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 _____	**06/01/2020**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the responsible party (RP) for one of three sampled residents (Resident 1) of a change in condition (COC) that occurred on 3/23/20. This deficient practice had the potential to violate resident's rights to be informed. Resident 1's RP was not aware of the residents COC. Findings: A review of Resident 1's Admission Record indicated an initial admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a screening and assessment tool), dated 2/22/20, indicated Resident 1 required extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff with transfers, dressing and toilet use. A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, technique provides a framework for communication between members of the health care team and can be used as a tool to foster a culture of patient safety) Communication Form, dated 3/23/20, indicated the resident had a left eyebrow cut 1.8 centimeter (cm, a unit of length) by 0.2 cm. A review of Resident 1's Order Summary Report for April 2020 indicated to clean the resident's left eyebrow cut with normal saline (NS, solution used to clean wounds), pat dry, apply triple antibiotic (a medicated ointment to treat and/or prevent infection), and apply a dry dressing every day shift for 21 days. A review of Resident 1's Nursing Progress Note, dated 3/25/20 at 12:43 p.m., indicated a Registered Nurse 1 (RN 1) conducted a head to toe assessment of Resident 1. The Nursing Progress Note indicated the resident's left eyebrow had a scratch mark with discoloration to the surrounding site. A review of Resident 1's Nursing Progress Notes from 3/21/20 to 3/25/20 did not indicate when the scratch mark was first identified and/or that there was any ongoing monitoring. During an interview on 4/10/20 at 12:02 p.m., the Responsible Party (RP) stated the day that Resident 1 was discharged , a laceration (a cut) on Resident 1's forehead was observed. The RP stated he did not receive notification of cut to the forehead. During an interview on 4/28/20 at 10 a.m., a Registered Nurse 1 (RN 1) stated on the day of Resident 1's discharge, the facility did an assessment because the skin integrity was not normal and the resident had discoloration and scratch marks to two different areas on Resident 1's left eyebrow. RN 1 stated the facility did a COC note on 3/23/20. RN 1 stated that the staff should notified the resident's physician and RP as part of the resident's rights to be informed. During an interview on 4/28/20 at 10:37 a.m., the Director of Nurses (DON) stated the day Resident 1 was discharged , a scratch on the forehead was identified by the RP. The DON stated he was surprised to hear when the RP stated he was not aware about the scratch mark on Resident 1's forehead. The DON stated that Resident 1's SBAR dated 3/23/20 indicated that staff notified the resident's Nurse Practitioner (NP) and RP of the laceration. The DON stated that Resident 1's cut was faded red and brown-blue to surrounding area without a scab. During a concurrent interview and record review on 4/30/20 at 10:12 a.m., a Licensed Vocational Nurse 1 (LVN 1) stated he completed COC Evaluation after assessing Resident 1's forehead on 3/23/20. LVN 1 stated that he documented that he notified Resident 1's primary care clinician and RP at 3 p.m. LVN 1 stated on he did not notify Resident 1's RP on 3/23/20 at 3 p.m. and was not able to leave a voice message at that time. LVN 1 also stated that he did not attempt to call the RP again. LVN 1 stated that there is no documentation indicating that the facility attempted to call the RP to notify him of the incident. A review of the facility's policy and procedure titled, Change of Condition Reporting, revised on 05/2007, indicated the licensed nurse will inform family of change of condition and document notification. The resident/ RP will be notified that there has been a change in the resident's condition and what steps are being taken.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate and/or update a care plan after a change of condition (COC) for one of three sampled Residents (Resident 1). This deficient practice had the potential for the resident to not receive specific person-centered care and/or monitoring for the identified COC. Findings: A review of Resident 1's Admission Record indicated an initial admission to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a screening and assessment tool), dated 2/22/20, indicated Resident 1 required extensive assistance (resident involved in activity, staff provided weight-bearing support) from staff with one person physical assist for bed mobility, transfers, dressing and toilet use and limited assistance (resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance) from staff for eating and personal hygiene. A review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR, technique provides a framework for communication between members of the health care team and can be used as a tool to foster a culture of patient safety) Communication Form, dated 3/23/20, indicated the resident had a left eyebrow cut 1.8 centimeter (cm, a unit of length) by 0.2 cm. A review of Resident 1's Order Summary Report indicated to clean the left eyebrow cut with normal saline (NS, solution used to clean wounds), pat dry, apply triple antibiotic (a medicated ointment to prevent and/or treat infection), and apply a dry dressing every day shift for 21 days. During an interview on 4/28/20 at 10:13 a.m., a Registered Nurse 2 (RN 2) stated that Resident 1 had a skin discoloration to the forehead with scratch marks. RN 2 described the skin discoloration as purplish/maroonish with two areas having scratch marks. During an interview on 4/28/20 at 10:37 a.m., the Director of Nurses (DON) stated the discoloration on Resident 1's forehead had a faded redness and brownish/blue discoloration around cut area. The DON stated there was no scab present. During a concurrent interview and record review on 4/30/20 at 10:12 a.m., a Licensed Vocational Nurse 1 (LVN 1) stated that after a SBAR form was filled out, staff are to document a COC note for continued monitoring. LVN 1 stated the staff are to initiate a care plan after a COC occurred for Resident 1. LVN 1 stated there is no documentation of a care plan for Resident 1's left eyebrow cut. During a concurrent interview and record review on 4/30/20 at 10:41 a.m., RN3 stated Resident 1 had an SBAR form dated 3/23/20 and a Nursing Progress Note dated 3/25/20 addressing Resident 1's cut to the left eyebrow. RN 3 stated there was no care plan initiated for Resident 1's left eyebrow cut and discoloration. RN 3 stated the care plan is important to communicate plan of care, goals, and precautions needed to help prevent incidents or issues from occurring again. During a concurrent interview and record review on 4/30/20 at 11 a.m., the DON stated that there is no care plan for Resident 1's cut to the left eyebrow as indicated on Resident 1's Nursing Progress Note dated 3/25/20. The DON further stated that a short term, specific care plan should have been initiated. A review of the facility's policy and procedure titled, Comprehensive Person- Centered Care Planning, revised on 8/2017, indicated the facility shall develop a person-centered care plan for each resident that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental and

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) psychosocial need identified. The care plan should include information necessary to properly care for each resident and instructions needed to provide effective and person- centered care that meet professional standards of quality.