STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055706	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE ORCHARD - POST ACUTE CARE	12385 E. WASHINGTON BLVD WHITTIER, CA 90606

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to acknowledge and provide facility residents' care needs for three of three sampled residents (Residents 4, 5, and 7). 1. Resident 4 asked three staff members repeatedly to return her to her room, because she was tired. The facility staff took Resident 4 to the dining room, left the resident at a table, and gave resident coffee. 2. Resident 5 expressed fears of urinating more than twice during the night and fear of having bowel movements in bed. Resident 5 stated having two urinals in bed due to staff not assisting the resident at night when the resident called for assistance. 3. Resident 7 stated being thirsty to multiple staff members, and facility staff ignored resident's request for a drink. These deficient practices resulted Residents 4 and 7's care needs being ignored multiple times by facility staff, and Resident 5 feeling neglected. Findings: 1. A review of Resident 4's Face Sheet (a record of admission), dated 3/05/20, indicated Resident 4 admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 4's History and Physical (H&P), dated 7/29/19, indicated Resident 4 has fluctuating capacity to understand and make decisions. The H&P indicated Resident 4 was wheelchair dependent and the facility staff was to assist with transfers. A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 1/05/20, indicated Resident 4 was totally dependent on staff for transferring from one place to another. A review of Resident 4's care plan titled, Activities of Daily Living (ADL) Self Care Deficit, with a revised date of 7/27/19, indicated interventions, which included encouraging Resident 4 to participate to the fullest with each interaction. During the same facility tour on 3/05/20 at 6:35 a.m., Resident 4 was observed sitting in a wheelchair, legs raised, contracted, and covered with a blanket. Resident 4 was calling out repeatedly stating, I'm tired and Please help. Resident observed to continue to call out, while staff members passed the resident in the hallway and entered the nurses' station. At 6:55 a.m. a Registered Nurse Supervisor (RNS) passed by Resident 4 and resident repeatedly stated, I'm tired. RNS did not look at or speak to the resident. Resident 1 observed not acknowledge and ignored by staffs. At 6:57 a.m., RNS approached Resident 4. Resident 4 stated, I'm tired, I want to go back to my room. RNS replied, Okay you want to go to the dining room? Resident 4 replied, No, repeatedly. The RNS observed wheeling Resident 4 into the dining room, placed resident at a table in the dining room, and walked away. A Rehabilitation Nurse Aide 1 (RNA 1) approached Resident 4. Resident 4 observed stating, Estoy cansada (I'm tired in Spanish), to RNA 1. RNA 1 replied, Okay, let me get you some coffee. Resident 4 observed stating and repeating feeling tired as RNA 1 walked away. During an interview on 3/05/20 at 7:04 a.m., Resident 4 stated she was tired, and her leg hurt as she rubbed her right leg. Resident 4 stated she did not want to be in the dining room and wanted to go to her bed. Resident 4 stated staff do not listen and felt, helpless. During a concurrent observation and interview, on 3/05/20 at 7:10 a.m., RNA 2 approached Resident 4 and informed her the coffee was coming. Resident 4 stated she did not want coffee. RNA 2 was about to walk away as RNA 1 returned with the coffee and placed it on the table. RNA 1 and RNA 2 stated they did not listen to what Resident 4 was saying. RNA 1 stated she violated Resident 4's rights by not respecting her wishes. RNA 1 stated she would return Resident 4 to her room. During an interview on 3/05/20 at 7:15 a.m., RNS stated he did not hear Resident 4 say she wanted to go to her room. 2. A review of Resident 5's Face Sheet, dated 3/05/20 indicated Resident 5 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 5's H&P, dated 2/14/20, indicated Resident 5 had the capacity to make and understand decisions. A review of Resident 5's MDS, dated [DATE], indicated Resident 5 required supervision with toileting. During an interview on 3/05/20 at 8:14 a.m., Resident 5 observed in bed with his right leg resting over a pillow. Urinals observed on both upper side rails of the resident's bed. Resident 5 stated he has two urinals because urinals are often left overnight without being emptied. Resident 5 stated he needed to have the extra one because they wouldn't come to empty it, and there had been multiple episodes when he urinated on himself because when he pushed the call light they wouldn't come. Resident 5 stated he was in daily fear of urinating more than once during the night because he only had two urinals. Resident 5 stated, I am an adult I shouldn't pee in bed. Resident 5 stated he feared drinking a lot of fluids or eating because then he would have to pee more than twice and often held his bowel movements in fear of having to lay in his feces for hours. Resident 5 stated he felt, Neglected, at the facility. Resident 5 stated there had been times when he wasn't feeling well and wanted to stay in bed. Resident 5 stated the nurses would not listen to him and take him to the patio. Resident 5 stated, When is it okay to be human again? Resident 5 stated he was very depressed and didn't feel he was respected as a human being by the nurses at the facility. Resident 5 observed to have tears rolling down cheeks. During a telephone interview on 3/05/20 at 8:39 a.m., a Family Member 1 (FM 1), stated she had noticed her husband becoming depressed since being at the facility. FM 1 stated she was not sure what the call light was for because the staff did not answer it. FM 1 stated she had to clean her husbands' urinals the night before (3/04/20) because they were full of urine and smelled. During an interview on 3/05/20 at 9:40 a.m., the Director of Nursing (DON) stated it was the facility's policy to empty and clean urinals every 2 hours. The DON stated urinals are not to be kept on the bedside tables and should be kept within reach of the resident. The DON defined resident's rights as the residents should be heard and listened to. The DON stated if a resident is left asking for help their needs are being neglected. 3. A review of Resident 7's Face Sheet, dated 3/05/20, indicated Resident 7 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 7's H&P, dated 8/1/19, indicated Resident 7 had the capacity to make and understand decisions. A review of Resident 7's MDS, dated [DATE], indicated Resident 7 required oversight and encouragement with eating. A review of Resident 7's care plan titled, Resident may have water pitcher at bedside with allotted amount of fluid as ordered, with a revised date of 1/8/20, indicated the resident's rights were to be honored. During an observation on 3/05/20 at 11:15 a.m., Resident 7 observed in hallway in front of nurse's station, repeating in Spanish, Tengo sed, (I am thirsty in Spanish). LVN 1 observed standing directly in front of the resident by the medication cart. LVN 1 observed looking at the resident and then looked away. Resident 7 observed for 10 minutes and no staff responded to Resident 7's requests for something to drink from staff walking by the resident or from LVN 1 who was standing at a medication cart. At 11:25 a.m., Resident 7 observed still saying being thirsty and LVN 1 observed asking Resident 7, Agua o jugo (water or juice in Spanish). Resident 7 stated, Jugo. LVN 1 observed poured juice from the med cart and gave some to Resident 7. Resident 7 stated she didn't like that juice. LVN 1 went to the medication cart, poured water in a cup, and gave it to Resident 7. Resident 7 stated she did not want water and wanted juice. LVN 1 stated, This is all I have. During an interview on 3/05/20 at 11:20 a.m., LVN 1 stated she gave Resident 7 what she had and since the resident did not like the juice she had on her med cart, she gave the resident water. A review of the facility's policy and procedure titled, Resident Rights: Abuse Prevention and Prohibition, with a revised date of 9/2017, indicated residents must not be subjected to abuse by anyone, including but not limited to facility staff. The policy defined abuse as willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or mental anguish.

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.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) This includes deprivation by an individual, including caretaker, of good or services that are necessary to attain or maintain physical, mental or psychosocial well-being. The policy defined involuntary seclusion as separation of a resident from other residents or from his/her room or confinement to his/her room (with or without roommates) against the resident's will, or the will of the resident's representative. The policy defined mental abuse as including humiliation. The policy also defined neglect as the failure of the facility and its employees to provide goods and services to a resident. A review of the facility's policy and procedure titled, Resident Rights: Resident Rights, with a revised date of 5/2007, indicated residents had the right to be treated with consideration, respect, and full recognition of his or her dignity and individuality. The policy also indicated the residents had the right to be free from different types of abuse including mental and involuntary seclusion. A review of the facility's policy and procedure titled, Quality of Care: Toileting Plan, Prompted/Scheduled, with a revised date of 8/2007, indicated residents were to be checked at regular intervals and asked if they were wet or dry.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote infection control measures by improperly disinfecting a shower chair used by multiple residents. This deficient practice had the potential for cross contamination and the spread of infection to other residents. Findings: During a tour of the facility on 3/05/20 at 6:20 a.m., an unlabeled pink water pitcher was on the handrail outside the door of an isolation room (room [ROOM NUMBER]). During an interview on 3/05/20 at 6:25 a.m., a Certified Nursing Assistant 1 (CNA 1) stated the unlabeled pink water pitcher belonged to the resident in the isolation room. CNA 1 stated that it should not be left out in the hallway because it could spread infection. During an observation on 3/05/20 at 11:00 a.m., CNA 2 wheeled the shower chair with three trash bags on it outside and returned inside the facility with the shower chair. CNA 2 used a paper towel and wiped down shower chair and returned it to the shower room. During a concurrent observation and interview with CNA 2 on 3/05/20 at 11:10 a.m., 15 shower chairs were in the shower room. CNA 2 stated the very first chair closest to the entrance door was the chair she placed in there. CNA 2 then stated she did not disinfect the chair and should have cleaned with disinfectant to prevent the spread of infection. During an interview on 3/05/20 at 12:35 p.m., the Director of Nursing (DON) stated that trash should be placed in a bag and carried to the trash bin outside. The DON stated it was acceptable to use a shower chair to transport trash as long as the staff wiped it down afterwards. The DON stated the staff are to use disinfectant wipes to clean the shower chair and/or other equipment to prevent the spread of infections. Paper towels are not appropriate for disinfection. A review of the facility's policy titled, Infection Prevention: Cleaning and Disinfection of Wheelchairs, Walkers, and Shower Chairs, revised on 12/2019, indicated it is the facility's policy to clean and disinfect wheelchairs, walkers, and shower chairs when dirty and between resident use. Only approved cleaning products may be used. The cleaning products manufacturers' recommendations will be followed in the cleaning and disinfection of equipment. A review of the facility's policy titled, Infection Control Prevention and Control Program, date revised on 9/2017, indicated staff and resident education is done to identify risk of infection and promote practices to decrease the risk. The facility staff will follow its policies, procedures, and aseptic practices in performing procedures, linen handling, and disinfection of equipment.