets that were hung up in the closet and went through Resident 1's closet drawers and was unable to find his check book, wallet or bank card. CNA 1 looked through two pink bags, one white bag and one [retail store] bag that were stored in the closet and was unable to find Resident 1's check book, wallet or bank card. CNA 1 stated, she was not able to find Resident 1's wallet, check book or bank card in his belongings.</p> <p>During an interview on 11/5/24 at 1:48 p.m. with the Social Services Director (SSD), the SSD stated, an outside agency social worker filed a grievance that Resident 1's wallet and check book were missing. The SSD stated, she checked Resident 1's inventory list and did not find the wallet and check book on the inventory list. The SSD stated, Resident 1's wallet, checkbook and bankcard were found in the back of the dining room. The SSD stated, she did not know how Resident 1's items ended up in the dining room. The SSD stated, the CNA and the LVN admitting the resident were responsible for inventorying the resident's belongings. The SSD stated, the LVN was responsible for entering the resident's inventory into the residents EMR. The SSD stated, it was important for resident's belongings to be inventoried to ensure personal items and reimbursement to a resident if something went missing.</p> <p>During an interview on 11/5/24 at 2:54 p.m. with the LVN, the LVN stated, when a resident was admitted to the facility, the CNA or the LVN would make a list of the resident's inventory on paper. LVN stated, it was the LVN's responsibility to enter the inventory into the EMR and make a copy for medical records. LVN stated, if the CNA made the list of items, the LVN had to verify everything on the list was physically present. The LVN stated, the resident or their RP needed to sign the inventory form. The LVN stated when a resident was admitted they had to have an inventory list completed. The LVN stated, if a resident came in with no belongings, they would still had to do an inventory list and document there was no belongings. The LVN stated, it was important to complete an inventory list in case something went missing.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/7/24 at 2:03 p.m. with the Director of Nursing (DON), the DON stated, it was her expectation that an inventory list be completed when a resident was admitted and readmitted to the facility. The DON stated the process of completing the inventory was that the LVN or CNA would fill out the inventory form and the nurse would enter it into the EMR. The DON stated, Resident 1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] and 10/28/24. The DON stated, she was unable to find documentation that an inventory list had been completed on 7/12/24, 10/4/24 or 10/28/24 in the EMR or in Resident 1's hard chart (physical medical record). The DON stated, it was important for resident's belongings to be inventoried when they were admitted to ensure their personal belongings were tracked. The DON stated, when inventories were not completed on admission there was a potential for resident's personal belongings to get lost. The DON stated, the facility's P&P for Personal Property required for an inventory to be completed upon admission. The DON stated, the P&P for Personal Property was not followed.</p> <p>During a review of RESIDENT GRIEVANCE FORM, dated 10/14/2024, the RESIDENT GRIEVANCE FORM indicated, . [Resident 1] . DESCRIBE THE NATURE OF THE GRIEVANCE: Patient lost items wallet / checkbook Last seen in 8/02/24 per email on 10/14/24 . INVESTIGATION: FINDINGS: . looked for items [at] bedside no findings writer added to communications to be on the look out for items . 10/18/2024 writer put on communications again . 10/21/2024 staff member [initials] looked through all Patient belongings no tracings of items . 10/22/24 Items Found [and] Placed in Social [services] Safe .</p> <p>During a review of the facility's (P&P) titled, Personal Property dated 2001, the P&P indicated, . Residents are permitted to retain and use personal possessions, including furniture and clothing, as space permits . The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary .</p> <p>During a review of Job Description LVN dated 2/2024, the Job Description LVN indicated, . Essential Duties . Charting and Documentation . Complete and file required recordkeeping forms/charts upon the resident's admission, transfer, and/or discharge .</p> <p>During a review of Resident 1's Clinical Census (CC) dated, 11/5/24, the CC indicated, Resident 1 was admitted [DATE], discharged on [DATE], readmitted on [DATE], discharged on [DATE] and readmitted on [DATE].</p> <p>During a review of professional reference from https://canhr.org/nursing-home-admission-agreements/#:~:text=Personal%20Possessions,current%20and%20save%20a%20copy.,titled,NURSING HOME ADMISSION AGREEMENTS dated, 9/4/2024, indicated, . When you are admitted to a nursing home, you will be asked to sign an admission agreement that explains your rights and responsibilities and those of the nursing home . Signing Other Documents at Admission . Personal Possessions . At admission, the nursing home must establish a personal property inventory and give you or your representative a copy. (California Health & Safety Code S1289.4) .</p> <p>(continued on next page)</p>		

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