STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056261	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards at Tulare	604 E. Merritt Ave. Tulare, CA 93274

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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38993 Based on observation, interview, and record review, the facility failed to implement a care plan for one of four sampled residents (Resident 1) when the hospital medical records were not requested after Resident 1 was readmitted from the hospital. This failure resulted in the facility being unaware of Resident 1 ' s weight bearing status and the need for a follow up appointment, placing Resident 1 at risk for re-injury and a delay in care. Findings: During an observation on 10/17/24 at 10:35 a.m. in the hallway, Resident 1 was ambulating with a four wheeled walker. During a review of Resident 1 ' s Progress Notes (PN), dated 10/4/24 at 11:05 a.m., the PN indicated, Date of Incident: 10/3/24.Unwitnessed fall.CNA (certified nursing assistant) was notified that resident fell on the floor.resident was noted to be on the floor trying to get herself back up.IDT (Interdisciplinary Team-a collaborative approach to patient care that involves multiple health professionals working together to provide comprehensive care) met and determined that resident while ambulating too fast with her walker, resident may have tripped over her walker and fell .Order put in for x-ray of the hip, pending results. During a review of Resident 1 ' s Radiology Results Report (RRR), dated 10/6/24, the RRR indicated, Resident 1 had a fracture (broken bone) involving right subcapital femur (partial break in thigh bone) with no displacement (moving of something from its position). The age of the fracture (broken bone) is acute (sudden). During a review of Resident 1 ' s PN, dated 10/7/24, the PN indicated IDT meeting follow up.(Resident 1) returned to facility from (hospital name) with NNO (no new orders).New interventions.Ward clerk to request medical records from the acute. During a review of Resident 1 ' s Care Plan (CP), dated 10/4/24 the CP indicated, (Resident 1) had an actual fall.r/t (related to) poor balance, unsteady gait, and tripping over the walker while ambulating.Interventions. x-ray of the hip.Date initiated: 10/4/24.send out to the acute for further evauations (sic) Date initiated: 10/7/24. request medical records from acute (hospital) Date initiated 10/7/24. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 11:15 a.m. with [NAME] Clerk (WC), WC stated she did not have the hospital records for Resident 1 and would have to request them. During a concurrent interview and record review on 10/17/24 at 1:50 p.m. with ADON, Resident 1 ' s Emergency Department Discharge Instruction (EDD), dated 10/6/24 was reviewed. The EDD indicated, . Ortho (orthopedist-doctor that treats injuries and diseases involving muscles, bones, joints, ligaments, and tendons) recommends keeping the patient (Resident 1) non weight bearing (leg should not touch the floor or support any body weight), no splinting (external device to stop movement), and outpatient follow up in his clinic in one week. ADON stated the hospital records were not received until 10/17/24 (11 days later) at 1:10 p.m. orders for non-weight bearing and ortho follow up in one week were not done. During a review of the facility ' s policy and procedure (P&P) titled, Care Area Assessments, dated November 2019, the P&P indicated, 2. The care area assessments (CAAs) process consists of the following steps: .e. Document interventions on the care plan: (2) Include recommendations for monitoring and follow-up time frames.