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	10/24/2024

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38993 Based on interview and record review, the facility failed to ensure discharge instructions were discussed with the responsible party (RP) of one of three sampled residents (Resident 1) when Resident 1 was discharged home. This failure resulted in the RP of Resident 1 being unaware of how to care for Resident 1 and Resident 1 being admitted to the hospital. Findings: During a review of the Progress Notes (PN), dated 10/18/24 at 8:03 p.m., the PN indicated, At 1125 resident discharges home to family.admitted for short term rehabilitation; PT (Physcial Therapy)/OT (Occupational Therapy), ST (Speech Therapy) and wound care. Past medical hx (history) of hemiplegia (condition that causes severe weakness in the muscles on one side of the body, often affecting the arm, leg, and face) % [sic] hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), muscle weakness, contracture of muscle, and pressure ulcer (injury to the skin and underlying tissue resulting from prolonged pressure on the skin) of left and lower back stage four (most severe type of pressure ulcer that extends to muscle, tendon, or bone). Resident was transported via medical transport, accompanied by transport attendant. All personal belongings, medication, medication list was taken by resident, inventory signed, and items accounted. Resident educated in the importance or following up with primary (physician) provided in a timely matter. Education in medication administration provided. During a review of Resident 1 ' s Admission Record (AR), dated 11/15/24, the AR indicated Resident 1 was admitted on [DATE] with diagnoses.hemiplegia and hemiparesis following cerebral infarction (medical condition that occurs when blood flow to the brain is blocked, causing brain tissue to die) affecting right dominant side, aphasia (difficulty speaking) following cerebral infarction.dysphagia (difficulty swallowing), oropharyngeal phase (active phase of swallowing, when food is moved from the mouth to the upper esophagus).cognitive communication deficit.pressure ulcer of left lower back, stage 4, pressure-induced deep tissue damage of left heel. During a review of Resident 1 ' s Minimum Data Set (MDS-resident assessment tool), dated 10/18/24, the MDS indicated, BIMS (Brief Interview for Mental Status) .04 (0-7 suggests severe cognitive impairment) (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: 056261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Orchards at Tulare		STREET ADDRESS, CITY, STATE, ZIP CODE 604 E. Merritt Ave. Tulare, CA 93274	

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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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Discharge Summary/Instructions (DSI), dated 10/15/24, the DSI indicated, Date of Discharge 10/18/24.Recapitulation of Stay Resident admitted for short stay rehab (rehabilitation) PT/OT? [sic] ST, and wound care.Skin condition.right buttock.left buttock.discharge location. Home/family assist.Wound care instructions.Education provided.Acknowledgements.I understand the above discharge instructions.Patient/Representative Signature.(document was unsigned).Completing Nurse Acknowledgements.(document was unsigned). During a review of Resident 1 ' s ED (Emergency Department) Physician Notes (EDPN) dated 10/20/24 at 2:53 p.m., the EDPN indicated, (Resident 1) is a [AGE] year old female who presents due to family concern over sacral wound. She was recently here in the hospital admitted for sacral (triangular bone at the base of the spine) decubitus (bed sore) wound.and then discharged to a skilled nursing facility. She left the skilled nursing facility yesterday and was discharged home. Her husband became very overwhelmed because he did not know how to care for her and was intimidated by the wound.Skin: wounds large sacral decubitus wound stage 3 (deep wound that involves full thickness tissue loss, but does not expose bone, tendon, or muscle) and a portion that appears to be stage 4 (deep wound that extends to muscle, tendon, or bone). During an interview on 11/14/24 at 12:45 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated when a resident discharges home the discharge paperwork should be discussed and provided to the resident or the RP who is responsible for providing the care, if the resident is unable to care for themselves. LVN 1 stated when a resident was sent home via transport the discharge instructions should be discussed over the phone with the care provider and a copy placed in the resident ' s belongings. During an interview on 11/14/24 at 12:55 p.m. with Director of Nursing (DON), DON stated when Resident 1 was discharged on [DATE], LVN 2 went over the discharge instructions with Resident 1 and did not discuss them with the RP. DON stated Resident 1 was a BIMS of 4 and would not have understood the discharge instructions provided. DON stated LVN 2 should have called Resident 1 ' s RP and discussed the discharge medications and wound treatments. During an interview on 11/15/24 at 9:10 a.m. with Family Member (FM) 1, FM 1 stated Resident 1 was discharged home via a transport van from the facility on 10/18/24. FM 1 stated staff did not speak to him regarding discharge instructions, or the care Resident 1 required upon discharge. FM 1 stated Resident 1 showed up at the house with papers that only contained medications that Resident 1 was receiving. FM 1 stated Resident 1 was home for one day and had to be transported by ambulance to the hospital due to an infected wound. FM 1 stated he was unaware that Resident 1 had a wound that needed to be treated. During an interview on 11/15/24 at 11:17 a.m. with Social Service Director (SSD), SSD stated Resident 1 was admitted to the facility for short term rehabilitation and the plan was for Resident 1 to return home with the RP. SSD stated when discharge plans were discussed with the RP, (SSD) was unaware Resident 1 had pressure ulcers that needed treatment and home health was not set up prior to discharge. SSD stated it was the nurse ' s responsibility to provide the discharge instructions to the RP. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s policy and procedure (P&P) titled Discharge Summary and Plan dated 10/22, the P&P indicated, The discharge summary includes a recapitulation of the resident ' s stay at the facility and a final summary of the resident ' s status at the time of the discharge.The discharge summary shall include a description of the resident ' s.ability to perform activities of daily living including: bathing, dressing and grooming, transferring and ambulating, toilet use, eating, and using speech, language, and other communication systems.special treatments or procedures.activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being).The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan.