| 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 _____ | C 07/12/2022 |

| 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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| F 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the California Department of Public Health during an abbreviated standard survey.<br>Complaint Number: 783559<br>Representing the Department:<br>39763, HFEN<br>The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility.<br>Two deficiencies were issued for complaint number 783559. | F 000 | | |
| F 691 SS=D | Colostomy, Urostomy, or Ileostomy Care<br>CFR(s): 483.25(f)<br><br>§483.25(f) Colostomy, urostomy,, or ileostomy care.<br>The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) colostomy care was provided. This failure had the potential for Resident 1 to develop adverse outcomes.<br>Findings:<br>During an interview on 5/31/22, at 9:48 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, residents with a colostomy "we check the site daily, we look at wafer, the stoma, and surrounding skin for signs and symptoms of infection, change colostomy when ordered and when necessary, and document that it was done." | F 691 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/22/22

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 691 | Continued From page 1<br>During a concurrent interview and record review, on 7/7/22, at 11:07 AM, with Director of Nursing (DON) , DON reviewed Resident 1 ' s Medication Administration Record (MAR) for 4/22 and confirmed the following:<br>"Colostomy: Assess site QS (every shift) for any skin breakdown or S/sx (signs and symptoms) of infection during care and notify MD (medical doctor) if any every shift related to ENCOUNTER FOR ATTENTION TO COLOSTOMY . . . -Start Date -4/12/2022 1500 (3 PM)"<br>4/12/22 at 2300 to 0700 (11 PM to 7 AM), no documentation.<br>4/13/22 at 0700 to 1500 (7 AM to 3 PM), no documentation.<br>4/13/22 at 1500 to 2300 (3 PM TO 11 PM), no documentation.<br>4/13/22 at 2300 to 0700, no documentation.<br>4/14/22 at 0700 to 1500, no documentation.<br>4/14/22 at 1500 to 2300, no documentation.<br>4/14/22 at 2300 to 0700, no documentation.<br>4/15/22 at 0700 to 1500, no documentation.<br>4/15/22 at 1500 to 2300, no documentation.<br>DON reviewed, Resident 1 ' s progress notes and confirmed no documentation the Resident 1 ' s colostomy site was assessed on 4/12/22 to 4/15/22. DON stated, "The expectation is nurses should by documenting their assessments were completed."<br>During a review of the facility ' s policy and procedure (P&P) titled, "Colostomy/Ileostomy Care," revised 10/10, the P&P indicated, "The purpose of this procedure is to provide guidelines that will aid in preventing exposure of resident ' s skin to fecal matter. . . Steps in the Procedure . . . 8. When evaluating the condition of the resident ' s skin, note the following: a. Breaks in the skin. B. Excoriation. C. Signs of infection (heat, swelling, pain, redness, purulent exudate, etc.). . . | F 691 | | |

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| F 691 | Continued From page 2<br>Documentation The following information should be recorded in the resident ' s medical record:1. The date and time the colostomy/ileostomy care was provided. 2. The name and title of the individual(s) who provided the colostomy/ileostomy care. 3. Any breaks in resident ' s skin, signs of infection (purulent discharge, pain, redness, swelling, temperature), or excoriation of skin. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason (s) why and the interventions taken. 6. The signature and title of the person recording the data." | F 691 | | |
| F 726 SS=E | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding | F 726 | | |

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| F 726 | Continued From page 3<br>to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure three of three sampled Certified Nursing Assistants (CNA 1, CNA 2, and CNA 3) had competencies upon hire and annually. This failure had the potential to negatively affect the residents' well -being related to the lack of staff competence in providing the necessary care and services.<br>Findings:<br>During a concurrent interview and record review, on 5/17/22, at 12:20 PM, with Director of Staff Development (DSD), DSD reviewed CNA 1, CNA 2, and CNA 3 employee files ' and DSD confirmed, no competencies in CNA 1, CNA 2, or CNA 3 employee files ' . DSD stated, "They [CNAs] should have them [all the needed competencies] we are currently working on that."<br>During an interview on 7/7/22, at 11:07 am, with the Director of Nursing (DON), DON stated, "We require competencies during new hire training, and annually."<br>During a review of the facility ' s policy and procedure (P&P) titled, "Competency of Nursing Staff," revised 10/17, the P&P indicated, "1. All nursing staff must meet the specific competency requirements of their respective licensure and certifications requirements defined by stated law. . . 6. Facility and resident-specific competency evaluations will be conducted upon hire, annually | F 726 | | |

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| F 726 | Continued From page 4<br>and as deemed necessary based on the facility assessment." | F 726 | | |

The Orchards Post-Acute
Plan of Correction (POC)

*This Plan of Correction is submitted as the facility's credible allegation of compliance.*

*This Plan of Correction is prepared as part of the Quality Assurance process for the provider. This Plan of Correction and any attached documents are prepared with substantial reliance upon privileged peer review information and/or reports and as such protected from discovery.*

*This Plan of Correction is prepared, submitted and/or executed solely because it is required by local, state and/or federal regulations, codes, and/or guidelines. As this transmission is required by law it is not a waiver of the provisions within applicable laws and regulations or any other codes, statutes or regulations.*

F 726 Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)

How Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

Staff provided education and competency check off for ostomy care at the CNA (certified nurses assistance) level of practice; emptying, burping, recording amount, and when to report to the licensed nurse on 7/20/22.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:

Staff provided education and competency check off for ostomy care at the CNA (certified nurses assistance) level of practice; emptying, burping, recording amount, and when to report to the licensed nurse on 7/20/22.

What measures will be put into place or what systemic changes will the facility make to ensure that deficient practice does not recur:

New staff members to be provided competency check off at the beginning of orientation and returned to DSD (director of staff development) at the end of orientation to verify completion and sign off. If no residents are available to demonstrate competency at time of orientation, additional inservice to be provided when a resident with an ostomy appliance is admitted to the facility.

How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:

DSD will track and monitor CNA initial competencies and evaluations with competency review (annually) for inclusion of ostomy care within the CNA scope of practice. DON (director of nursing) will inform DSD if a new ostomy resident is admitted to the facility to ensure new hires have received competent training. DSD will report results to QAPI over the next six months.

Date when corrective actions will be completed: July 20th 2022