

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

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No. 0938-0391

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 06/09/2026
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)		
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. Based on interview and record review, the facility failed to ensure medication administration services were provided in accordance with professional standards for one of one sampled resident (Resident 1) when the Registered Nurse (RN 1) directed Certified Nursing Assistant (CNA 1) to administer medication to Resident 1. This failure had the potential to result in Resident 1 receiving medications from unlicensed personnel, increasing the risk for medication administration errors and compromising resident safety. Findings: During an interview on 6/9/26 at 11:30 a.m. with CNA 1, CNA 1 stated her current assignment was the low 100 hall. CNA 1 stated she had passed medication to Resident 1 after being asked by a nurse. CNA 1 stated the nurse remained present and observed the administration. CNA 1 stated, She just asked me to take the medication to the Resident 1, and I thought I had to do what my nurse asked of me. CNA 1 stated she did not know what medication was administered. CNA 1 stated she later learned she was not permitted to administer medications because it was outside her scope of practice. CNA 1 stated she notified the facility management of the incident. CNA 1 stated the Development of Staff Director (DSD) educated her regarding her responsibilities and informed her CNAs are not permitted to administer medications. CNA 1 stated she received disciplinary action related to the incident and believed the nurse involved also received disciplinary action. During an interview on 6/9/26 at 12:57 p.m. with RN 1, RN 1 stated she was conducting a medication pass when the incident occurred. RN 1 stated Resident 1 was on isolation precautions (infection prevention measures requiring the use of Personal Protective Equipment [PPE] before entering resident room). RN 1 stated PPE included a gown, gloves, and mask, and was available outside Resident 1's room; however, CNA 1 was already inside the room providing care. RN 1 stated she asked CNA 1 to administer the medication to Resident 1 while RN 1 remained standing in the doorway. RN 1 stated, I did not know a CNA could not pass medication. I thought if I was standing there watching, she could give the resident the medication. RN 1 stated she prepared the medication, which was an antibiotic pill (Vancomycin), and handed the medication cup to CNA 1. RN 1 stated CNA 1 then physically handed the medication to Resident 1 for administration. RN 1 stated she continued administering medications to other residents and was subsequently approached by the DSD regarding the incident. RN 1 stated she received education regarding medication administration responsibilities and received disciplinary action. RN 1 stated it was the first time she had asked another staff member to administer medication on her behalf. RN 1 confirmed she prepared the medication and documented the medication administration in Resident 1's medical record. RN 1 confirmed CNA 1 physically administered the medication to Resident 1 while RN 1 remained outside the room. During a concurrent interview and record review on 6/9/26 at 12:00 p.m. with the Director of Nursing (DON), Resident 1's Medication Administration Record (MAR) was reviewed. The MAR indicated, on 6/8/26 for the 12:00 p.m. administration pass, medication Vancomycin was documented as administered by RN 1. The DON stated the facility's medication administration process requires a licensed nurse to identify the resident, verify the medication order, and perform the medication administration process utilizing the rights of medication administration, including the right resident, the right medication, right dose, right route, right time, and right documentation. DON stated the nurse who prepared the medication must be the same nurse who administered and documented the medication. The DON stated, Who pours it, (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	gives it, and signs it. The DON stated CNA's could not administer medications. DON stated an in-service took place the day before. The DON confirmed RN 1 prepared a medication for Resident 1, who resided in room on the low 100 side and was on isolation precautions. DON stated RN 1 did not want to don (put on) PPE and remained outside Resident 1's room. The DON stated RN 1 handed the medication to CNA 1 and observed CNA 1 administer the medication to Resident 1. DON confirmed the statement provided by CNA 1 and RN 1 regarding the incident. DON stated the DSD became aware of the incident while addressing an unrelated matter involving CNA 1. The DON stated CNA 1 disclosed administering the medication at the direction of RN 1. The DON stated she instructed the DSD to immediately remove RN 1 from her duties and an investigation was initiated. The DON stated CNA 1 received education regarding scope of practice, was re-trained, and received disciplinary action related to the incident. The DON stated RN 1 also received education and disciplinary action. During a record review on 6/9/26, a facility document titled, Registered Nurse Job Description, signed by RN 1 on 3/19/26, was reviewed. Under the section titled Nursing care Functions, the job description indicated RN responsibilities included ensuring all Registered Nurses (RNs) and Licensed Practical/Vocational Nurses comply with written procedures for administration, storage, and control of medication passes and treatment. Under the section titled Qualifications, the job description indicated the RN must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines pertaining to nursing care facilities. The document indicated RN 1 acknowledged and understood the responsibilities and qualifications required for the RN position by signing the job description on 3/19/26. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 3/2026, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The person who prepares the dose for administration is the person who administers the dose. During a review of the Nursing Home Care Standards-CANHR.org Professional Reference titled, Medication, unnecessary Drugs and chemical Restraints, dated 2026, (Found https://canhr.org/nursing-home-care-standards/) the reference indicated, .medications must be administered by licensed nurses or medical personnel. 22 CCR S72313(a)(5). Unlicensed staff may administer certain laxatives, non-prescription lotions, medicinal shampoos and baths, subject to specific training, demonstrated competence and direct supervision by licensed nursing or medical personnel. 22 CCR S72313(a)(5)(B). The person who administers the drug or treatment must record the date, time, and dosage in the resident's individual medication record. 22 CCR S72313(c).		