

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>056261                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                             | (X3) DATE SURVEY<br>COMPLETED<br><br>11/24/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Orchards at Tulare                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>604 E. Merritt Ave.<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when:1. A glucometer (used to take residents blood sugar) was not sanitized after use for one of three sampled residents (Resident 1);2. Personal Protective Equipment (PPE-gown, gloves, mask, eye protection) was not worn when entering a droplet precaution (used to prevent the spread of germs transmitted through large respiratory droplets from coughing, sneezing, or talking) isolation room.These failures had the potential for spread and risk of infections to residents, visitors, and staff.Findings:1. During a concurrent observation and interview, on 11/24/25 at 12:22 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 1's room, LVN 1 placed a glucometer test strip in the glucometer, cleaned Resident 1's finger with alcohol, poked Resident 1's finger with the lancet (small, disposable, sterile needle used to prick the skin), placed a drop of blood on the test strip, reviewed the result, removed the test strip from the glucometer and placed the glucometer back in the medication cart. The glucometer was not sanitized prior to placing it in the medication cart. LVN 1 stated she forgot to sanitize the glucometer, and it should have been done after using the glucometer.During an interview on 11/24/25 at 1:53 p.m. with Infection Preventionist (IP), IP stated the glucometers were to be sanitized after each use.During a review of the facility's policy and procedure (P&amp;P) titled Glucometer Disinfection dated 2025, the P&amp;P indicated The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use.2. During a concurrent observation and interview on 11/24/25 at 12:49 p.m. outside Resident 2's door, there was a sign on the door that indicated Droplet Precautions. Certified Nursing Assistant (CNA) 2 entered the room and picked up a food tray without putting PPE on. CNA 2 stated he was unaware of the type of precautions required when entering Resident 2's room.During an interview on 11/24/25 at 12:50 p.m. with Director of Staff Development (DSD), DSD stated Resident 2 was in droplet precautions and the staff should be wearing PPE when entering the room.During an interview on 11/24/25 at 12:54 p.m. with CNA 2, CNA 2 stated when he entered Resident 2's room, he should have had full PPE on including an N95 (a type of respirator that filters at least 95% of air particles), gown, gloves and eye protection.During an interview on 11/24/25 at 1:53 p.m. with IP, IP stated Resident 2 was on droplet precautions and when staff entered the room, they should be wearing a N95, gown, gloves and eye protection.During a review of the facility policy and procedure (P&amp;P) titled, Transmission-Based (Isolation) Precautions dated 2025, the P&amp;P indicated, Droplet Precautions.Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.Based upon the pathogen or clinical syndrome, if there is a risk of exposure of mucous membranes or substantial spraying or respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn.</p> |                                                                                      |                                                 |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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