STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056225	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchard Post Acute	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48713 Based on interview and record review the facility failed to ensure services were provided that met professional standards of quality for one of four sampled Residents (Resident 1), when Licensed Nurses did not document Resident 1 's change of condition for an episode of hypoglycemia (low blood sugar) on 12/16/24 in accordance with facility's policy and procedure on nursing documentation and change of condition. This failure resulted in an incomplete documentation and assessment for Resident 1 and had the potential for delay in care. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis for type 2 diabetes mellitus (condition when the body doesn ' t use insulin properly, resulting in high blood sugar). 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 12/30/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a record review of Resident 1 ' s, Progress Note (PN), dated 12/16/24, the PN indicated, . Staff reported resident to be sweating and clothes were changed twice within the last 30 minutes of this shift. When writer entered the room resident was found awake but not verbally responsive . fasting blood sugar noted 51 . (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 1/8/25 at 11:40 a.m. with Registered Nurse (RN) 1, Resident 1 ' s electronic medical record (EMR) was reviewed. The EMR indicated there was no change of condition assessment completed for Resident 1 on 12/16/24. RN 1 stated there should have been a change of condition assessment completed for Resident 1 on 12/16/24 when Resident 1 was sent to the acute care hospital. RN 1 stated it was the facility ' s process to complete a change of condition assessment when there was a change in Residents health status. RN 1 stated it was important to complete a change of condition assessment because it was a form of communication used to document change of residents ' condition for other staff members and physicians. During an interview on 1/8/25 at 12:21 p.m. with the director of nursing (DON), the DON stated it was the facility 's expectation that a change of condition assessment be completed when there was a change in resident health status. The DON stated completing the change of condition assessment was an important form of communication between staff and initiated an appropriate response for Resident 1. During a telephone interview on 1/8/25 at 4:16 p.m. with Licensed vocational nurse (LVN) 1, LVN 1 stated on 12/16/24, Resident 1 experienced a change in condition when his blood sugar was documented at 51. LVN 1 stated the expectation was to complete a change of condition assessment when there was a change in residents ' health status. LVN 1 stated the purpose for completing a change of condition assessment was to effectively communicate the change of condition and interventions completed to other staff. During a review of the facility 's policy and procedure (P&P) titled, Change in a Resident ' s Condition or Status dated 2/2021, the P&P indicated, . A significant change of condition is a major decline or improvement in the residents status that will normally not solve itself without intervention by staff . the nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition or status. If a significant change in the residents physical or mental condition occurs, a comprehensive assessment of the resident ' s condition will be conducted . During a review of the facility ' s P&P titled, Charting and Documentation, dated 2001 , the P&P indicated, . All services provide to the resident, progress towards the care plan goals, or any changes in the resident ' s medical, physical, functional or psychosocial condition, shall be documented in the resident ' s medical record . the following information is to be documented in the resident medical record . treatments or services performed, changes in resident ' s condition, events, incidents or accidents involving the resident . documentation in the medical record will be objective, complete and accurate . documentation of procedures and treatments will include care specific details, including . the assessment data and or/any unusual findings obtained . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a professional reference review titled, Lippincott Manual of Nursing Practice 11th Edition dated 2020, pages 15 indicated, . Standards of Practice . General Principles . These standards describe what nursing is, what nurses do, and the responsibilities for which nurses are accountable . A deviation from the protocol should be documented in the patient ' s chart with clear, concise statements of the nurse ' s decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . Common Departures from the Standards of Nursing Care . Legal claims most commonly made against professional nurses include the following departures from appropriate care: .follow physician orders, follow appropriate nursing measures, communicate information about the patient . document appropriate information in the medical record . and follow physician ' s orders that should have been questioned or not followed . Common Legal Claims for Departure from Standards of Care . Failure to implement a physician ' s . order properly . Based on interview and record review the facility failed to ensure services were provided that met professional standards of quality for one of four sampled Residents (Resident 1), when Licensed Nurses did not document Resident 1 's change of condition for an episode of hypoglycemia (low blood sugar) on 12/16/24 in accordance with facility's policy and procedure on nursing documentation and change of condition. This failure resulted in an incomplete documentation and assessment for Resident 1 and had the potential for delay in care. Findings: During a review of Resident 1's Admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis for type 2 diabetes mellitus (condition when the body doesn ' t use insulin properly, resulting in high blood sugar). 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 12/30/24, the MDS indicated, Resident 1's Brief Interview for Mental Status (BIMS- screening tool used to assess resident cognitive level) score was 15 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8 12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 1 was cognitively intact. During a record review of Resident 1 ' s, Progress Note (PN), dated 12/16/24, the PN indicated, . Staff reported resident to be sweating and clothes were changed twice within the last 30 minutes of this shift. When writer entered the room resident was found awake but not verbally responsive . fasting blood sugar noted 51 . (continued on next page)

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