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	11/15/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34401 Based on observation, interview, and record review, the facility failed to follow its own policy and procedure for one for four sampled residents (Resident 1), when Resident 1 was not immediately assessed, and Attending Physician (AP) was not notified of Resident 1 ' s discoloration (bruise) to left inner corner eye, discoloration to right eyebrow, discoloration to bilateral upper extremities (region of the body that includes arm, forearm, and hand), discoloration to the back of left thigh. This failure resulted in a delay in treatment for Resident 1. Findings: During a concurrent observation and interview on 10/24/24 at 12:20 p.m. with Resident1, Resident 1 was in her room, sitting in a chair eating lunch. Resident 1's left outer eye was noted with red/purple/black discoloration measuring approximately 2.5 centimeters (cm) and left inner eye with red discoloration measuring approximately 1 cm. Resident 1 only smiled when spoken to. During an interview on 10/24/24 at 12:52 p.m. with Director of Nurses (DON), DON stated on 10/21/24 at approximately 5 p.m. Licensed Vocational Nurse (LVN 1) reported Resident 1 having a new discoloration to left and right eye. DON stated upon further assessment, Resident 1 also had discoloration to the back of her left thigh and discoloration to bilateral upper extremities. DON stated all injuries looked really fresh. DON stated Resident 1's new discoloration to her left eye, discoloration to the back of her left thigh, and bilateral upper extremities were reported to LVN 2 by CNA 2 on 10/21/24 at the beginning of her shift (6:30 a.m.). DON stated LVN 2 did not assessed Resident 1, and did not notify Resident 1's AP. During an interview on 10/24/24 at 1:06 p.m. with LVN 2, LVN 2 stated on 10/21/24 before breakfast trays were served, CNA 2 had reported Resident 1 having like minor or whatever in her left eye. LVN 2 stated Resident 1 was in bed with eyes closed and did not assessed Resident 1. LVN 2 stated she did not notify Resident 1's AP. LVN 2 stated, I didn ' t know we had to report every little thing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 11:32 a.m. with CNA 2, CNA 2 stated after clocking in to work on 10/21/24 at 6:30 in the morning, she saw Resident 1 walking in the hallway with discoloration to her left eye. CNA 2 stated she went directly to the nurse station and told LVN 2. CNA 2 stated while changing Resident 1 with CNA 3, they noticed new discolorations to bilateral upper extremities extending from wrist all the way up below the elbow. CNA 2 stated CNA 3 immediately reported the discoloration found on Resident 1's bilateral upper extremities to LVN 2. During an interview on 10/30/24 at 12:01 p.m. with CNA 3, CNA 3 stated on 10/21/24, while changing Resident 1 with CNA 2, they noticed discoloration to bilateral upper extremities extending from wrist all the way up below the elbow. CNA 3 stated he immediately informed LVN 2. During an interview on 10/30/24 at 11:48 a.m. with LVN 1, LVN 1 stated on 10/21/24 at 5:30 p.m. a full body assessment on Resident 1 was completed. LVN 1 stated Resident 1 had left and right eye discoloration, and discoloration to upper extremities. LVN 1 stated it was the facility practice to immediately assessed and notify AP of any new skin changes. During a review of Resident 1's Progress Notes (PN), dated 10/21/24 at 9:21 p.m., the PN indicated, Heat [sic] to toe assessment performed. Discoloration noted to bilateral (right and left side) forearms. Discoloration to left eye. Redness noted to upper right eyebrow. 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, 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an): .d. significant change in the resident ' s physical/emotional/mental condition;. 3. Prior to notifying the physician or healthcare provider, the nurse will make a detailed observations and gather relevant and pertinent information. 8. The nurse will record in the resident ' s medical information relative to changes in the resident ' s medical/mental condition or status.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34401 Based on observation, interview, and record review, the facility failed to: 1. Ensure one of four sampled residents (Resident 1) was free from physical abuse by facility staff (Certified Nursing Assistant-CNA 1). This failure resulted in Resident 1 sustaining discoloration (bruise) to left inner corner eye, discoloration to right eyebrow, discoloration to bilateral upper extremities (region of the body that includes arm, forearm, and hand), discoloration to the back of left thigh, a bald spot to the back of head, and hospitalization . 2. Ensure one of four sampled residents (Resident 3) was free from verbal abuse by facility staff (Licensed Vocational Nurse-LVN 3). This resulted in staff verbally abused Resident 3 and resulted in Resident 3 feeling angry and frustrated. Findings: 1. During a review of Resident 1's Admission Record (AR), dated 10/28/24, the AR indicated Resident 1's diagnoses included Alzheimer (a disease characterized by a progressive decline in mental abilities and Dementia (a progressive state of decline in mental abilities). Resident 1's annual Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 10/11/24, indicated Resident 1 had a BIMS (Brief Interview for Metal Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 0 (score range from 0-7 severe impairment). During a review of Resident 1's Progress Notes (PN), dated 10/21/24 at 9:21 p.m., the PN indicated, At Approx. (approximately) 1930 (7:30 p.m.) Resident (Resident 1) was sent to ER (emergency room) for further eval (evaluation) per MD (Medical Doctor) orders.Heat [sic] to toe assessment performed. Discoloration noted to bilateral (right and left side) forearms. Discoloration to left eye. Redness noted to upper right eyebrow. Approx. Nickel size abrasion to left shin. During a review of the facility's Investigation Report (IR), dated 10/28/24, the IR indicated, This nurse immediately assessed (Resident 1) for reported skin changes at approximately 1730 (5:30 p.m.) and noted skin intact, with discoloration to left inner corner eye, discoloration to right eyebrow, discoloration to bilateral upper extremities, and to left posterior (back) thigh. (Resident 1) is unable to verbalize events surrounding discoloration due to cognition (process of knowing) impairment.During initial investigation (Resident 1) is noted to share roommate (Resident 2) with a BIMS of 14 (score range from 13-15 intact cognition), who (Resident 2) verbalizes that this morning (Resident 1) was being combative with the CNA (CNA 1) and was kicking and hitting the CNA, but the CNA was also hitting her back and had her against a corner holding her down. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/24/24 at 12:11 p.m. with Administrator in Training (AIT), AIT stated a facility investigation was completed regarding the allegation of staff to resident abuse reported on 10/21/24 at 5:30 p. m. AIT stated Resident 2 had witnessed CNA 1 cornering her (Resident 1), holding her down, pulling her hair. AIT stated Resident 1 sustained injuries which included, discoloration to left and right eye, discoloration to bilateral upper extremities, discoloration to the back of left thigh, a bald spot to the back of head. AIT stated based on Resident 2's witnessed statement and Resident 1 ' s injuries, lead us to believe it could be caused from (CNA 1) doing that. During a concurrent observation and interview on 10/24/24 at 12:20 p.m. with Resident 1, Resident 1 was in her room, sitting in a chair eating lunch. Resident 1's left outer eye was noted with red/purple/black discoloration measuring approximately 2.5 centimeters (cm) and left inner eye with red discoloration measuring approximately 1 cm. Resident 1 only smiled when spoken to. During an interview on 10/24/24 at 12:52 p.m. with Director of Nurses (DON), DON stated on 10/21/24 at approximately 5 p.m. Licensed Vocational Nurse (LVN 1) reported Resident 1 having a new discoloration to left and right eye. DON stated upon further assessment, Resident 1 also had discoloration to bilateral upper extremities and discoloration to the back of her left thigh. DON stated all injuries looked really fresh. DON stated Resident 1 had diagnosis of Alzheimer and Dementia and was not able to verbalize how she sustained her new injuries. DON stated Resident 2 witnessed CNA 1 putting Resident 1 against the wall, holding her down, and pulled her hair. DON stated Resident 2 is alert and oriented, and cognitively (process of knowing) intact. During a concurrent observation and interview on 10/24/24 at 1:26 p.m. with Resident 2, Resident 2 was in her room, sitting in her bed. Resident 2 stated on 10/21/24 at approximately 6 a.m. CNA 1 entered the room to provide care for Resident 1. Resident 2 stated the privacy curtain between the beds was halfway open and saw Resident 1 with eyes closed, when CNA 1 pulled her clothes down and attempted to change Resident 1. Resident 2 stated Resident 1 allowed CNA 1 to remove and change her top shirt but became combative. Resident 1 was kicking CNA 1 and refusing to change her pants. Resident 2 stated CNA 1 held Resident 1 with one hand and managed to pull Resident 1's pants off. Resident 2 stated she saw CNA 1 holding Resident 1 on the bed, pulled her hands by the wrist, got her up, placed her in the corner of the room, and pulled Resident 1 by the hair. Resident 2 stated Resident 1 continued to fight to be released. During an interview on 10/30/24 at 11:32 a.m. with CNA 2, CNA 2 stated on 10/21/24 at 6:30 in the morning, she saw Resident 1 walking in the hallway with discoloration to her left eye. CNA 2 stated while changing Resident 1 with CNA 3, they noticed discoloration to bilateral upper extremities extending from wrist all the way up below the elbow. CNA 2 stated Resident 1's discoloration to left and right eye, discoloration to her bilateral upper extremities found on 10/21/24 were not there on 10/20/24. CNA 2 stated Resident 1's discoloration to her left eye looked like someone punched her in the eye and the discoloration on bilateral upper extremities could be caused from being held too tight or pressing on her like in a forceful way. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/30/24 at 11:48 a.m. with LVN 1, LVN 1 stated on 10/21/24 a full body assessment on Resident 1 was completed. LVN 1 stated Resident 1 had left and right eye discoloration and discoloration to bilateral upper extremities. LVN 1 stated the discoloration on both upper extremities would not have been caused by bumping into something. LVN 1 stated Resident 1's left and right eye discoloration and discoloration to her bilateral upper extremities found on 10/21/24, were not there on 10/20/24. LVN 1 stated Resident 1 was transferred to the acute hospital for further evaluation. During an interview on 10/30/24 at 12:01 p.m. with CNA 3, CNA 3 stated on 10/21/24, during breakfast, he noticed Resident 1's left eye and right with red discoloration. CNA 3 stated while changing Resident 1 with CNA 2, they noticed discoloration to bilateral upper extremities. CNA 3 stated, Really bad discoloration, like purple from wrist to below elbow. CNA 3 stated while combing Resident 1's hair, he noticed bald spot in the back of her (Resident 1) head that had not been there before. During a review of Resident 1's Emergency Documentation (ED-acute hospital), dated 10/21/24 at 9:12 p.m. the ED indicated Resident 1 had left periorbital (tissues around the eye) ecchymosis (bruise, discoloration) and bilateral forearm bruising. 2. During an interview on 10/30/24 at 10:20 a.m. with DON, DON stated on 10/24/24, Resident 3 sent her a text message alleging LVN 3 of calling Resident 3 names including drug addict. During a review of Resident 3's Admission Record (AR), dated 10/31/24, the AR indicated Resident 3's diagnoses included Schizoaffective disorder (a mental health condition with symptoms including hallucination [false perception of an object or event that involves one of the senses, such as sight, sound, smell, touch or taste] and mania [period of extreme mood swings, high energy]) Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). The admission MDS dated [DATE], indicated under BIMS a score of 15 (cognitively intact). During a concurrent observation and interview on 10/30/24 at 10:53 a.m. with Resident 4, Resident 4 was in his room sitting in a wheelchair. Resident 4 stated on 10/24/24, he was headed to the day room to watch Thursday night football with Resident 3 when LVN 3 went behind Resident 3, started pulling on his wheelchair, and telling Resident 3 he was not allowed to go into the day room. Resident 4 stated Resident 3 became upset at LVN 3. Resident 4 stated LVN 3 was doing most of the yelling calling Resident 3 a drug addict, pill seeker. During a review of Resident 4 quarterly MDS dated [DATE], the MDS indicated under BIMS a score of 15 (cognitively intact). During a concurrent observation and interview on 10/30/24 at 11:03 a.m. with Resident 3, Resident 3 was in the activity room, sitting in a wheelchair. Resident 3 stated on 10/24/24, he was entering the day room to watch Thursday night football with Resident 4 when LVN 3 told him he was not allowed to go in the day room. Resident 3 stated LVN 3 then began calling him a drug addict, pill seeker, just calling me names. Resident 3 stated he felt angry and frustrated. Resident 3 stated, I ' m here to get better, I ' m not here to be called names. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 10/30/24 at 4:25 p.m. with LVN 4, LVN 4 stated she was at the nurse station when she saw LVN 3 grabbed Resident 3 ' s wheelchair away from the day room, saying he was not allowed to go in the day room. LVN 4 stated she heard LVN 3 calling Resident 3 a drug addict, a pill seeker. LVN 4 stated calling Resident 3 names was not appropriate and should not be done. During an interview on 10/31/24 at 9 a.m. with Director of Staff Development (DSD), DSD stated calling resident names including drug addict, pill seeker is not appropriate and a form of verbal abuse. During a review of the facility IR dated 10/28/24, the IR indicated, At approx. [sic] 20:26 (8:26 p.m.) (Resident 3) made an allegation .that she (LVN 3) .pulled me away from the day room, calling me a drug addict. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, the P&P indicated, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not acquired to treat the resident's symptoms. The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation, or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff;