

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555922	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Orchards Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Amistad Drive Rancho Mission Viejo, CA 92694	
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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of 13 final sampled resident (Resident 2) remained free from accident hazards. * Resident 2's bilateral floor mats were not in place as ordered. This failure had the potential to put the resident at risk for further injury in the event of a possible fall. Findings: Review of the facility's P&P titled Falls Intervention Policy and Procedure revised 1/29/26, showed the residents' care plans will address interventions based on the resident's fall risk and other input as appropriate. On 7/14/26 at 0916 hours, Resident 2 was observed in bed with Sitter 1 at his bedside. Resident 2's floor mats were observed propped up against the wall, not on the floor next to his bed. Sitter 1 stated Resident 2 was confused and unable to answer questions appropriately. Sitter 1 verified the floor mats were already propped up against the wall when they arrived and were only used at night-time. Medical record review for Resident 2 was initiated on 7/14/26. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed a physician's order dated 6/23/26, for bilateral floor mats at bedside while in bed every shift, to mitigate the risk of injury related to a fall. Review of Resident 2's H&P examination dated 6/24/26, showed the resident had a spinal fracture resulted from a fall. Review of Resident 2's Care Plan Report (undated) showed a focus for Resident 2 being at risk for falls or injury related to a history of falls. Interventions included bilateral floormats at bedside while the resident was in bed and a caregiver for cuing and redirection. On 7/14/26 at 0927 hours, an observation and concurrent interview was conducted with RN 1. RN 1 stated Resident 2 ambulates without direction, and family provides the sitter for safety. RN 1 verified the bilateral floor mats were propped against the wall and should be placed on the floor next to each side of the bed. RN 1 stated floor mats are to be in place at all times, while the resident was in the bed.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555922 If continuation sheet Page 1 of 3

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the pharmaceutical processes was followed. * The facility failed to ensure Resident 5 received a multivitamin with minerals medication as ordered by the physician. * The facility failed to ensure the incoming and outgoing licensed nurses signed the reconciled controlled medications sheet at shift change for Medication Cart A. * Resident 20's lidocaine 5% topical patch was removed as ordered by the physician. These failures had the potential to result in inaccurate controlled medication reconciliation and a delay in identifying potential drug diversion; and the potential to develop adverse outcomes to the residents due to not following medication orders. Findings: 1. Review of the facility's Medication Administration P&P revised March 2021 showed to reorder medications at least three days before the supply is exhausted. Medical record review for Resident 5 was initiated on 7/14/26. Resident 5 was readmitted to the facility on [DATE]. Review for Resident 5's Order Summary Report showed a physician's order dated 3/3/26, for liquid multivitamin with mineral, administer 15 ml via GT daily. On 7/15/26 at 0838 hours, a medication administration observation for Resident 5 was conducted with LVN 2. During the observation, LVN 2 was unable to locate multivitamin with mineral in the medication cart and therefore, did not administer it to the resident as ordered. LVN 2 stated she would look in the stock room for multivitamin with mineral supply. On 7/15/26 at 1015 hours, LVN 2 stated there was no multivitamin with mineral in stock at the facility. 2. Review of the facility's P&P titled Controlled Drugs revised October 2018 showed controlled drugs have a potential for abuse, and may also lead to physical or psychological dependence. Controlled medications are subject to special handling, which includes storage under separate lock from non-controlled drugs, use of a count sheet for accounting usage, and routine auditing. Controlled medications shall be audited at shift change and a record of the audit shall be kept. On 7/15/26 at 1208 hours, an inspection of Medication Cart A was conducted with LVN 2. Review of the narcotic/controlled medication reconciliation count sheet titled Narcotic Book #3, showed signatures for incoming and outgoing licensed nurses for each shift change. Signatures to show a controlled medication audits were conducted at shift change were observed to be incomplete on the following dates:- On 5/12/26 at 2300 hours, the outgoing licensed nurses' signature was missing;- On 6/1/26 at 2300 hours, the outgoing licensed nurses' signature was missing; and- On 7/8/26 at 2300 hours, the outgoing licensed nurses' signature was missing.LVN 2 verified the missing signatures. 3. Medical record review for Resident 20 was initiated on 7/14/26. Resident 20 was admitted to the facility on [DATE]. Review for Resident 20's Order Summary Report showed a physician's order dated 9/3/25, to apply a lidocaine (a fast-acting local anesthetic) external patch 5% to the resident's left shoulder daily for pain, and to remove the patch as scheduled. Review of Resident 20's MAR for July 2026 showed the lidocaine patch was scheduled to be applied at 0900 hours, and removed at 2059 hours. On 7/15/26 at 0826 hours, a medication administration observation for Resident 20 was conducted with LVN 1. When LVN 1 exposed Resident 20's shoulder to apply the lidocaine external 5% patch, a patch was already observed on the resident's shoulder. LVN 1 removed the old patch and applied the new patch. LVN 1 verified she removed the old lidocaine patch, and the patch should have been removed the night before at 2059 hours.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services to one of five final sampled residents (Resident 13) reviewed for unnecessary medications. * The facility failed to hold Resident 13's BP medication per the physician's ordered parameters. This failure had the potential for the resident to develop significant adverse and side effects from the medication. Findings: Review of the facility's Medication Administration P&P revised March 2021 showed the prescriber's orders will be used to verify the medication and dosage. Medical record review for Resident 13 was initiated on 7/14/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Order Summary Report showed a clinician's order dated 6/23/26, for lisinopril (medication to treat high blood pressure) 30 mg daily by mouth for hypertension, and to hold the medication for a SBP less than 130 mmHg. Review of Resident 13's MAR for June 2026 showed the lisinopril medication was administered to the resident when it should have been held for a SBP below 130 mmHg, on the following dates:- On 6/24/26 at 0900 hours for a BP of 128/80 mmHg;- On 6/25/26 at 0900 hours for a BP of 124/80 mmHg;- On 6/27/26 at 0900 hours for a BP of 124/26 mmHg;- On 6/28/26 at 0900 hours for a BP of 128/57 mmHg; and- On 6/30/26 at 0900 hours for a BP of 120/68 mmHg. Review of Resident 13's MAR for July 2026 showed the lisinopril medication was administered to the resident when it should have been held for a SBP below 130 mmHg, on the following dates:- On 7/1/26 at 0900 hours for a BP of 118/67 mmHg;- On 7/3/26 at 0900 hours for a BP of 129/69 mmHg;- On 7/4/26 at 0900 hours for a BP of 122/76 mmHg;- On 7/5/26 at 0900 hours for a BP of 120/64 mmHg;- On 7/8/26 at 0900 hours for a BP of 122/60 mmHg;- On 7/9/26 at 0900 hours for a BP of 123/73 mmHg;- On 7/10/26 at 0900 hours for a BP of 120/65 mmHg;- On 7/11/26 at 0900 hours for a BP of 124/67 mmHg; and- On 7/12/26 at 0900 hours for a BP of 120/82 mmHg. On 7/15/26 at 1144 hours, an interview and concurrent medical record review for Resident 13 was conducted with LVN 1. When asked how the hold parameters for the BP medications are determined, LVN 1 stated the facility's hold parameters for the BP medications were to hold the medication for a SBP less than 110 mmHg. LVN 1 reviewed Resident 1's MAR for June and July 2026, and verified the above doses were administered. LVN 1 then reviewed the physician's order, and verified the above medication doses should have been held per the physician's ordered hold parameters.		