STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555702	A. BUILDING _____ B. WING _____	**10/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure licensed nurses received training and competencies on the use of LifeVest wearable cardioverter defibrillator (WCD - a device monitor worn by a resident at risk for a [MEDICAL CONDITION] that delivers a shock treatment when there is an abnormal heartbeat) for one of three sampled residents (Resident 1). This failure had the potential to result in delay of identifying possible complication of the device and compromise safety of the residents and staff. Findings: During a review of Resident 1's, Admission Record (AR), undated, the AR indicated, Resident 1 was admitted at the facility on [DATE] with a [DIAGNOSES REDACTED]. During a review of Resident 1's Progress Notes (PN), dated [DATE], the PN indicated, Resident (1) was admitted with a WCD and died on [DATE]. During an interview on [DATE], at 10:10 AM, with Licensed Vocational Nurse (LVN 1), LVN 1 stated, I don't even know what a (WCD) is. I didn't get any training on it. During an interview on [DATE], at 10:19 AM, with Registered Nurse (RN), RN stated, the facility did not provide any training on how to use the (WCD). RN stated she was unaware of the different WCD alarm sounds and what actions to take for any complications or malfunction of the device. During an interview on [DATE], at 10:30 AM, with LVN 2, LVN 2 stated, I took care of (Resident 1) one time . I didn't receive any training or an in-service on the (WCD). During an interview on [DATE], at 11:27 AM, with the Director of Staff Development (DSD), DSD stated, she did not provide any training or education on the use of WCD. DSD stated, We're supposed to provide training on any new equipment, but I didn't. During an interview on [DATE], at 12:18 PM, with LVN 3, LVN 3 stated, he did not receive any training on the use of WCD and unable to verbalize on what to do when the WCD delivers a shock treatment. During an interview on [DATE], at 12:53 PM, with the Director of Nursing (DON), DON stated, her expectation is for all staff to have training and competencies on all new equipment and devices including the WCD. During a review of the manufacturer's, Information for Family and Caregivers (IFC), dated 2020, the IFC indicated, Wash the LifeVest WCD garment every ,[DATE] days. Do not touch the patient when there are loud two- tone sirens broadcasting from the LifeVest WCD. The patient may be in the process of receiving a shock and you can be shocked if you are touching them at this time. During a review of the facility's policy and procedure (P&P) titled, Staff Development Program, dated ,[DATE], the P&P indicated, The primary objective of our facility's Staff Development Program is to ensure that staff have the knowledge, skills and critical thinking necessary to provide excellent resident care.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.