

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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024
NAME OF PROVIDER OR SUPPLIER The Orchards Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 730 34 Street Bakersfield, CA 93301	
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 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. 39763 Based on interview and record review, the facility failed to ensure professional standards were followed when: 1. Medications were not administered according to physician's order for one of three sampled residents (Resident 2). This failure had the potential for Resident 2's infection (invasion and growth of germs in the body) to worsen. 2. Treatment orders were not administered according to physician's orders for one of three sampled residents (Resident 3). This failure had the potential for Resident 3's wounds to worsen. Findings: 1. During a concurrent interview and record review on 11/12/24 at 12:59 p.m. with Director of Nursing (DON). Resident 2's IV (Intravenous- administration of fluids, medications or nutrients directly into a vein) Medication Administration Record, (IVMAR) dated October 2024 was reviewed. The IVMAR indicated the following: Cefazolin (medication use to treat infection) .2 GM (gram - unit of measure) . Use 1 application intravenously every 8 hours for osteomyelitis (infection in the bone) to the foot for 6 Weeks -Start Date- 09/30/2024 2100 (9 p.m.) The IV MAR indicated, on 10/8/24 for the 5 a.m. administration time, no documentation Resident 2's cefazolin was administered (blank). DON confirmed Resident 2's cefazolin on 10/8/24 at 5 a.m. was not documented as administered (blank). (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Administering Medications, revised April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initials and circle the MAR space provided for that drug dose. 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; . g. The signature and title of the person administering the drug. 2. During a concurrent interview and record review on 11/12/24 at 12:59 p.m. with Director of Nursing (DON). Resident 3's TAR, dated October 2024, the TAR indicated the following: Cleanse Keloid to the tip of the penis with NS (normal saline-salt water solution), pat dry, apply zinc oxide (a medicated cream, ointment or paste that treats or prevents skin irritation like cuts, burns or diaper rash) 1% (percent) every day shift for wound healing -Start Date- 05/25/2024 0600 (6 a.m.) -D/C (discontinued) Date- 11/14/2024 1906 (7:06 p.m.) The TAR indicated, on 10/17/24 for the 6 a.m. administration time, no documentation Resident 3's treatment was administered (blank). The TAR indicated, on 10/25/24 for the 6 a.m. administration time, no documentation Resident 3's treatment was administered (blank). Cleanse moisture associated skin damage MASD to the buttocks with NS, pat dry, apply Triad cream (a sterile coating that can be used on broken skin, adhere to wet skin, keeping the wound covered and protected from incontinence) cover with dry dressing after each incontinent care. Monitor and assess during treatment for any worsening, s/sx (signs and symptoms) of infection, skin breakdown, or if treatment is ineffective and call MD (medical doctor). every day shift -Start Date- 07/18/2024 0600 -D/C Date 11/14/2024 1905 (7:05 p.m.) The TAR indicated, on 10/17/24 for the 6 a.m. administration time, no documentation Resident 3's treatment was administered (blank). The TAR indicated, on 10/25/24 for the 6 a.m. administration time, no documentation Resident 3's treatment was administered (blank). Cleanse suprapubic catheter site with NS, then pat dry, apply dry dressing QD and PRN every day shift -Start Date- 05/29/2024 0600 -D/C Date 11/14/2024 1907 The TAR indicated, on 10/17/24 for the 6 a.m. administration time, no documentation Resident 3's treatment was administered (blank). The TAR indicated, on 10/25/24 for the 6 a.m. administration time, no documentation Resident 3's treatment was administered (blank). DON confirmed Resident 3's treatments were not documented as administered on 10/17/24 and 10/25/24 (blank). (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Wound Care, revised October 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data.		

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F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39763 Based on interview and record review, the facility failed follow their policy and procedure (P&P) titled, Enteral Feedings (a method of delivering nutrients and fluids to the body for patients who cannot safely chew or swallow) - Safety Precautions, for one of three sampled residents (Resident 1) who was on gastrostomy tube (G- tube- a tube which delivers liquid, nutrition, and medications through a flexible tube that goes directly into the stomach) feeding when G-tube placement was not checked, gastric residual volume (measures the amount of fluid or contents remaining in the stomach after feeding) was not checked, and signs and symptoms of complications were not reported timely to the physician. These failures resulted in Resident 1 being transferred to the acute hospital and being diagnosed with aspiration pneumonia (a lung infection that occurs when something other than air, like food, liquid, saliva, or vomit, is inhaled into the lungs). Findings: During a review of Resident 1's Admission Record, (AR) the AR indicated, Resident 1 was admitted on [DATE], with diagnoses including acute (symptoms or signs that begin and worsen quickly) and chronic (continuing or occurring again and again for a long time)respiratory failure (a serious lung condition which makes it difficult to breathe on your own) with hypoxia (a medical condition that occurs when there's not enough oxygen in the body's tissues), paraplegia (paralysis of the legs and lower body, typically caused by spinal cord [part of the body that connects the brain and the body]injury or disease) dysphagia (swallowing problems occurring in the mouth and/or the throat), disorders of diaphragm (diaphragm- is a muscular barrier between the chest and the abdominal cavity; disorders of the diaphragm often interfere with breathing), and gastrostomy status (the presence of a surgical opening into the stomach). During a review of Resident 1's quarterly Minimum Data Set, (MDS- an assessment tool) dated 10/8/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status- test to evaluate cognitive [how well a person thinks, remembers, and learns] function) score was 12 (a score of 8 to 12 indicates moderately impaired cognition). During a review of Resident 1's Order Summary Report, (OSR- physicians' orders) undated, indicated, continuous feeding via G- tube Glucerna 1.2 (specialized source of nutrition) 90 ml (millimeter- unit of measure) x (times) 20 hours. Enteral Feed (G- tube feeding- delivers liquid nutrition through a flexible tube that goes directly into your stomach) Order every shift Enteral: Assess for any s/sx (signs and symptoms) of aspiration (when food or drink are breathed into the lungs). crackles (abnormal breath sounds that occur when fluid builds up in the airways of the lungs) in lungs, . SOB (shortness of breath) regurgitation (vomiting), drooling (excess saliva flows out of the mouth involuntarily), wheezing (a high-pitched whistling sound that occurs when breathing due to narrowed or obstructed airways, noisy breathing QS (every shift) and notify MD (Medical Doctor)- Start Date- 07/09/2024 0600 (6 a.m.) and Enteral Feed Order every shift Enteral: Assess for formula intolerance QS- NV (nausea [uneasiness in the stomach] and vomiting), . and notify MD if any- Start Date- 07/09/2024 0600 . (continued on next page)		

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F 0693 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's SBAR, (situation, background, appearance, and review- a communication form) dated 10/25/24 documented by Licensed Vocational Nurse (LVN) 2, the SBAR indicated, Upon on coming [sic] of my shift (LVN 2 shift started at 6 p.m. on 10/25/24) the (Resident 1) had noted N/V (nausea and vomiting), looked pale and had a noted wheeze (a high-pitched whistling sound that occurs when the airways in the lungs become blocked, making it difficult to breathe) .later (between 7 p.m. and 8 p.m.) due meds (medications) were given (via G-tube) without A/R (adverse result- negative or harmful results). During rounding per shift change (10:30 p.m.) for the CNA'S (certified nursing assistant) the (Resident 1) was found Diaphoretic (excessive sweating due to a secondary condition), labored breathing (increase in effort to breathing) with noted crackles while sitting in high fowlers position (seated upright) and on 2L (liters- unit of measure) O2 (oxygen) via NC (nasal cannula- thin plastic tube placed in nostrils to deliver oxygen). The (Resident 1) looked cyanotic (having a bluish or purplish discoloration of the skin or mucous membranes (moist tissues that line the inside of your mouth and nose) due to low oxygen levels in the blood).Blood sugar was assessed and recorded at 151 mg/dl (milliliter per deciliter- unit of measure [normal blood sugar between 70-100]) O2 sat (saturation-oxygen absorb in blood) @ (at) 88 (percent [unit of measure] a normal oxygen saturation level is between 95 percent and 100 percent). (Resident 1's physician) notified at 10:47 (10:47 p.m.), order given to send out (to the acute hospital). (Ambulance) arrived at 10:58 [sic] (10:58 p.m.). During an interview on 11/24/24 at 1:22 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 10/25/24 (10:30 p.m. to 6 a.m.) she was assigned to Resident 1. CNA 1 stated she checked Resident 1 at approximately 10:30 p.m. CNA 1 touched Resident 1 and noticed he was damp and sweaty. Resident 1 did not verbally respond when she greeted him. CNA 1 stated Resident 1 moaned which was unlike him. CNA 1 stated Licensed Vocational Nurse (LVN) 2 and Registered Nurse (RN) were notified of Resident 1's condition (damp and sweaty) and LVN 2 and RN came into the room with a crash cart (a cart stocked with emergency supplies, used for cardiac [relating to the heart] and respiratory [made up of your lungs, airways, throat, nose, and mouth] emergencies).CNA 1 stated Resident 1 was sent out (acute hospital) via ambulance at approximately 11 p.m. (10/25/24). During an interview on 11/26/24 at 10:03 a.m. with LVN 2, LVN 2 stated on 10/25/24 she came to work at 6 p. m. and noted Resident 1 was vomiting and wheezing. She stated she waited 45 minutes and administered Resident 1's due medications via G- tube at approximately 6:45 p.m. LVN 2 stated Resident 1 had vomited several times from 6 p.m. to 10:30 p.m. and she stopped the G- tube feeding (no time given), Every time I tried to connect (Resident 1) to his feeding tube (Resident 1) would vomit to the point of projectile vomiting (a type of severe vomiting that involves the forceful expulsion of stomach contents). LVN 2 stated, As soon as the CNA would get him cleaned up (Resident 1) would vomit again. LVN 2 stated she did not immediately report Resident 1's vomiting and wheezing to the MD on 10/25/24 at 6 p.m. LVN 2 stated, I felt it was necessary to get (Resident 1) out to the hospital. During a concurrent interview and record review on 12/11/24 at 3:30 p.m. with Director of Nursing (DON), Resident 1's SBAR dated 10/25/24 was reviewed. DON stated LVN 2 noted Resident 1 had vomiting and wheezing episodes at between 6 p.m. and 6:30 p.m. DON confirmed the MD was not notified until 10:47 p.m. (approximately 4 hours and 30 minutes after the first episode of vomiting was noted). Resident 1's medical record was reviewed. DON confirmed no documentation the G- tube placement and/or residuals were checked prior to LVN 2 administration of medication to Resident 1 at 8 p.m. (10/25/24). DON stated the MD should have been notified immediately (after the first episode of vomiting and wheezing were noted between 6:15 p.m. to 6:30 p.m.). (continued on next page)		

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F 0693 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Pre-hospital Care Report, (PCR- paramedic's documentation) dated 10/25/24 the PCR indicated dispatch was notified at 11:01 p.m., the unit arrived at the facility at 11:06 p.m., and arrived at the hospital at 11:25 p.m. The PCR indicated, (Resident 1) is presenting with respiratory distress (difficulty breathing, rapid breathing, and low blood oxygen levels). Staff stated patient had been in the current condition for close to thirty minutes into her shift (6:30 p.m.). Staff stated that the earlier shift had reported (Resident 1) was presenting in the same condition . (Resident 1) has rhonchi (a low-pitched, loud, continuous lung sounds that resemble snoring or gurgling (growing); usually means a blockage or an increased mucus in the airways) on all pulmonary (lungs) fields. (Resident 1) has partial airway obstruction (blockage) due to phlegm (thick mucus produced by the lungs) build up. (Resident 1) has an increased respiratory rate and effort . (Resident 1) has cool, moist, and pale skin signs. During a review of Resident 1's ED (emergency department) Physician Note, (EDPN) dated 10/25/24 at 11:38 p.m. the EDPN indicated, Medical Decision Making . have ordered Rocephin (medications used to treat bacterial infections- no route indicated) and clindamycin (medications used to treat bacterial infections) to cover aspiration pneumonia . (Resident 1) chest x-ray (generate images of tissues and structures inside the body) shows elevation of right hemi (half) diaphragm (is the major muscle of respiration, located below the lungs) is along with what I suspect are infiltrates (a substance that is denser than air and is present in the lung tissue, such as fluid) in the right lung.This chest x-ray was interpreted by myself (ED physician). During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings-Safety Precautions, November 2018, the P&P indicated, To ensure the safe administration of enteral nutrition.Preventing aspiration 1. Check enteral tube placement prior to feeding or administration of medication. 2. Check gastric residual volume as ordered. 4. Monitor the resident for signs and symptoms of respiratory distress during enteral feedings and medication administration. Recognizing and reporting other complications 1. g. Nausea; . i. c. Difficulty breathing. Documentation Document all assessments, findings, and interventions in the medical record. Reporting Report unusual findings and/or signs of complications to the Physician.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 39763 Based on interview and record review, the facility failed to ensure two of three sampled staff members (Licensed Vocational Nurse [LVN] 2 and Certified Nursing Assistant [CNA] 2) were competent in caring for residents with gastrostomy tubes (G- tube- the presence of a surgical opening into the stomach to provide fluids, nutrition, and medications). This failure had the potential to negatively affect the residents' well -being related to the lack of staff competence in providing the necessary care and services. Findings: During a concurrent interview and record review on 12/11/24 at 4:01 p.m. with Director of Staff Development (DSD) and Director of Nursing (DON), Licensed Vocational Nurse (LVN) 2 and Certified Nursing Assistant (CNA) 2's employee files were reviewed. DSD confirmed LVN 2 did not have competencies for caring residents with G- tubes (checking G-tube placement, checking gastric residual volume [the amount of fluid in the stomach after feeding] monitoring for signs and symptoms of respiratory distress [a condition where the body needs more oxygen], recognizing complications, reporting complications to the physician) and CNA 2 did not have competencies for caring residents with G-tube (resident positioning and how care is provided during feedings). DSD stated competencies were important to ensure the staff have the knowledge to care for the residents assigned to them. DSD stated competencies were also an opportunity to correct and educate staff on resident care. During a review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, revised May 2019, the P&P indicated, 1. All nursing staff must meet the specific competency requirement of their respective licensure and certification requirements defined by state law. 2. In addition, licensed nurse and nursing assistants employed (or contracted) by the facility will: a. participate in a facility-specific, competency-based staff development and training program; and b. demonstrate specific competencies and skill sets deemed necessary to care for the needs of the residents, as identified through resident assessments and described in the plans of care. 1. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents. 3. The facility assessment includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population. 4. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: . d. carrying out of physician's orders; e. person centered care; f. communication; g. basic nursing skills; . m. identification of change in condition . 5. Training and competency evaluations include elements of critical thinking and processes necessary to identify and report resident change of condition. The type and amount of this training is based on the facility assessment and specific to the different skill levels and licensure of staff. For example, CNAs are trained for and evaluated on competency in identifying and reporting resident change of condition to LPN or RN, while LPNs or RNs are trained for and evaluated on managing and reporting pertinent findings to the provider. 6. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment.		