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	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards Post-Acute	730 34 Street Bakersfield, CA 93301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview and record review the facility failed to ensure two of 29 sampled residents (Resident 69 and Resident 5), was able to exercise their rights when: 1. Resident 69 was not provided with a shower when requested. This failure resulted in Resident 69 feeling dirty when going to an appointment. 2. Resident 5 was not provided with a hair cut that he had requested. This resulted in a violation of Resident 5's right to dignified care.Findings: 1. During an interview on 6/15/26 at 10:40 a.m. with Resident 69, Resident 69 stated that when she requests a shower, staff often respond that they are too busy. Resident 69 stated she would like to have showers more frequently than twice a week. Resident 69 stated that she felt unclean when attending physical therapy and believed she should be able to feel clean rather than smell of feces. During an interview on 6/15/26 at 10:55 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated that they maintain a daily shower list for residents, and if a resident requests a shower but is not included on that list, it might not be possible to accommodate them. During a review of Resident 69's Brief Interview for Mental Status (BIMS - an assessment of cognition [how well a person thinks, remembers, and learns] with scores ranging from 0 - 15, the higher the score the more intact the resident's cognition. A score of 0 – 7 suggests severe cognitive impairment, 8 – 12 suggests moderate cognitive impairment and 13 – 15 suggests the cognition is intact), dated 1/6/26 the BIMS indicated Resident 69's score was 15. During a review of Resident 69's Skin Care Alert (SCA), dated June 2026, the SCA indicated, Resident 69 received a shower on 5/30/26, 6/3/26, 6/6/26, 6/10/26, and 6/13/26. During a review of the facility's P&P titled, Bath, Shower/Tub, dated February 2018, the P&P indicated, The purpose of this procedure are to promote cleanliness, provide comfort to the resident. 2. During an interview on 6/16/26 at 8:49 a.m. with Resident 5, Resident 5 stated he had asked multiple times for a haircut but had not had one. Resident 5 stated his hair had gotten too long and It bugs the hell out of me. Resident 5 stated he liked to wear his hair short and could not recall the last time he had a hair cut. Resident 5 stated he cannot get out of bed by himself and requires help from staff. During a review of Resident 5's Brief Interview for Mental Status [BIMS - an assessment of cognition (how well a person thinks, remembers, and learns]. A score of 0 – 7 suggests severe cognitive impairment, 8 – 12 suggests moderate cognitive impairment and 13 – 15 suggests cognition is intact], dated 5/26/26, the BIMS indicated Resident 5's BIMS score was 12. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/26 at 9:58 a.m. with Activities Aide (AA), AA stated the hair stylist came to the facility every Wednesday or Thursday and Friday. AA stated during one to one (1:1) resident room visits they offer haircuts to the residents. AA stated they do not document when a resident was offered or refused a haircut. During a concurrent interview and record review on 6/18/26 at 10:35 a.m. with Director of Activities (DA), the facility's Beautician Services logs (BS), dated 1/30/26 through 6/18/26 were reviewed. The BS indicated on 1/30/26 Resident 5 received a hair cut. DA stated the last time Resident 5 had a hair cut was on 1/30/26. During an interview on 6/18/26 at 11:01 a.m. with Resident 5, Resident 5 stated he was not offered a haircut on 6/18/26 but would have liked to have one. During a concurrent interview and record review on 6/18/26 at 12:01 p.m. with DA, Resident 5's Activities Progress Notes (APN), dated 2/2/26 through 6/17/26 were reviewed. The APNs did not indicate Resident 5 was offered or refused a haircut. DA stated the activities staff did not document that a haircut was offered or refused by Resident 5. During an interview on 6/18/26 at 12:07 p.m. with Administrator, Administrator stated the facility did not have a policy and procedure (P&P) that addressed who was responsible for overseeing resident hair care services. Administrator stated the activities staff were currently overseeing the hair care services but it was the facility's responsibility to ensure residents are well groomed and feel good about themselves. During a review of the facility's P&P titled, Resident Rights, dated December 2016, the P&P indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . f. communication with and access to people and service, both inside and outside the facility. h. be supported by the facility in exercising his or her rights. During a review of the facility's P&P titled, Quality of Life – Dignity, dated February 2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. 3. Some examples of ways in which respect for choices and values are exercised include: a. Personal grooming – residents are groomed as they wish to be groomed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure a discharge notice was sent to the Ombudsman (an advocate for residents of nursing homes, board and care centers and assisted living facilities) for one of one sampled residents (Resident 143). This failure had the potential to result in Resident 143 not having an advocate who could inform them of their admission, transfer, and discharge rights. Findings:During a review of Resident 143's electronic medical record (EMR), Resident 143 was transferred to the hospital for evaluation and treatment on 4/24/26, 5/6/26, and 5/28/26. During a concurrent interview and record review on 6/18/26 at 9:44 a.m. with Social Services (SS), Resident 143's EMR was reviewed. The EMR did not contain a written notice of transfer for Resident 143 for 4/24/26, 5/6/26, and 5/28/26. SS stated the facility did not provide written notification of transfer to hospital, to Resident 143 or to the Ombudsman for Resident 143's 4/24/26, 5/6/26, and 5/28/26 hospitalizations. During an interview on 6/18/26 at 11:35 a.m. with SS, SS stated the facility did not have a policy and procedure for written notice of discharge/transfer.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure two of 71 sampled residents (Resident 137 and Resident 2) IDT (interdisciplinary) comprehensive, nutrition care plan interventions could be effectively monitored and implemented when there was inconsistent and inaccurate meal, meal substitute and snack consumption documentation.This failure had the potential for unrecognized nutrition care needs to not be addressed in a timely manner to prevent a potential outcome such as weight loss or decreased quality of life. Findings:1.During an observation on 6/15/26 at 12:37 p.m. in the dining room, staff were observed checking resident meal tray cards compared to meal trays for accuracy.During a concurrent observation and interview on 6/15/26 at 12:42 p.m. Licensed Vocational Nurse (LVN) 1 in the dining room, approximately four staff stood next to the meal delivery cart, leaving trays undistributed while residents waited at the tables. LVN 1 stated they were waiting another five to 10 minutes for a second cart to arrive before beginning service. LVN 1 stated they usually get the meal trays around 12 p.m.During a concurrent observation and interview on 6/15/26 at 12:43 p.m. with Resident 137 outside the dining room, Resident 137 was rapidly propelling his own wheelchair out of the dining room before his lunch was provided. Resident 137 stated he was upset, very upset.During an observation on 6/15/26 at 1:17 p.m. Resident 137 was in his wheelchair next to his bed in his room using his phone. No lunch meal tray was observed in his room. During an observation on 6/15/26 at 1:50 p.m. in the hallway near Resident 137's room, LVN 1 was checking resident meal trays against their meal tray cards.During an observation and interview on 6/15/26 at 1:59 p.m. with Infection Preventionist (IP) in the hallway near Resident 137's room, IP stated that was the last meal delivery cart for lunch meal service and no residents were waiting on a lunch meal tray.During an observation on 06/15/26 at 2 p.m. Resident 137 was outside on the patio in his wheelchair for a smoke break. Concurrently, there was no meal tray observed in his room.During an observation on 6/15/26 at 2:03 p.m. Resident 137 propelled his wheelchair from the outside patio back into his room.During a concurrent interview and record review on 6/16/26 at 9:17 a.m. with Certified Nursing Assistant (CNA) 4, Resident 137's Electronic Medical Record (EMR) was reviewed. The EMR indicated Scheduled Date: 6/15/26 13:00 [1 p.m.], Effective Date: 6/15/26 10:29 [10:29 a.m.], What percentage of the meal was eaten? 76% [percent] - 100%, Offer Substitute if meal intake is 50% or less: Response Not Required, What percentage of the substitute meal was eaten? - Response Not Required. CNA 4 stated she was assigned to care for Resident 137 during lunch on 6/15/26.CNA 4 stated Resident 137 ate 25% of his lunch while in the dining room as reported to her by CNA 5 who was in the dining room during that time. CNA 4 stated since Resident 137 had eaten 25% of his lunch, she offered him a ham sandwich as a snack. CNA 4 stated Resident 137 ate 75-100% of the ham sandwich. CNA 4 stated that she charted intake of the snack under What percentage of the meal was eaten? in error, as the ham sandwich was not his lunch nor was it a meal substitute, but instead she should have documented the 75-100% intake under snack which normally gets distributed from the kitchen at 2 p.m. During a record review of Resident 137's Documentation Survey Report [DSR], dated 6/16/26 the DSR indicated, 6/15/26, 13:29, 3 [76-100% of meal eaten], [initials of CNA 4].During record review of Resident 137's DSR, dated 6/16/26 the DSR indicated, Snacks, 14:29 [2:29 p.m.], 2 [51-75% consumption of snack], [initials of CNA 4].During a concurrent interview and record review on 6/16/2026 at 9:25 a.m. with CNA 4 the DSR dated 6/16/26 was reviewed. CNA 4 stated she charted 75%-100% due to Resident 137 eating his ham sandwich as a snack after lunch trays were delivered late and he didn't eat in the dining room. CNA 4 stated the percent documented was dependent on what he had in the dining room, resident room, and snack after lunch together. During a concurrent interview and record review on 6/17/26 at 12:22 p.m. with Director of Nursing (DON), Resident 137's Care Plan Report [CP], dated 5/1/24, was reviewed. The CP indicated, [Resident 137] is at risk for altered nutrition/weight loss. The CP indicated, Interventions: Assess [Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	137] eating patterns at every meal, alert nurse/dietician if resident continues to consume 50% of his meal, Monitor and document fluid intake every shift, Offer substitute if meal intake is 50% or less, Provide & encourage fluids & food intake. DON stated staff did report to her the untimeliness of lunch being served on 6/15/26, the inaccurate and inconsistent documentation of lunch, meal substitute and snack consumption. DON stated the facility would be unable to monitor and implement Resident 137's nutrition IDT (interdisciplinary) care plan when staff were not accurately, and consistently, monitoring and documenting Resident 137's food/fluid intake. 2. During an observation on 6/15/26 at 12:37 p.m. in the dining room, staff were observed checking resident meal tray cards compared to meal trays for accuracy.During a concurrent observation and interview on 6/15/26 at 12:58 p.m. in the dining room, Resident 2 began to propel his wheelchair out of the dining room before his lunch was provided. Resident 2 stated they did this before and he didn't get food. During an observation on 6/15/26 at 1:30 p.m. in central hallway near Resident 2's room, Resident 2 sat in his wheelchair with a large blue bucket on his lap and leaning his face over the bucket.During an observation on 06/15/26 at 1:42 p.m. in central hallway near Resident 2's room, Resident 2 sat in his wheelchair holding a grey bin with 3 cans of unopened Mountain Dew.During a concurrent observation and interview on 06/15/26 at 1:44 p.m. with Resident 2 in the hallway in front of his room, Resident 2 was propelling his wheelchair into his room. Resident 2 stated he was not provided lunch yet. Resident 2 stated he had an appetite and was hungry. During a concurrent observation and interview on 6/15/26 at 1:50 p.m. with Resident 2, all the meal trays that were in the meal delivery cart were distributed to residents based on residents assigned meal tray cards located on the trays. Resident 2 was not provided a lunch tray.During an interview on 6/15/2026 at 3:35 p.m. with Resident 2, Resident 2 stated he did not have lunch. During a concurrent interview and record review on 6/16/26 at 9:53 a.m. with CNA 6 Resident 2's EMR was reviewed. The EMR indicated, Scheduled Date: 6/15/26 11:30 [11:30 a.m.], Effective Date: 6/15/26 11:42 [11:42 a.m.], What percentage of the meal was eaten? Resident Refused, Offer Substitute if meal intake is 50% or less: Yes, What percentage of the substitute meal was eaten? -76-100%. CNA 6 stated he was assigned to care for Resident 2 during lunch on 6/15/26.CNA 6 stated, CNA 6 brought Resident 2's lunch meal tray to Resident 2 in his room. CNA 6 stated Resident 2 refused the food, saying it was cold and he didn't want it. CNA 6 stated he offered a snack when the snack cart came by but resident [Resident 2] got stuff from the vending machine instead. CNA 6 stated he documented that on 6/15/26 Resident 2 consumed a substitute meal with a 76-100% intake at 14:42 [2:42 p.m.] and had a snack with consumption of 76-100% intake at 14:42. CNA 6 stated the documentation was not accurate as Resident 2 did not consume a meal substitute and that he intended to document only a snack consumption of 76% to 100% intake of snacks Resident 2 purchased from a vending machine located inside the facility.During a concurrent interview and record review on 6/17/26 at 12:26 p.m. with DON, Resident 2's CP dated 2/12/26 the CP indicated, [Resident 2] re-admitted at nutritional risk for malnutrition. Goal: Consume at least 76-100% of 3 meals/day, Interventions: Provide, serve diet as ordered. Monitor intake and record q [every] meal. DON stated staff did report to her the untimeliness of lunch being served on 6/15/26, the inaccurate and inconsistent documentation of lunch, meal substitute and snack consumption. DON stated the facility would be unable to monitor and implement Resident 2's nutrition IDT care plan when staff were not accurately, and consistently, monitoring and documenting Resident 2's food/fluid intake. During a review of the facility's policy and procedure (P&P) titled, Documentation Of Food And Fluid Intake, dated 2023, the P&P indicated, Policy: Staff will document the percentage of each meal consumed and fluid intake for each resident on a daily basis. Procedures: 1. Staff will record the percentage of all food and fluid intake in the resident's medical record or electronic format for each meal. The percentage of between meal snacks and milliliters of supplement intake and nourishments will be recorded separately from the meal/fluid intake on the ADL [Activities of Daily Living] sheets or electronic record by the facility designee.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 2016, the P&P indicated, A comprehensive, person-centered care plan that includes measurable (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation: The comprehensive, person-centered plan will: Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; Incorporate identified problem areas; Incorporate risk factors associated with identified problems; Aid in preventing or reducing decline in the resident's functional status and/or functional levels; Reflect currently recognized standards of practice for problem areas and conditions. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making.

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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 follow its policy and procedure (P&P), titled Nephrostomy Tube [a thin catheter inserted through your lower back directly into your kidney to drain urine into an external collection bag] Care of, for one of three sampled residents (Resident 11), when Resident 11 had a non-sterile (reduced microbe levels but not completely germ-free) dressing change to her nephrotomy tubes. This failure had the potential for a severe infection in the blood stream with negative outcomes up to and including death.Findings:During a review of Resident 11's Order Summary Report (OSR), dated 5/22/26, the OSR indicated, Cleanse Surgical Site (Nephrostomy Tube) on L [left] posterior flank [back] with iodine & [and] cover with split dressing QD [every day] and prn [as needed]. Monitor and assess during treatments for any worsening, s/sx [signs and symptoms] of infection, or if treatment is ineffective and notify MD.During a concurrent interview and record review on 6/17/26 at 11:22 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 11's Treatment Administration Record (TAR), dated June 2026 was reviewed. The TAR indicated, LVN 1 changed Resident 11's Nephrostomy tube dressing on 6/1/26, 6/2/26, 6/4/26, 6/5/26, 6/8/26, 6/9/26, 6/11/26, 6/12/26, 6/15/26, 6/16/26, and 6/17/26. LVN 1 stated she completed Resident 11's TAR on those days per OSR on the TAR. LVN 1 reviewed the OSR on the TAR and LVN 1 stated the dressing that was changed was a clean dressing, not a sterile dressing. LVN 1 stated she did not use sterile gloves or had a sterile field for the dressing. LVN 1 stated she did not change the dressing per the facilities P&P.During a review of the facility's P&P titled, Nephrostomy Tube Care of, dated October 2010, the P&P indicated, Dressing Change.Put on sterile gloves.Place 1-2 sterile dressings on the nephrostomy tube site.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure prescribed oxygen therapy was administered in accordance with physician orders when:1. Two of two sampled residents (Resident 14 and Resident 78) portable oxygen cylinders were empty. 2. One of two sampled residents (Resident 14) oxygen flow rate did not match physician order. These failures had the potential to result in ineffective respiratory management, respiratory compromise and adverse outcomes.Findings:1. During a concurrent observation and interview on 6/15/26 at 12:42 p.m. with Resident 14 in the dining room, Resident 14 was sitting in a wheelchair that had a portable oxygen cylinder attached. Resident 14 was wearing a nasal cannula (NC, a device with two small prongs that fit into the nostrils and deliver oxygen from the oxygen source) that was attached to the portable oxygen cylinder. The oxygen cylinder pressure gauge needle was in the red zone, which indicated the oxygen cylinder was empty and unavailable to provide oxygen therapy to Resident 14. Resident 14 stated she had told staff in the morning that she did not think the oxygen cylinder attached to her wheelchair was working. During a concurrent observation and interview on 6/15/26 at 12:45 p.m. with Licensed Vocational Nurse (LVN) 1 in the dining room, Resident 14's portable oxygen cylinder had a pressure gauge needle that was in the red zone which indicated the oxygen cylinder was empty. LVN 1 disconnected Resident 14's nasal cannula from the oxygen cylinder and manually assessed for oxygen flow at the outlet. LVN 1 stated no oxygen flow was present and Resident 14's oxygen cylinder was empty. During a review of Resident 14's Order Summary Report (OSR), dated 1/8/25, the OSR indicated, OXYGEN: Administer 02 [oxygen] @ [at] 2 L/min [liters per minute] via NC continuously.During an observation on 6/15/26 at 12:49 p.m. in the dining room, Resident 78 was sitting in a wheelchair that had a portable oxygen cylinder attached. Resident 78 was wearing a NC that was attached to the portable oxygen cylinder. The oxygen cylinder pressure gauge needle was in the red zone, which indicated the oxygen cylinder was empty and unavailable to provide oxygen therapy to Resident 78. During a concurrent observation and interview on 6/15/26 at 12:50 p.m. with LVN 1 in the dining room, Resident 78's portable oxygen cylinder had a pressure gauge needle that was in the red zone which indicated the oxygen cylinder was empty. LVN 1 disconnected Resident 78's nasal cannula from the oxygen cylinder and manually assessed for oxygen flow at the outlet. LVN 1 stated no oxygen flow was present and Resident 78's oxygen cylinder was empty. LVN 1 stated Resident 78's oxygen cylinder should have been changed prior to Resident 78 being brought into the dining room. During a review of Resident 78's OSR, dated 9/11/25, the OSR indicated, OXYGEN: Administer 02 @ 2 L/min via NC continuously.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration.12. Check the mask, tank.to make sure they are in good working order.13. Observe the resident upon setup and periodically thereafter to ensure oxygen is being tolerated. 2. During an interview on 6/15/26 at 12:42 p.m. with Resident 14, Resident 14 stated she had a physician order to use oxygen at 2 L/min via NC. During a concurrent observation and interview on 6/15/26 at 1 p.m. with LVN 3 in the dining room, Resident 14's portable oxygen cylinder was set to dispense oxygen at 4 L/min. LVN 3 stated Resident 14 was receiving oxygen at 4 L/min. LVN 3 stated she was unsure how much oxygen Resident 14 was ordered to receive. During a concurrent interview and record review on 6/15/26 at 1:08 p.m. with LVN 3, Resident 14's OSR, dated 9/11/25 was reviewed. The OSR indicated, OXYGEN: Administer 02 @ 2 L/min via NC continuously. LVN 3 stated Resident 14 should have been receiving oxygen at 2 L/min. During a review of the facility's P&P titled, Oxygen Administration, dated 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for safe oxygen administration.Verify there is a physician's order for this procedure. Review the physician's order.Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at a rate of 2 to 3 liters per minute.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to implement infection control standards when:The floor of the over the counter (OTC- medications not requiring a prescription) medication storage room was not cleaned. This failure had the potential to spread infection to residents and staff.The OTC medication storage room's temperature was not monitored or recorded. This failure had the potential to affect the potency of all medications stored in the room. Findings:During a concurrent observation and interview on 6/15/26 at 11:20 a.m. with Registered Nurse (RN) 2, in the OTC storage room, the floor had debris including hair, the top portion of a broken white plastic spoon, and the shell of a flower seed. The tile of the floor was discolored with grime. At the entry, on the floor on left side, there was a black plastic milk crate, placed at an angle, turned upside down, and an air-cooling unit was on top. The milk crate was covered in dust, and the door's threshold (flat, visible piece you step on) was full of dust, and a piece of paper. Behind the milk crate was a white plastic pill bottle, covered in dust. RN 2 stated the OTC storage room is cleaned daily by housekeeping. RN 2 stated the debris on the floor and the pill bottle should not be there.During an interview on 6/15/26 at 11:29 a.m. with Housekeeping/Central Supply Supervisor (HSK/CSS), at the entrance to the OTC storage room, HSK/CSS stated she checked the OTC medication storage room daily but only swept and mopped the room every two to three days.During an interview on 6/16/26 at 8:40 a.m. with Infection Preventionist (IP), IP stated it was her expectation for housekeeping staff to check the OTC storage room, sweep, and mop daily and as needed.During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program dated 12/25, the P&P indicated, An infection prevention and control (IPC) program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 2. During a concurrent observation and interview on 6/15/26 at 1:40 p.m. with RN 1, in the OTC medication storage room, no room temperature log was found. RN 1 stated HSK/CSS is supposed to monitor the temperature in the room.During an interview on 6/15/26 at 1:55 p.m. with HSK/CSS, HSK/CSS stated she checked the temperature of the OTC medication storage room, but she did not enter the temperatures into a log. HSK/CCS stated she did not know the temperature parameters for a room that stores mediation.During an interview on 6/15/26 at 1:56 p.m. with Director of Nursing (DON) and Administrator In-Training (AIT). DON and AIT stated the OTC medication storage room should have a log of the room's temperature. DON stated the task should have been a nursing responsibility.During a review of the facility's P&P titled, Storage of Medication dated 11/20, the P&P indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls.

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The Orchards Post-Acute	730 34 Street Bakersfield, CA 93301

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 5) was provided with follow up dental care and treatment in a timely manner. This failure resulted in prolonged dental pain for Resident 5 and the potential for Resident 5 developing an infection. Findings:During a concurrent observation and interview on 6/16/26 at 8:40 a.m. with Resident 5, in Resident 5's room, Resident 5 had multiple bottom front teeth that were visible at the gumline. Resident 5 stated his teeth hurt. Resident 5 stated he had been seen by a dentist while at the facility and was supposed to have the teeth removed, but the dentist had not been back. During a review of Resident 5's Brief Interview for Mental Status [BIMS - an assessment of cognition (how well a person thinks, remembers, and learns]. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests cognition is intact], dated 5/26/26, the BIMS indicated Resident 5's BIMS score was 12.During a concurrent interview and record review on 6/17/26 at 2:34 p.m. with Social Services (SS), Resident 5's electronic medical record (EMR) was reviewed. The EMR indicated Resident 5 was admitted to facility on 8/25/25 and had a dental exam in January 2026. SS stated the exam notes indicated Resident 5 had discomfort, did not want dentures and only wanted extractions. During an interview on 6/17/26 at 2:43 p.m. with SS, SS stated it had been approximately five months since the dental visit in January 2026 and Resident 5 had not received the dental treatment. SS stated the facility does not have a process for ensuring residents receive needed dental treatment. During a review of the facility's policy and procedure (P&P) titled, Dental Services, dated December 2016, was reviewed. The P&P indicated, Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. 6. Social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure the Director of Dietary Services (DDS) met state education qualifications to supervise Food and Nutrition Service (FNS) operations when Title 22 (Section 72035) of the California Code of Regulations and CA Health and Safety Code (HSC) 1265.4(b) Pathway 4 (one of the education-and-experience combination used to qualify for higher-grade certification) was not met as required per the federal regulations. This failure had the potential to adversely affect the foodservice operation related to sanitation, food safety and meeting residents' nutritional needs in accordance with recognized dietary practices.Findings: During an interview on 6/15/26 at 8:31 a.m. with DDS, DDS stated she was full-time and responsible for the day-to-day foodservice operation. During an interview on 06/15/26 at 10:52 a.m. with Registered Dietitian (RD), RD stated she was a consultant RD and worked at the facility 3 to 4 days a week.During a concurrent interview and record review on 6/17/26 at 3:55 p.m. with DDS, and RD, a certificate titled Pathway III(b) Nutrition & Foodservice Professional Training Program, dated 8/14/2024, provided by DDS was reviewed. DDS stated the certificate meant that she had completed the coursework required by ANFP (Association of Nutrition & Foodservice Professionals) to be eligible to sit for the Certified Dietary Manager (CDM) Credentialing Exam. DDS stated she had not taken the CDM credentialing exam and therefore, was not a CDM.During a review of HSC 1265.4 pathway 4 indicated, (4) Is a graduate of a dietetic services program approved by the Dietary Managers Association and is a certified dietary manager credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations [CCR] prior to assuming full-time duties as a dietetic services supervisor at the health facility.During a review of CCR Title 22, 72035. Dietetic Service Supervisor. Dietetic service supervisor means a person who has completed the training requirements specified in section 1265.4(b) of the Health and Safety Code.During a concurrent interview and record review on 6/17/26 at 4:55 p.m. with the Administrator, a job description (JD) titled Director of Dietary Services, (undated) was reviewed. The JD indicated, Delegation of Authority: As the Director of Dietary Services, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties. Duties and Responsibilities: Administrative Functions: Assume administrative authority, responsibility, and accountability of supervising the Dietary Department. Education: Be a graduate of an accredited course in dietetic training approved by the American Dietetic Association. Specific Requirements: Must be registered as a Food Service Supervisor in this state. Administrator stated the job description belonged to the DDS. During a review of the facility's contract with the company to provide RD services to the facility (Contract/RD), dated 2/1/2023, the Contract/RD indicated, IV. Responsibilities of the Facility: 1. Provide procedures of communication for the dietitian with Facility's.dietetic services manager. 2. Identify the person designated as the qualified dietetic services manager. Contracted hours for the Facility will be 24-32 hours a week as negotiated with Consultant and Facility's appointed person of contact.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure competency of their dietary aides of what consists of a full liquid diet for one of two sampled residents (Resident 39). This failure had the potential for Resident 39 to not meet his nutritional needs.Findings:During a concurrent observation and interview on 6/16/26 at 12:35 p.m. with Dietary Aide (DA) 1 in the kitchen during lunch trayline, DA 1 removed the pudding from the meal tray and placed apple juice in its place. DA 1 stated she checked the meal tray for accuracy to the meal tray ticket and it is full liquid diet, the meal tray had two bowls of soup and removed the pudding because it was not a liquid.During an interview on 6/16/26 at 12:40 p.m. with Registered Dietitian (RD), RD stated it is okay to place pudding on the tray per the full liquid diet.During a review of Resident 39's admission Record, (AR) dated 6/17/26, the AR indicated, Resident 39 was admitted on [DATE] with a diagnosis of Dysphagia [difficulty swallowing], Weakness, and Hemiplegia [total or partial paralysis of one vertical half of the body] and Hemiparesis [weakness, or partial paralysis on one side of the body] Following Cerebral [relating to the brain] Infarction [death of tissue (necrosis) caused by sudden, severe lack of blood supply and oxygen to affected area] Affecting Right Dominant Side.During a review of Resident 39's Diet Order (DO), dated 6/15/26, the DO indicated, Full Liquid Diet.During a review of Resident 39's Meal Tray Ticket, (MTT) dated 6/16/26, the MTT indicated, Full Liquid for breakfast, lunch and dinner.During a review of the facility's Diet Manual (DM) for the diet titled, Full Liquid Diet, dated 2023, the DM indicated, The full liquid diet consists of foods which are liquid or become liquid at body temperature and are easily digested. Desserts: Custard, plain flavored gelatin, plain ice cream, milk shakes, plain ice, sherbets, hard candy, popsicles, plain yogurt (no seeds or fruit), pudding.During a concurrent interview and record review on 6/6/26 at 12:40 p.m. with RD, a facility provided untitled document, (undated), was reviewed. The document indicated, Full Liquid Diet Menu Options: Pudding: Vanilla or Chocolate. The RD stated the facility used the document as a cheat sheet to help guide dietary aides on what to place on the meal tray and it was posted in the kitchen.During a review of the facility's job description (JD) titled, Job Description: Dietary Aide, (undated), the JD indicated, Dietary Service: Assist in preparing palatable and appetizing meals in accordance with planned menus and temperature requirements on timely basis. Assist in preparing food for therapeutic and texture modified diets in accordance with planned menus with established portion control procedures. Serve supplements, snacks, nourishments and beverages consistent with orders.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the planned menu for regular diet for one of six sampled residents (Resident 121). This failure had the potential to result in serving low-fat milk to residents on a regular diet which posed a risk for decreased milk consumption. During a concurrent observation and interview on 6/16/26 at 12:25 p.m. with Registered Dietitian (RD) in the kitchen during tray line, a dietary aide placed whole milk or 2% milk on regular diet trays. RD stated, it is regular diet, it can be either or, if no preference indicated.During a review of Resident 121's Meal Tray Ticket (MTT), dated 6/16/26, the MTT indicated, Puree Diet: Preferences Milk for breakfast, lunch and dinner.During a review of the facility's dietary menu titled, Winter Menus, (undated), the dietary menu indicated, The regular IDDSI [International Dysphagia Diet Standardization Initiative - a set of testing methods for texture-modified foods and thickened liquids to ensure safe consumption for individuals with swallowing difficulties] menu: 4oz Milk, regular CCHO [Consistent Carbohydrate Diet to manage diabetes] menu: 4oz Milk.During a review of the facility's nutritional breakdown menu titled, Nutritional Breakdown, dated Winter 2024-25, the nutritional breakdown indicated, Regular diet nutritional breakdown based on Whole Milk.During a review of the facility's dietary menu titled, Regular Diet/ IDDSI Level #7, dated 2024, the dietary menu indicated, Description: The regular diet is designed to meet the nutritional needs of residents who do not need dietary modification or restrictions. Individual preferences or intolerances may necessitate the exclusion of certain food items, the diet consists of items served in a variety of unmodified textures and consistencies Nutritional Breakdown: Calories - 2100-2400 .Dairy Group: 16 ounces of milk each day with meals. Whole milk is used in the above nutritional breakdown.During the review of the facility's policy and procedure (P&P) titled, Resident Tray Card, dated 2023, the P&P indicated, 1. A resident tray card should be filled out by the Director of Food and Nutrition Services or designee or electronically produced when the diet order is received. 2. The tray card should include: Resident Name, Diet, Texture Modification, Allergies/Intolerances, Dislikes, Special Requests, Beverages and amount desired for each meal.5. Residents Profile should be updated after receiving diet changes or updates to food preferences. Tray cards will reflect change.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to honor the food preferences for two of 15 sampled residents (Resident 2 and Resident 137) when:1. Resident 2's request for sunny-side up eggs was not honored because the facility stopped purchasing the pasteurized shell eggs required to prepare them safely.2. Resident 137 did not receive margarine on vegetables as indicated on his meal tray card during lunch trayline.These failures had the potential to result in decrease nutritional intake and a decline in the quality of life for Resident 2 and Resident 137.Findings: 1. During an observation on 6/15/26 at 8:40 a.m. in the kitchen, inside the walk-in refrigerator was a box containing an open, unsealed bag of frozen fried eggs with hard egg yolk.During an interview on 06/15/26 at 10:38 a.m. with Director of Dietary Services (DDS), DDS stated they did not have pasteurized shell eggs. DDS stated they also did not have regular (non-pasteurized) shell eggs. DDS stated they purchased pre-cooked fried eggs that they just needed to heat up and/or pre-cooked hard -boiled eggs from their vendor. They also had pasteurized liquid eggs to prepare scrambled eggs. DDS stated if a resident requested a sunny side up (not fully cooked, runny yolk) egg and she did not have pasteurized shell eggs she would not honor the residents request as it would not be safe food preparation. The DDS stated she occasionally purchased pasteurized shell eggs from the local grocery store to prepare sunny side up eggs for residents upon request, but she could not recall when she last did so. DDS was requested to provide receipts for the last time she purchased pasteurized shell eggs from a grocery store for residents.During a concurrent interview and record review on 06/17/26 at 9:58 a.m. with DDS, the facility's food inventory list (undated) was reviewed. DDS stated pasteurized shell eggs were not on the food purchasing inventory list. DDS stated she was unable to provide receipts for pasteurized shell eggs that may have been obtained at a local grocery store.During a concurrent interview and record review on 6/16/26 at 10:00 a.m. with DDS, an invoice from the facility's food vendor, dated 4/11/26, was reviewed. The invoice indicated, Delv. [delivery] Date: 4/11/26, 1 CS [case] pack -1, Size - 15 DZ [dozen], WHLFIMP [Wholesome Farms Imperial] Egg Shell LG [large] Pasteuri [pasteurized]. DDS stated that was the last day the facility received pasteurized shell eggs from their approved vendor.During a concurrent interview and record review on 06/17/2026 at 10:18 a.m. with RD, Resident 2's Nutritional Assessment [NA], dated 2/12/26, was reviewed. The NA indicated, Comments/Food Preferences: Will only [eat] sunny side up eggs, no scrambled or boiled eggs. RD stated she knows they don't have pasteurized shell eggs or regular (non-pasteurized) shell eggs. RD stated it has been at least a month since she last visually saw either regular hard-shell eggs or pasteurized shell eggs in the kitchen. RD stated they should have pasteurized shell eggs readily available at the facility to honor any resident requests for sunny side up eggs. RD stated she should have advised the Administrator the kitchen did not have pasteurized shell eggs. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, dated 2023, the P&P indicated, Procedures: The Director of Food and Nutrition Services or designee should visit residents within 24-48 hours of admission to determine food preferences. Food preferences are recorded in the medical record, profile, and tray card.During a review of Resident 2's tray card, the tray card indicated, Dislikes: corn flakes, no beef or pork, no bread, no chicken, no fish, no scrambled eggs. Preferences: Mashed potatoes with gravy, tomato soup, milk. Sunny side up eggs were not listed as a food preference on Resident 2's tray card for breakfast, lunch or dinner. During a review of the facility's P&P titled, Guidelines For Approved Vendors and Food Purchasing, dated 2023, the P&P indicated, All eggs will be Grade AA, inspected fresh pasteurized or pasteurized frozen.During a review of the Centers for Medicare & Medicaid Services (CMS) Survey and Certification Letter (Ref: S&C: 14-34-NH), dated May 20, 2014, the S&C letter indicated, The use of pasteurized eggs allows for resident preference for soft-cooked, undercooked or sunny-side up eggs while maintaining food safety. Pasteurized shell eggs are (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	commercially available, are clearly labeled and allow the safe consumption of undercooked eggs. Federal regulations expect nursing facilities to make reasonable efforts to respect resident choices and can honor resident choice while maintaining health and safety standards through the use of pasteurized eggs.2. During a concurrent observation and interview on 6/16/26 at 12:19 p.m. with Dietary Aide (DA) 1 and RD in the kitchen during lunch trayline, DA 1 placed Resident 137's lunch meal tray onto the meal delivery cart for distribution to the residents. DA 1 was asked to remove Resident 137's tray and review Resident 137's meal tray card in comparison to what was plated on his lunch plate. DA 1 stated Resident 137's meal tray card indicated, Margarine On Veggies. DA 1 stated Resident 137 was served cooked broccoli without margarine on the broccoli. DA 1 asked the RD if margarine should have been served on Resident 137's broccoli. RD stated either margarine could have been served on top of the cooked broccoli or pats of butter could have been placed on Resident 137's lunch meal tray. DA 1 and RD stated there was neither margarine on the cooked broccoli nor pats of butter on Resident 137's lunch meal tray and should have been.During a review of Resident 137's Care Plan Report [CP], dated 5/01/24, the CP indicated, [Resident 137] is at risk for altered nutrition/weight loss.Goal: Staff will honor food preferences as best as able through next review date.During a review of the facility's P&P titled, Resident Food Preferences, dated 2023, the P&P indicated, Procedures: The Director of Food and Nutrition Services or designee should visit residents within 24-48 hours of admission to determine food preferences. Food preferences are recorded in the medical record, profile, and tray card.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store food in accordance with professional standards for food service safety when food items were not covered, were not dated as to when opened, and manufacturer's guidelines were not followed. These failures had the potential to place residents at an increased risk for foodborne illness.Findings:During a concurrent observation and interview on 6/15/26 at 8:31 a.m. with Director of Dietary Services (DDS) in the dry food storage room in the kitchen, there was a large, opened bag of dry pasta without an open date. DDS stated the bag of uncooked pasta should of been labeled with an open date.During a concurrent observation and interview on 6/15/26 at 8:36 a.m. with DDS in the dry food storage room in the kitchen, there was an opened bag of uncooked dry pasta that was not sealed or labeled. DDS stated, the bag of uncooked pasta should have been sealed and labeled with an open date.During a concurrent observation and interview on 6/15/26 at 8:39 a.m. with DDS in the dry food storage room in the kitchen, there was an opened bottle of Kikkoman Teriyaki Marinade and Sauce stored on a wire shelf. DDS stated, it [bottle of Kikkoman Teriyaki Marinade and Sauce] was not used this morning and that location was its [bottle of Kikkoman Teriyaki Marinade and Sauce] permanent place to be stored. DDS read the manufacturer's guidelines on the bottle and DDS stated, Refrigerate after opening. During a concurrent observation and interview with DDS on 6/15/26 at 8:40 a.m. in the kitchen, inside the walk-in refrigerator one box contained an open, unsealed bag of frozen fried eggs. DDS stated the bag of frozen eggs should have been closed.During a concurrent observation and interview on 6/15/26 at 8:42 a.m. with DDS inside the walk-in refrigerator inside the kitchen, there were two unopened cases/boxes of frozen Vital Mighty Shakes without a date indicating when placed in the refrigerator. DDS stated, there was no date to indicate when the box of frozen health shakes were placed in the refrigerator. DDS stated kitchen staff dated the unopened case/box of Vital Mighty Shakes as 06/03/26 and another unopened case/box located in the back of refrigerator as 6/10/26 were dates the facility received the frozen health shakes from the vendor and were placed in the freezer located in the kitchen.During a review of the facility's P&P titled, Food Receiving and Storage of Cold Foods, dated 2023, the P&P indicated, Policy: All the perishable food items purchased by the department of food and dining services will be stored properly. All open food items will have an open date and use-by-date per manufacturer's guidelines . 9. All refrigerated foods will be covered properly . 12. All meat and perishable food, e.g. pudding, milkshakes, juices, etc placed in the refrigerator for thawing must be labeled on pull date and used by date when item was transferred to the refrigerator . 15. Refer to Refrigerated Storage Guidelines for recommended storage time.During a review of the facility's dry goods storage guidelines titled, Dry Goods Storage Guidelines, dated 2023, the dry goods storage guidelines indicated, Pasta and rice mixes: Opened on shelf - 1 year .Sauces - bottled (steak sauce, soy sauce, teriyaki, Worcestershire): Opened on Shelf - refrigerate.During a review of the facility's refrigerated storage guidelines titled, Refrigerated Storage Guide, (undated). the refrigerated storage guide indicated, Supplemental shakes taken from the frozen state and thawed in the refrigerator will be dated as soon as they are placed in the refrigerator. Follow the manufacturer's recommendations (specifications) for shelf life.During review of the manufacturer's guidelines (MGs) listed on each individual sized carton of health shakes, the MGs indicated, Use thawed product within 14 days. Keep refrigerated.During a review of the facility's P&P titled, Canned and Dry Goods Storage, dated 2023, the P&P indicated, 9. Metal, plastic containers (with tight fitting lids and NSF[National Sanitation Foundation] approved), or resealable plastic bags will be used for staples and opened packages of items such as pastas, rice, dry cereals, etc. Food items will be labeled and dated when placed into containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure an infection control program was implemented when: 1. Infection surveillance (the systematic, ongoing collection and analysis of data to prevent the spread of healthcare associated infections [HAI]) was not performed. This failure resulted in an increase in urinary tract infections. 2. One of one sampled resident (Resident 101) on Enhanced Barrier Precautions (EBP - gown and gloves are used during care of residents with indwelling medical devices and open wounds, to prevent infection) had foam material wrapped and secured with tape around both upper bed rails. This failure had the potential to result in Resident 101 developing an infection. 3. Two Certified Nurse Assistants (CNA 3 and CNA 4) did not follow EBP for one of one sampled resident (Resident 138) while providing direct care to Resident 138. This failure had the potential to result in Resident 138 developing an infection. Findings: 1. During a review of the facility's Monthly Infection Surveillance [observation, monitoring, or tracking] Report (MISR), dated February 2026, the MISR indicated, there was five HAI for urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of the facility MISR, dated March 2026, the MISR indicated there was ten HAI for UTI. During a review of the facility MISR, dated April 2026, the MISR indicated there was 13 HAI for UTI. During a concurrent interview and record review on 6/17/26 at 9:32 a.m. with Infection Preventionist (IP), the MISR for February, March, and April of 2026 were reviewed. The MISR indicated there were an increase in UTI's. IP stated she did not completing training or surveillance rounds to identify or prevent further infections. During a review of the facility's P&P titled, Infection Prevention and Control Program, undated, the P&P indicated, Surveillance tools are used for recognizing their currents of infection recording their numbers and frequency detecting outbreaks and epidemics monitoring employee infection monitoring adherence to infection prevention and control practices and detecting unusual pathogens [germs] with infection control implication. 2. During an observation on 6/15/26 at 8:44 a.m. in Resident 101's room, Resident 101 was lying in bed with both upper bedrails in the up position. The top of the bedrails were covered by a foam like material that was secured in place with four separate pieces of tape. The tape was pulling away on the left bedrail exposing the adhesive underneath. During a concurrent observation and interview on 6/18/26 at 10:41 a.m. with IP in Resident 101's room, Resident 101's upper bedrails were covered in a foam like material that was secured with tape. IP stated Resident 101 was on EBP for an open wound. IP stated the tape was not changed everyday, and was pulling away from the foam and caused a potential risk for infection for Resident 101. 3. During an observation on 6/15/26 at 9:09 a.m. outside Resident 138's room, an EBP sign was on the wall beside the door and an orange dot was on the nameplate next to Resident 138's name. During an observation on 6/15/26 at 9:12 a.m. in Resident 138's room, CNA 3 was changing Resident 138's bed linens while only wearing gloves. During an observation on 6/15/26 at 9:13 a.m. outside Resident 138's room, CNA 4 entered Resident (continued on next page)

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	06/18/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	138's room, donned gloves and went to Resident 138's bedside to assist CNA 3 with care of Resident 138. During an interview on 6/15/26 at 9:18 a.m. with CNA 4, CNA 4 stated the orange dot on Resident 138's name plate indicated Resident 138 was on EBP and she needed to wear gloves and a gown when providing care to Resident 138. During an interview on 6/18/26 at 10:07 a.m. with IP, IP stated staff are expected to wear a gown and gloves when providing care to residents on EBP. IP stated EBP were used to help prevent the resident from developing an infection. During a concurrent interview and record review on 6/18/26 at 10:14 a.m. with IP, Resident 138's Physician Order (PO), dated 3/10/26 was reviewed. The PO indicated, Enhanced Barrier Precautions during high contact time. IP stated Resident 138 was on EBP for history of Multidrug Resistant Organism (MDRO – bacterial infections that are resistant to antibiotic treatment). During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated December 2024, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multidrug-resistant organisms (MDROs) to residents. 2. Enhanced barrier precautions apply when: a. A resident is infected or colonized with a CDC – targeted MDRO, but does not have a wound or indwelling medical device. 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities. a. Gloves and gown are applied prior to performing high contact resident care activity.