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	06/29/2026

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. Based on interview and record review, the facility failed to ensure the physician was made aware of one of three sampled residents (Resident 4)'s request to be sent to the hospital. This failure resulted in Resident 4's rights being violated.Findings:During a review of the text messages between Licensed Vocational Nurse (LVN) 2 nurse and the physician, dated 5/18/26 at 9:52 p.m., the text message indicated, Patient (Resident 4's name) is 94% (oxygen) SAT (saturation) room air, he is complaining of vomiting but he barley [sic] threw up on my shift regular clear w (with) some food chunk he's just gagging a lot. He's saying his testicle hurt very bad and is having chest pain. He is stating he can't swallow pills right now because he throw the [sic] up. His VS (vital signs) when last checked were 152/80 (blood pressure-the force of blood pushing against the walls of your arteries as your heart pumps it though your body. Pulse 82 (heart rate).(Physician response).zofran (medication used to treat nausea) 4 mg (milligrams) TID (three times a day) PRN (as needed) x (times) 3 days.Is he still having chest pain?During a review of the text messages between LVN 2 and the physician, dated 5/18/26 at 10:11 p.m., the text message indicated, Hes [sic] just saying everything hurts now but we got the order for Zofran He's stating he can't swallow pills because he's gonna throw them up so he's denying it at thistime [sic].(Physician response.sublingual (administered under the tongue) Zofran?During a review of Resident 4's text messages between LVN 3 and the physician, dated 5/18/26 at 10:39 p.m., the text message indicated, Sending out pt (Resident 4) attempted all other methods requested to be sent out per pt request.During a review of Resident 4's Progress Notes (PN) (documented by LVN 2) dated 5/18/26 at 10:21 p.m., the PN indicated, Resident has been wanting to be sent out (to the hospital) since start of shift for pain and vomiting. Resident NOC (night) and AM (morning) nurse denied emesis (vomiting) being coffee ground like and stated he barley [sic] threw up. During my shift he barley [sic] had any throw up in his bag during the whole 8 hours. Resident is having pain to his testicle area which is very swollen, but due to his liver failure no pain medications have been prescribed. Notified (physician) of this and he ordered zofran sublingual due to resident stating that he can swallow pills or he will throw them up. Resident is now stating his chest is hurting MD notified as well. Resident VS are 158/80 P (pulse) 82 at SAT 94% room air resident already has a PRN for 3L (liters) of oxygen as needed.During a review of Resident 4's PN (documented by LVN 3) dated 5/18/26 at 10:42 p.m., the PN indicated, Upon arrival to shift, resident stating being unable to breath and having chest pain checked O2 (oxygen) levels resident was at 97% on room air, at approx 10:43 p.m. resident had emesis x (times) 1 but is refusing zofran states not wanting to throw up again and requesting to besent (be sent) out MD (Doctor of medicine) notified RP (responsible party) notified. Attempted to get order for nitroglycerin (medication used to treat chest pain) for chest pain resident is stating not wanting and wanting to be sent out of facility. ADON (Assistant Director of Nursing) notified and approved send out.During an interview on 6/4/26 at 3 p.m. with LVN 2, LVN 2 stated she was assigned to Resident 4 on 5/18/26, LVN 2 stated during the shift Resident 4 was complaining of pain and was requesting to be sent to the hospital. LVN 2 stated she did not notify the physician of Resident 4's request to be sent to the hospital and she should have. LVN 2 stated Resident 4 was sent to the hospital by the next shift. During an interview on 6/4/26 at 3:34 p.m. with (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON), DON stated when Resident 4 was requesting to go to the hospital at the beginning of the shift, the physician should have been notified right away.During an interview on 6/4/26 at 4:07 p.m. with Resident 4, Resident 4 stated on 5/19/26 he was feeling miserable and experiencing chest pain and vomiting. Resident 4 stated it took about 12 hours for the facility to send him to the hospital after he requested to be sent.During a review of the facility's policy and procedure (P&P) titled, Resident Rights undated, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.be informed of, and participate in, his or her care planning and treatment.choose an attending physician and participate in decision-making regarding his or her care.

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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 physician orders were followed for one of three sampled residents (Resident 4) when eye drops were not initiated. This failure had the potential for Resident 4 to experience discomfort.Findings:During a review of Resident 4's Ophthalmology Notes (ON) dated 11/24/25, the ON indicated, Care Plan.Add Cosopt (eye drop medication used to lower eye pressure) bid (twice a day) OU (both eyes) for comfort.During a concurrent interview and record review on 6/25/26 at 10:49 a.m. with Director of Nursing (DON), DON reviewed Resident 4's clinical record. DON stated the Cosopt eye drops were never implemented for Resident 4.During a review of the facility's policy and procedure (P&P) titled Consulting Physician/Practitioner Orders dated 5/20/26, the P&P indicated, Consulting physician/practitioner orders are those orders provided to the facility by a physician/practitioner other than the resident's attending physician.who is acting on behalf of the attending physician. A consulting physician/practitioner may include, but is not limited to, a resident's.specialist such as.ophthalmologist.for consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will.call the attending physician to verify the order.document the verification order by entering the order and the time, date.follow facility procedures for verbal or telephone orders including.noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure supervision was provided when 15 minutes checks were not completed for one of three sampled residents (Resident 1) with a history of elopement. This failure resulted in Resident 1 eloping through his bedroom window, found approximately two blocks away and potential for harm.Findings:During a review of Resident 1's admission Record (AR) undated, the AR indicated Resident 1 was a [AGE] year-old male with diagnoses that included unspecified dementia (a decline in mental abilities severe enough to interfere with memory, thinking, language, reasoning and behavior), severe, with mood disturbance.major depressive disorder.anxiety disorder.During a review of Resident 1's Elopement Evaluation (EE) dated 2/13/26, the EE indicated, Does the resident have a history of or attempted leaving the facility without informing staff.yes.Has the resident verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door.yes.Does the resident wander.yes.Is the wandering behavior a pattern, goal-directed.yes.During a review of Resident 1's Cognitive Patterns (CG) dated 4/15/26, the CG indicated, BIMS (Brief Interview for Mental Status) Summary Score 00 (indicating severe cognitive impairment) .During a review of the document titled List of Resident's on Q Monitor Checks (LRQMC) dated 4/27/26, the LRQMC indicated, (Resident 1 and room number) Q (every) 15 mins checks for elopement.During a review of Resident 1's Change in Condition (COC) dated 5/29/26 at 8:36 a.m., the COC indicated, Elopement.5/29/26.Review & Notify.Writer came back from lunch approx. (approximately) 2:34 a.m. Around 2:40 a.m. CNA (Certified Nursing Assistant) notified writer that resident was missing and his room's window screen was broken or cut. Immediate search of facility and surrounding grounds initiated per DON (Director of Nursing) made (aware) approx. 2:50 a.m., ADON (Assistant Director of Nursing) made aware, MD (Doctor of Medicine) made aware.Tulare Police department made aware.Resident came back to facility approx. 5:30 a.m. Head to toe assessment done, no physical injuries noted.During a review of Resident 1's Progress Notes (PN) dated 6/1/26 at 7:25 a.m., the PN indicated, Nurse came back from lunch approx. 2:34 a.m. Around 2:40 a.m. CNA notified nurse that resident was missing and his room's window screen was cut open. Immediate search of facility and surrounding grounds initiated, resident was not in facility or on facility grounds. Per CNA's monitoring resident was last visualized at approximately 2:00 a.m., and at the time CNA had gone to relieve a sitter in the hall for their lunch. Tulare PD (police department) was contacted and was located and returned to facility at approximately 5:30 a.m.Root cause.Resident is on monitoring for exit-seeking behaviors and wandering. Resident does wear a wander guard and has a history of prior elopement attempts. Nurses do door alarm checks Q (every) shift to ensure all doors are locked and armed for our dementia and elopement risks residents. Resident however did not utilize a door during his elopement. Resident is believed to have eloped through his bedroom window as evidenced by the screen in the window beingcut [sic] out, at this time making his wander guard ineffective as resident did not elope through the facility's doors.During a review of Resident 1's Noc (night) Q 15 min monitoring check (NQMMC) dated 5/28/26 (includes 5/29/26), the NQMMC indicated, Time. (5/29/26) 2:15 a.m.-5:15 a.m. (three hours) were blank (indicating no monitoring was completed).During a review of Resident 1's PN dated 5/29/26 at 6:02 a.m., the PN indicated, Received a call from Tulare PD approx. 5:25 a.m., that they found resident. Resident came back to facility approx . 5:30 a.m.During an interview on 6/4/26 at 1:30 p.m. with DON, DON stated on 5/29/26 at the time of the elopement, Resident 1 was on Q15 minute checks due to being an elopement risk. DON stated CNA 1 was assigned to Resident 1 and was responsible for the Q 15 minute checks. DON stated CNA 1 checked on Resident 1 at 2 a.m. and then relieved another staff for lunch. DON stated when CNA 1 returned she checked on Resident 1 between 2:30-2:45 a.m. (approximately 30-45 minutes later) and Resident 1 was not in his bed. DON stated when CNA 2 went to relieve staff for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lunch she should have passed on the Q 15 minute checks to CNA 1 and she did not do that.During an interview on 6/17/26 at 1:29 p.m. with CNA 2, CNA 2 stated on 5/29/26 she was hall partners with CNA 1. CNA 2 stated CNA 1 went to lunch at 1:30 a.m. and she (CNA 2) was responsible to do Q 15 minute checks on Resident 1. CNA 2 stated she last seen Resident 1 at approximately 1:41 a.m. and when CNA 1 returned from her lunch at 2 a.m. she (CNA 2) went to relieve other staff for lunch breaks. CNA 1 stated there was a form that was completed when the 15 minute checks were done and she last documented at 1:45 a.m.During an interview on 6/24/26 at 4:15 p.m. with CNA 1, CNA 1 stated on 5/29/26 she was assigned to Resident 1 at the time of the elopement. CNA 1 stated she went to lunch at 1:30 a.m. and returned at 2 a.m. she checked on Resident 1 and then relieved another staff for their lunch break. CNA 1 stated she returned at approximately 2:30 a.m. and when she checked on Resident 1 she realized he wasn't in bed and the bathroom door was open. CNA 1 stated when she got closer to the window, she could see the screen was broken. CNA 1 stated she notified the nurse and went to search for Resident 1 but he was not on the facility grounds. CNA 1 stated when she relieved staff for lunch she should have given the Q 15 minute form to CNA 2 so she knew she was responsible for the Q 15 minute checks.During a concurrent interview and record review on 6/24/26 at 4:40 p.m. with DON, Resident 1's Care Plan was reviewed, the CP indicated, Resident is a high elopement risk and is a wanderer that is currently being monitored for exit seeking behaviors.date initiated 2/9/26.Goal.resident will be free from injury while monitoring for elopement is in place through review date.Interventions.Monitor resident q30 minutes for elopement and exit seeking behaviors.Date initiated.2/9/26. DON stated the care plan was incorrect and should have indicated Q15 minute monitoring.During a review of the facility's policy and procedure (P&P) titled Wandering and Elopement undated, the P&P indicated, If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.During a review of the facility's policy and procedure (P&P) titled, Accidents and Supervision undated, the P&P indicated, Each resident will receive adequate supervision.this includes.identifying hazard(s) and risk(s).implementing interventions to reduce hazard(s) and risk(s).Implementation of interventions-using specific interventions to try to reduce a resident's risks form hazards in the environment. The process includes.communicating the interventions to all relevant staff.assigning responsibility.documenting interventions.ensuring the interventions are put into action.supervision.supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision.defined by type and frequency.based on the individual resident's assessed needs and identified hazards in the resident environment.