STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555702	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards Post-Acute	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 0689 Level of Harm - 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 observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1) safety when:1. Physician's order (any time the doctor writes or gives verbal instruction for nursing staff to follow) for bilateral landing mats (high-density foam cushions placed beside beds to reduce injury from falls) was not followed for one of three sampled residents (Resident 1).2. Care plan (CP- a comprehensive, personalized document that outlines the specific needs of an individual requiring care, detailing the type of support, how it will be provided, and the goals of the care) for bilateral landing mats was not implemented for one of three sampled residents (Resident 1).3. Care plan was not updated and implemented to reflect two-persons assistance during toileting hygiene (the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement) while on a low air loss mattress (LAL- specialized medical surfaces designed to prevent and treat pressure injuries [localized damage to the skin and underlying soft tissue, typically over a bony prominence, caused by prolonged pressure, friction, or shear, frequently affecting immobile individuals] by utilizing a constant flow of air through tiny holes in the mattress cover to manage skin moisture and reduce heat) for one of three sampled resident (Resident 1).These failures resulted in Resident 1 sustaining a fall, suffering a laceration (tear or break in the skin caused by blunt trauma or a sharp object) to the back of his head, which resulted in Resident 1 being sent to the acute hospital where he was admitted for three days and was diagnosed with a subarachnoid hemorrhage (bleeding into the space surrounding the brain, usually caused by head trauma from falls and accidents). Findings:During a review of Resident 1's admission Record, (AR) the AR indicated Resident 1 was admitted on [DATE], with diagnoses including traumatic hemorrhage (condition where bleeding occurs inside the brain or skull due to head trauma, such as falls, accidents, or assaults) of cerebrum (the largest, uppermost part of the brain, responsible for high-level functions like thought, memory, emotion, language, and sensory processing), dementia (brain disorders causing memory loss and behavioral changes that interfere with daily life), bipolar disorder (a chronic mental health condition characterized by extreme mood swings, alternating between intense highs and lows), chronic pain (pain that lasts for over three months), contractures (a permanent, often painful stiffening and shortening of muscles, tendons [thick tissue that connect muscle to bone], or skin, causing joint deformity and limited range of motion (ROM- how the body moves), and abnormal posture (a severe, uncontrolled stiffening of the body or positioning of the body such as arched backs, clenched fists, or stretched out and stiff arms and legs).During a review of Resident 1's Minimum Data Set, (MDS - an assessment tool) dated 11/24/25, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status- standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember) score was 99 (score 99 indicates the resident was unable to complete the interview). The MDS indicated Resident 1 had short and long-term memory problems. The MDS indicated Resident 1 had impairments of both lower extremities (hips, knees, ankles, and feet). Resident 1 was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required to complete the activity) for toileting (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 0689 Level of Harm - Actual harm Residents Affected - Few	hygiene and with roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed).During a review of Resident 1's SBAR (Situation, Background, Assessment, & Recommendation- communication form used in healthcare) & Initial COC (Change of Condition)/Alert Charting & Skilled Documentation, (SBAR/COC) dated 1/25/26, the SBAR/COC indicated Resident 1 had a witnessed fall with laceration (cut/no measurement noted) to the back of head, on 1/25/26 at approximately 9:50 p.m. The SBAR/COC indicated, Other pertinent data: LAL mattress is present which was fully inflated. No fall matts [sic] present. (Resident 1) was lying on his back next to his bed. Blood was dripping back of his head . CNA (certified nursing assistant 2) was standing to left side of bed, CNA turned the (Resident 1) to his right side. The (Resident 1's) lower extremities shifted toward the edge of the bed to the right side, when CNA was walking to right of bed to put his legs back to bed, meantime he fell from bed.During a review of Resident 1's Physicians Orders, (PO) dated 1/25/26, the PO indicated, May Transfer To Acute Hospital For Further Evaluation And Treatment . for s/p (status post-after) fall with injury .During a review of Resident 1's acute hospital Computerized Tomography (a rapid, non-invasive imaging procedure that combines specialized X-rays with computer software to create detailed, cross-sectional images of body tissues, organs, and bones), (CT) dated 1/25/2026, the CT indicated, Indications: head injury . Findings: . Trace subarachnoid hemorrhage within the sulci (groove) of the right frontal (area of the brain located behind the forehead) and, to a lesser degree, parietal lobes (a major brain area of the brain located behind the frontal lobe)During a review of Resident 1's admission Nursing Assessment, (facility ANA-readmission from the acute hospital) dated 1/29/26, the ANA indicated, Reason for admission: Traumatic subarachnoid hemorrhage . Relevant History/Dx (diagnosis): s/p (status post) fall.1. During a review of Resident 1's Physicians Orders, dated 7/13/2020, the PO indicated, May have Bilateral landing mats to sides of bed. LN (licensed nurse) to check placement Q (every) shift every day and night shift.During an observation on 2/11/26 at 11:17 a.m. in Resident 1's room. Resident 1 was observed lying in a regular bed and no bilateral landing mats were noted at bedside.During a concurrent interview and record review on 2/11/26 at 12:47 p.m. with Director of Nursing (DON), Resident 1's physicians order was reviewed and indicated, May have Bilateral landing mats to sides of bed ordered on 7/13/20. Resident 1's Treatment Administration Record, (TAR) and Medication Administration Record, (MAR) for January 2026 were reviewed. DON stated no documentation LN checked for Resident 1's landing mat placement every shift. DON stated the bilateral landing mats were not in place at the time of Resident 1's fall on 1/25/26 and the PO was not followed.During an interview on 3/11/26 at 10:15 a.m. with CNA 2, CNA 2 stated on 1/25/26 at approximately 9:30 p.m. she was providing toileting care for Resident 1. CNA 2 stated Resident 1 fell out of bed and hit his head. CNA 2 stated there were no bilateral landing mats at bedside when Resident 1 fell (1/25/26) and she does not know if Resident 2 hit his head on the floor or cabinet.On 2/27/26, 3/12/26, 4/9/26, and 4/10/26, requests were sent to the facility for its policy and procedure regarding the implementation of physicians' orders. On 4/10/26 at 12:01 p.m., the DON replied via email, stating that the facility does not maintain a policy or procedure specifically for following physicians' orders.2. During a review of Resident 1's care plan with the focus on (Resident 1) is at risk for Pressure Injury development, The care plan indicated, May have Bilateral landing mats to sides of bed, initiated 07/22/2021.During an observation on 2/11/26 at 11:17 a.m. in Resident 1's room. Resident 1 was observed lying in a regular bed and no bilateral landing mats were noted at bedside.During a concurrent observation and interview on 2/11/26 at 12:23 p.m. with DON in Resident 1's room. DON stated Resident 1 did not have bilateral landing mats at bedside. DON stated Resident 1 did not have bilateral landing mats when he fell (1/25/26) and the CP was not implemented. DON stated she did not know why the bilateral landing mats were indicated under the CP for Pressure Injury Development and not under the Fall CP.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised March 2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: . (3) which professional services are responsible for each element of care; .3. During a review of Resident 1's care plan with the focus on (Resident 1) is at risk for Pressure Injury development, initiated on 6/14/20. The care plan indicated Apply LAL mattress for wound management/preventive measures. (the CP did not indicate the need for two-persons assistance during ADL [activities of daily living - support provided to individuals struggling with basic, essential self-care tasks required for daily life, such as bathing, dressing, eating, toileting, and transferring] care).During a review of Resident 1's Physicians Orders, dated 3/8/24, the PO indicated, LAL mattress for wound management/preventive measures. Check placement, settings and functionality QS (every shift) every shift.During a review of Resident 1's Medication Administration Record, (MAR) for January 2026, the MAR indicated, LAL mattress for wound management/preventive measures. Check placement, settings and functionality QS (every shift) every shift -Start Date- 03/08/2024 1800 (6 pm). The LAL was documented as in place, functioning, and at the correct setting from January 1, 2026, to January 25, 2026 (date of fall 1/25/26).During a review of Resident 1's care plan with the focus on Presence of contracture on BUEs (bilateral upper extremities- arms and hands) Functional loss in ROM (range of motion- how the body moves) Episodes of striking out others H/o (history of) falls, initiated 9/2/19.During a review of Resident 1's care plan with the focus on (Resident 1) was observed to have Limited functional ROM (range of motion). Related to the following Diagnosis/conditions: Contractures on lower Extremities ., initiated 8/1/23.During an interview on 3/11/26 at 10:15 a.m. with CNA 2, CNA 2 stated when she received report at change of shift, she was told Resident 1 was a one-person assist and easy to manage. CNA 2 stated she had not worked with Resident 1 for some time. CNA 2 stated she worked a double shift on 1/25/26 and at approximately 9:30 p.m. she provided toileting care for Resident 1. CNA 2 stated, When I was rolling (Resident 1) was kind of middle of the bed, cleaning from the side, I was rolling up the dirty chux (absorbent under pad designed to protect bedding, furniture, and car seats from moisture) and placing the new one (chux) under him so when he was on the edge of the bed he began to tense up, his legs went up and he went off (the bed) legs first. CNA 2 stated she tried to get to the other side of the bed to move Resident 1's legs back onto the bed, but Resident 1 fell out of bed and hit his head but does not know if Resident 1 hit his head on the floor or cabinet.During an interview on 3/19/26 at 1:20 p.m. CNA 3 stated Resident 1 was a total dependent on ADL care. CNA 3 stated Resident 1 was always two-persons assistance because Resident 1 could not help with turning on toileting hygiene. CNA 3 stated residents on LAL mattress were always two-persons assistance.During an interview on 3/19/26 at 1:27 p.m. with the Director of Staff Development (DSD), DSD stated she educated the CNAs (no date given) to use two-persons assistance for residents on LAL mattresses, one person on each side of the bed. DSD stated the LAL mattress was too risky because it could move during care. DSD stated the CP should have been updated to indicate two-persons assistance and should have been implemented for Resident 1. DSD stated two-persons assistance for residents on LAL mattress had been the facility's practice before Resident 1 sustained a fall on 1/25/26.On 3/12/26, 4/9/26, and 4/10/26, requests were sent to the facility for its policy and procedure regarding care provided to dependent residents on LAL mattress On 4/10/26 at 12:01 p.m., the DON replied via email, stating that the facility does not maintain a policy or procedure specifically care provided to dependent residents on LAL mattress.During a review of the facility's P&P titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated, Our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risk and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes . 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	identify and report accident hazards, and try to prevent avoidable accidents. Individualized, Resident-Centered Approach to Safety. 1. Our individualized, resident-centered approach to safety address safety and accidents hazards for individual residents. 3. The care team shall target interventions to reduce individual risk related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accidents risks and hazards shall include the following: a. communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; c. Providing training, as necessary; d. Ensuring that interventions are implemented; and e. Documenting interventions. 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently; . Resident Risk and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in the dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety; b. Safe lifting and movement of residents; c. Falls .