

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

Printed: 08/27/2026
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 06/18/2026
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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure oral care was provided for one of three sampled residents (Resident 156). This failure resulted in Resident 156's lips to be dry and cracked. Findings: During a concurrent observation, interview, and record review, on 5/18/26 at 1:38 p.m. in Resident 156 room with Registered Nurse (RN) 1. Resident 156 was sitting up in bed with dry and cracked lips with brown crusty material at the corners of his lips. RN 1 stated Resident 156's lips were dry and chapped; RN1 stated the brown crusty material by the corners of his lips was possibly dry skin. RN 1 stated Resident 156 needed oral care. RN 1 stated residents that are NPO (nothing by mouth) and receiving tube feeding would need oral care and chap stick to keep their lips moist. During a review of Resident 156's Minimum Data Set [MDS - an assessment tool], dated 4/15/26, the MDS indicated, Resident 156's BIMS [Brief Interview for Mental Status - standardized assessment tool used to evaluate the mental processes that allow individuals to think, learn, and remember] was not conducted. The MDS indicated, (resident is rarely/never understood). The MDS indicated Resident 156 was dependent [helper does all the effort] for oral hygiene. During an interview on 5/22/26 at 10:05 a.m. with the Director of Staff Development (DSD), DSD stated certified nursing assistant (CNA) should check residents who are NPO and receive tube feeding every two hours while providing care and provided oral care as needed. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, the P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing dressing, grooming, and oral care). e. Total Dependence- Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident was unwilling or unable to perform any part of the activity over entire 7-day look-back period. 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals, and recognized standards of practice.		

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 0693 Level of Harm - Minimal harm or potential for 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. Based on observation, interview, and record review, the facility failed to ensure safe administration of enteral feeding [liquid nutrition delivered through a flexible tube directly into the stomach] when two of three sampled residents (Resident 127 and Resident 97) head of bed (HOB) was not positioned between 30-45 degree angle during administration of feeding. This failure had the potential to result in Resident 97 and Resident 127 to aspirate [accidental inhalation of liquids or stomach contents into the airway and lungs] and develop an infection. Findings: During an observation on 6/15/26 at 10:09 a.m. in Resident 97's room, Resident 97 was lying in bed with enteral tube feeding running and HOB was slightly elevated. During a concurrent observation and interview on 6/15/26 at 10:18 a.m. with Licensed Vocational Nurse (LVN) 4, in Resident 97's room, Resident 97 was lying in bed with enteral tube feeding running and HOB was slightly elevated. LVN 4 stated while the enteral tube feeding was running Resident 97's head of bed should have been elevated to a 45 degree angle to help prevent aspiration. LVN 4 stated she did not have anything to measure the angle of the bed. During a concurrent observation and interview, on 6/16/26 at 1:38 p.m. with Registered Nurse (RN) 1, in Resident 127's room. Resident 127 was receiving enteral feeding at a rate of 50cc/hour [cubic centimeters per hour - unit of measure]. RN 1 stated Resident 127 was at a 10 to 15 degree angle during enteral feeding administration. RN 1 stated residents who are receiving enteral feeding should be at a 35 to 45 degree angle. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings & Safety Precautions, revised November 2018, the P&P indicated, To ensure the safe administration of enteral nutrition. Preparation 1. All personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. 2. The facility will remain current in and follow accepted best practices in enteral nutrition. Preventing aspiration 1. Check enteral tube placement prior to feeding or administration of medication. 2. Check gastric residual volume as ordered. 3. Elevate the head of the bed (HOB) at least 30 [degrees] during tube feeding and at least 1 hour after feeding. If elevating the HOB is medically contraindicated, use reverse Trendelenburg position. Monitor the resident for signs and symptoms of respiratory distress during enteral feedings and medication administration. During a review of the facility's P&P titled, Enteral Tube Feeding via Continuous Pump, dated November 2018, the P&P indicated, Steps in the Procedure. 4. Position the head of the bed at 30 degrees & 45 degrees. for feeding.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure call lights were in reach of one of 71 sampled residents (Resident 127). This failure had the potential for Resident 127 not to be able to call for needed care and assistance. Findings: During a concurrent observation and interview, on 6/16/26 at 1:38 p.m. in Resident 127's room with Registered Nurse (RN) 1. Resident 127's call light was observed on the floor on the side of Resident 127's bed. RN 1 stated Resident 127 could not reach his call light. During a review of the facility's policy and procedure (P&P) titled, Call System, Residents, revised September 2022, the P&P indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.		