Revised as accepted - agreement 11/16/11

PRINTED: 10/28/2011
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056709	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12669 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during a re-certification survey. Representing the Department of Public Health: [redacted] Total Resident Population: 138 Total Resident Sample Size: 24 Highest Scope and Severity: E	F 000	This Plan of Correction constitutes The Orchard Post Acute Care's written evidence of its achievement of Substantial compliance of the deficiencies shown on this statement of deficiencies (CMS-2567 dated 11/01/2011) and its ability to maintain substantial Compliance through the monitoring of its quality assurance programs. Preparation and or execution of this Plan of Correction Does not constitute admission and/or agreement by The Orchard Post Acute Care of the alleged and/or Conclusion set forth on this Statement of Deficiencies, this Plan of Correction is prepared and/or executed because the provisions of Health and Safety Code, Section 1250 and 42 code of Federal Regulations. 405.1907 requires it.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure monitoring of a resident's episodes of diarrhea and monitoring the resident's condition before and after dialysis treatment in accordance with the comprehensive assessment and plan of care for three of 24 sample residents (1, 19, 20). Resident 1's nurse practitioner was notified the resident had	F 309	A. IMMEDIATE CORRECTIVE ACTION: F309 Resident#1 was assessed and episode of diarrhea was monitored immediately and MD was notified. Resident#19 The communication record during dialysis procedure was reviewed and updated including consistency of pre and post dialysis weight. Resident#20 A monitoring of condition of pre and post dialysis was put in place promptly. B. IDENTIFICATION OF OTHERS AT RISK: All residents on dialysis have the potential to be affected.	

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2011 NOV 10 PM 2:33
HEALTH FACILITIES INSPECTION DIVISION ADMINISTRATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert E. Gaston	Administrator	11/10/2011

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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	055709	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12365 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 diarrhea, however, there was no ongoing monitoring for further episodes and a stool sample for a laboratory test was not collected as ordered. Resident 18, who was receiving dialysis treatment, had no consistent ongoing pre and post dialysis weight assessment and the ordered fluid restriction was not implemented. Resident 20's condition was not monitored after a dialysis treatment as indicated in the plan of care. This deficient practice had the potential for undetected complications of the residents' condition and delayed interventions. Findings: 1. On 10/13/11, at 8:40 p.m., Resident 1 was observed in bed on a low air loss mattress (a pressure relieving mattress for pressure ulcer treatment), with the head of the bed elevated to a sitting position. The resident was lying on a total of six layers of linen that were on the mattress. The resident had an indwelling catheter for urine drainage connected to a drainage bag which had clear yellow urine. The resident who was able to communicate, indicated she felt uncomfortable in the bed and wanted to change position. On 8/14/11, a review of the clinical record revealed the resident was admitted to the facility on 3/4/10, with diagnoses that included secondary Parkinsonism, diabetes mellitus and hypertension. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 8/25/11, indicated the resident had memory recall problems, was unable to walk and required extensive assistance with bed mobility, transfers,	F 309	**C. PROCESS TO PREVENT RECURRENCE:** Director of Nursing and/or designee conducted an in-service training regarding completion of communication record of pre and post dialysis including weights. And other pertinent change of condition. Medical record and/or designee will continue to monitor and audit dialysis communication record. **D. MONITORING PROCESS:** QAA/CQI will monitor compliance by review of the quarterly "Dialysis communication record" necessary correction will be made.	11/03/11

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	055706	A. BUILDING _____ B. WING _____	10/10/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 toilet use and personal hygiene. According to the nurse's note dated 9/30/11, a new order was obtained for stool for Clostridium Difficile (C. Diff - a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon) to be collected on 10/3/11. The nurse did not indicate the reason for the order. According to the Physician Progress Notes form, on 10/13/11, a geriatric nurse practitioner (GNP) documented being informed by a registered nurse (RN) staff member that the resident was still having diarrhea but the stool for C. Diff ordered for 10/3/11, was not collected. The GNP documented a possible C. Diff infection and ordered again to collect the stool sample for C. Diff. Further review of the licensed nursing notes from 9/25/11 to 10/14/11, revealed no documented evidence the licensed nurses were monitoring the resident for episodes of diarrhea. The daily licensed nursing notes did not address bowel movements. There was no plan of care developed to address the resident's diarrhea and to implement interventions including monitoring the resident's progress and signs and symptoms of complications including dehydration, skin breakdown, etc. A review of the certified nursing assistants (CNAs) documentation in the Bowel and Bladder Detailed Entry Report from 9/15/11 to 10/14/11, revealed the resident had 20 episodes of loose stools in different days.	F 309		

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	056706	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12395 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 According to the facility's nursing administration policy and procedure on Change of Condition Reporting, revised 5/2007, the licensed nurse is responsible to continue an assessment and documentation of the resident's condition for at least 72 hours or until the condition has stabled. Resident with acute medical changes and some routine changes, will be listed on the 24 Hours Report and have progress and needs clearly communicated to each shift. A comprehensive care plan would be completed. On 10/14/11, at 8 p.m., during an interview, a RN supervisor stated she was no aware the resident had episodes of diarrhea and if there was any diarrhea, the licensed nurses had to monitor and document in their nursing notes. 2. On 10/15/11, at 2 p.m., Resident 20 was observed lying in bed, awake and alert, with a right upper chest central line (vascular access for hemodialysis), and an arteriovenous (AV) shunt on the left forearm. A review of the clinical record disclosed the resident was readmitted to the facility on 8/17/11, with diagnoses that included end stage renal disease (ESRD), extracorporeal dialysis, coronary atherosclerosis, and diabetes. The quarterly Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 8/29/11, indicated the resident had no memory problems and was independent in cognitive skills for daily decision-making. The resident was frequently incontinent of bowel and occasionally incontinent of bladder, and required extensive staff assistance with most of his	F 309		

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	055708	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 309	Continued From page 4 activities of daily living (ADLs). A care plan dated 8/17/11, developed for problem/need of potential for complications related to diagnosis of renal failure/ESRD requiring dialysis, had a goal for the resident to remain free of complications related to renal disease or dialysis. The approaches included to assess the skin, vital signs, weights, and the vascular access pre and post dialysis. A physician's order dated 8/17/11, indicated dialysis treatment every Tuesday, Thursday, and Saturday. Further record review revealed the AV shunt was used for dialysis treatment and the central line was no longer used for dialysis. The facility's policy and procedure titled "Renal Dialysis, Care of Resident, Hemodialysis Access Site, Diet/Fluid Restrictions, Care Plan", dated 8/2009, indicated the facility will check AV Fistula and/or AV Graft site for bruit and thrill upon return from dialysis and every shift. The licensed nurses will complete the baseline information, pre and post dialysis section of the Nurses Dialysis Communication Record. A review of the Pre and Post Dialysis Assessment Form revealed the resident's post dialysis assessment was not done on 8/20/11. There was no assessment of the vascular access site, thrill, bruit, weight, vital signs, bleeding, and dressing. On 10/15/11 at 3:16 p.m. during an interview, Registered Nurse (RN 1) stated the resident's assessment must be done and recorded before and after dialysis treatment to monitor the resident's condition pre and post dialysis, such as	F 309		

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THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 309	Continued From page 6 bleeding, hypo/hypertension, and any other sign and symptom of complication from dialysis. At 3:20 p.m. during an interview, Licensed Vocational Nurse 1 (LVN 1) stated she overlooked completing the Post Dialysis Assessment form on 9/20/11. She further stated, the assessment of the vascular access site, thrill, bruit, weight, vital signs, bleeding, and dressing should have been done to detect/prevent complications. 3. On 10/16/11, at 8 a.m., during the breakfast meal observation for Resident 19, the meal tray by her bedside was noted to have mocha mix, juice, coffee and water for a total of 720 cubic centimeter (cc) of fluid. The meal tray card indicated to provide eight ounces of mocha mix and four ounces of juice (for a total of 360 cc). A review of clinical record indicated the resident was admitted to the facility on 9/26/11, with diagnoses that included end stage renal disease. The MDS assessment dated 10/3/11, indicated the resident was alert and oriented and required extensive assistance with ADLs. A plan of care dated 9/27/11, indicated the resident was on hemodialysis treatments, was at risk for weight fluctuation, fluid deficit, and edema. The approaches included to monitor weight pre and post dialysis by the facility or by the dialysis center. A physician's order dated 10/3/11, indicated fluid restriction of 1000 cc in 24 hours. The dietary staff was to provide 240 cubic centimeter of fluid for breakfast. In addition, the Pre and Post Dialysis Assessment form dated 10/5/11, lacked a post dialysis weight. The Pre and Post Dialysis Assessment form	F 309		

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THE ORCHARD - POST ACUTE CARE	12865 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 309	Continued From page 8 dated 10/10/11, had was no pre and post dialysis weight recorded. During an interview with the licensed nurse supervisor and the registered dietitian on 10/18/11, at 9:15 a.m., they stated the resident should have been served only 240 cc of fluids. The licensed nurse supervisor further indicated the resident's weight should be recorded pre and post dialysis treatment.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents having pressure sores received necessary services to promote healing for two of 24 sample residents (1, 11). Resident 1, who had a Stage III pressure sore on the coccyx (tail bone) area, was not kept off pressure and the plan of care was not revised to indicate areas of pressure to avoid, the length of time the resident could sit in the wheelchair, and a repositioning schedule for the staff to follow. For Resident 11, the plan of care was not individualized to address a turning schedule to manage pressure sores. This	F 314	A. IMMEDIATE CORRECTIVE ACTION: F314 Resident#1 her linens were changed right away in to one layer only. Resident#11 His care plan was revised promptly including time and tolerance to turning and repositioning. B. IDENTIFICATION OF OTHERS AT RISK: All residents have the potential to be affected.	

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	055709	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12288 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 314	Continued From page 7 deficient practice had the potential for delayed healing of pressure sores and further skin breakdown. Findings: 1. On 10/13/11, at 6:40 p.m., during an observation with Licensed Vocational Nurse 1 (LVN 1), Resident 1 was in bed with the head of the bed elevated to a sitting position. The mattress was a low air loss mattress (a pressure relieving mattress for pressure ulcer treatment). The resident was sitting on a total of six layers of linen that were covering the mattress, a bed sheet to the full length of the mattress, a bed sheet folded in four and placed in the middle of the mattress, and one reusable incontinent bed pad (made with thick waterproof fabrics). At the bottom of the bed, there were folded clean linen that included one bed sheet and one re-usable incontinent bed pad. The resident was noted to have an indwelling catheter for urine drainage connected to a drainage bag which had clear yellow urine. At the time of the observation, during an interview wit the resident, who was able to communicate in a low tone of voice, she indicated feeling uncomfortable and wanted to change her position in bed. The resident stated she was sitting up in bed since dinner and was tired. On 10/13/11, at 6:46 p.m., LVN 1 stated the low air loss mattress should only have one layer of linen in order for the resident's skin to benefit from the air mattress and only disposable incontinent pads (made of thin material) should be used. LVN 1 stated the certified nursing assistants (CNAs) would be in-serviced on the proper use of linen on low air loss mattresses.	F 314	C. PROCESS TO PREVENT RECURRENCE: Staff developer in-service the CNA's right away on proper use of linens especially on patients on low air loss mattress including skin management. License nurses & RN Supervisor will perform random rounds and check appropriate use of linens. Will report findings to DON & Staff Developer D. MONITORING PROCESS: QAA/CQI will report findings by quarterly review "Skin Management Protocol" necessary correction will be made.	10/13/11

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THE ORCHARD - POST ACUTE CARE	12356 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 314	Continued From page 8 According to the National Pressure Ulcer Advisory Panel (NPUAP - 2007), a low air loss mattress is a support surface that provides a flow of air to assist in managing the heat and humidity (microclimate) of the skin. On 8/14/11, at 7 p.m., the resident was again observed sitting up in her bed and asking to be repositioned. The resident stated she was sitting up in bed since before dinner (dinner sheduled to be served a 5 p.m.). A review of the clinical record revealed the resident was admitted to the facility on 3/4/10, with diagnoses that included secondary Parkinsonism, diabetes mellitus and hypertension. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 8/25/11, indicated the resident had memory recall problems, was unable to walk and required extensive assistance with bed mobility, transfers, toilet use and personal hygiene. According to the nursing notes, physician's orders and treatment record, the resident was identified with the coccyx pressure sore on 8/15/11. The wound had been evaluated by a wound care specialist weekly and the last wound evaluation dated 10/14/11, documented a coccyx Stage III pressure sore measuring 3.0 centimeters (cm) in length by 1.5 cm in width and 0.2 cm in depth. The wound bed had 95% pink color and 5% slough (dead tissue). The treatment plan included to continue repositioning the resident as planned. According to NPUAP -2007, a Stage III pressure sore is defined as full thickness tissue loss. Subcutaneous fat may be visible but bone,	F 314		

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F 314	Continued From page 8 tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The plan of care developed on 5/15/11, for the resident's problem of skin breakdown, included in the approaches to turn and reposition every two hours and encourage the resident to limit the time sitting in the wheelchair. However, the plan of care did not address to avoid/limit positioning the resident on her back to promote healing of the coccyx wound. The specific length of time the resident should be sitting in her wheelchair was not indicated and there was no system in place to ensure the resident was repositioned every two hours. On 10/15/11, at 9:40 a.m., during a treatment observation, with Treatment Nurse 1 providing treatment and Treatment Nurse 2 assisting with the treatment), the coccyx wound was observed as described by the wound specialist on 10/14/11. During the course of the treatment, the resident stated that she gets up in the wheelchair every day, but she is left sitting for four to five hours causing her pain in the buttocks/coccyx area. According to the resident, the CNAs do not want to take the time to put her back in bed. Treatment Nurses 1 and 2, present when the resident made the statement, had no comment. 2. During the initial tour of the facility on 10/13/11, at 5:15 p.m., Resident 11 was observed lying on his back and the mattress was a low air mattress. On 10/15/11 at 1 p.m., the resident was observed sitting in a wheelchair.	F 314		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	13158 E. WASHINGTON BLVD WHITTIER, CA 90603

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F 314	Continued From page 16 On 10/18/11, at 10:30 a.m., during a treatment observation, the resident had superficial open skin, red in color on the left and the right buttocks(Stage II pressure sores), and an open sore on the left inner buttock by the coccyx with yellow slough. The treatment nurse stated the scattered slough tissue was in process of separating from the healthy tissue. In an interview with the treatment nurse on 10/18/11, at 12:48 p.m. and with a certified nursing assistant at 3:10 p.m., both nursing staff stated the resident was repositioned every two hours included on his back, where the pressure sores were located. Further record review revealed the resident had a Stage IV pressure sore on the left buttock and Stage II pressure sores to the right and left buttocks. According to NPUAP - 2007, a Stage II is defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough. A Stage IV pressure sore is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The plan of care developed for the pressure sores dated 10/14/11, indicated in the approaches to assist as needed to reposition/shift weight to relieve pressure. However, the plan of care did not address avoiding/limiting positioning the resident on her back to promote healing of	F 314		

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F 314	Continued From page 11 the buttock wounds. The specific length of time the resident could sit in her wheelchair and the frequency to reposition the residentwhile in the wheelchair were not indicated. There was no system in place to ensure the resident was repositioned every two hours	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to apply ankle/foot orthotic devices to both lower extremities as ordered by the physician for 1 of 24 sample residents (4). Resident 4, who had stiffness and contractures on both lower extremities, was not wearing PRAFOs (pressure relief ankle foot orthosis - ankle/foot devices) as ordered. This deficient practice had the potential to result in decline in range of motion of the lower extremities. Findings: On 10/13/11, at 8:55 p.m., during the initial tour with LVN 4, Resident 4 was awake while lying in bed. A handwritten note, by a physical therapist (PT), was posted at the head of the bed indicating	F 318	A. IMMEDIATE CORRECTIVE ACTION: F318 Resident#4 MD was called and the use of PRAFO boots was clarified. Evaluation was done and the plan of care was updated as to the function of PRAFO boots which is for contracture management. A. IDENTIFICATION OF OTHERS AT RISK: All residents have the potential to be affected. B. PROCESS TO PREVENT RECURRENCE: Rehab Director gave in service to Rehab Staff, RNA and License Staff on functions and proper use of PRAFO boots. IDT Team perform weekly and monthly meeting to identify declines and improvements on residents range on motion and contractures.	11/04/11

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	055706	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12585 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 12 to keep the PRAFO on the right foot at all times. However, the resident was not wearing any ankle/foot devices. LVN 4 found a pair of PRAFO boots on top of the resident's wheelchair. At the time of the observation, during an interview, the resident stated she was not wearing any boots since she returned from therapy at 3 p.m. The resident stated that sometimes the staff places on the boots but the boots fall off when she lays in bed and the PT knew about it. A review of the clinical record indicated the resident was admitted to the facility on 8/22/11, with diagnoses that included cerebrovascular accident (stroke), difficulty walking, and muscular wasting. According to the Comprehensive Resident Admission Assessment dated 8/22/11, the resident was able to communicate her needs and had weakness and limitation on the range of motion of both lower extremities. A physician's order dated 9/27/11, indicated to apply the PRAFOs to both lower extremities (BLE) for contracture management. On 10/14/11, at 5:40 p.m., during an interview, the rehabilitation director stated the resident needed to use the PRAFOs because the muscles on her BLE were stiff and always contracting. The right leg was more affected than the left leg. After reviewing the clinical record, the rehabilitation director stated there was no care plan developed regarding the use and management of the PRAFOs. On 10/14/11, at 7:55 p.m., during an interview, LVN 6 stated she was not aware the resident had an order to wear PRAFOs.	F 315	C. MONITORING PROCESS: QAA/CQI will monitor compliance by quarterly review "Contracture Management" necessary correction will made.	

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	055705	A. BUILDING _____ B. WING _____	10/18/2011

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 13 On 10/14/11, at 8 p.m., after reviewing the communication book at the nurses' station, the rehabilitation director stated there was documentation the therapy services communicated to the nurses the resident's need to wear the PRAFOs. On 10/14/11, at 8:05 p.m., during a telephone interview, the PT stated she did not train the nursing staff on placing the PRAFOs because she was the one applying them.	F 318		
F 322 SS=E	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents dependent on gastrostomy tube (GT) feeding receive appropriate care and services to prevent complications for two of 24 sample residents (3, 16). For Resident 3, who went out on pass for several hours each time, there was no system in place to ensure the resident received the daily amount of feeding as ordered. Resident 16 had the feeding tube stopped and disconnected without reaching the prescribed amount of	F 322	A. IMMDIATE CORRECTIVE ACTION: F322 Resident# 3 The GT feeding order was verified with MD promptly. Calories was calculated by RD ensure that the resident receive appropriate amount of feeding and including when the resident is out on pass with family. Resident# 16 The GT feeding was rechecked and turns on immediately for the resident to receive total amount of calories required and prescribed. B. IDENTIFICATION OF OTHERS AT RISK: All residents have the potential to be effected.	

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	056706	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12869 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 14 feeding. This deficient practice had the potential to result in inadequate nutrition. Findings: 1. On 10/14/11, at 6:50 p.m., during an observation with Licensed Vocational Nurse 1 (LVN 1), Resident 3 was resting in bed with a GT (a tube which is surgically inserted into the stomach for purposes of feeding and medication administration), receiving Fibersource HN feeding formula at a rate of 55 cubic centimeters (cc) per hour (cc/hr) via feeding pump. The resident was unable to communicate and could not be interviewed. On 10/15/11, at 7 p.m., another observation of the resident was attempted but LVN 1 stated the resident was out of the facility with her husband. LVN 1 stated the resident left earlier that afternoon and did not know when she would be back. According to LVN 1 the resident's husband was provided with two cans of Glytrol (a different formula) for him to administer them to the resident by bolus (a set amount of formula run down the feeding tube at specific times) when out of the facility. At 7:15 p.m., an interview with a registered nurse (RN) supervisor, she confirmed LVN 1's information. The RN supervisor stated the resident's husband knew how to administer bolus feeding and was given the cans and the syringe for the formula administration. By 9 p.m., the resident had not arrived to the facility.	F 322	C. PROCESS TO PREVENT RECURRENCE: CNA's were in-service by Staff Developer on perform ADLs with patient on GT feeding. License Nurses and Nurse Supervisor will perform random rounds during their shift to verify the amount of calories and volume of GT feeding delivered. D. MONITORING PROCESS: QAA/CQI will review findings by quarterly meetings "NGT/GT Services" necessary correction will be made.	11/07/11

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	055706	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12388 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 15 A review of the clinical record indicated the resident was readmitted to the facility on 9/30/11, with diagnoses that included dysphagia (difficulty swallowing), gastrostomy tube (GT) and diabetes mellitus. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/7/11, indicated the resident was severely impaired in cognitive skills for daily decision-making, was totally dependent on staff for all activities of daily living (ADLs), and was dependent on a GT for feeding. A physician's order dated 9/29/11, indicated continuous feeding with Fiberesource HN at 55 cc/hr via GT for 20 hours to provide a total volume of 1100 cc and 1320 kilocalories in 24 hours via enteral pump. Start infusion at 12 p.m. until dose is completed. Further record review revealed no documentation by nursing or by the registered dietitian addressing the resident bolus feeding by the husband while out on a pass and the use of a different feeding formula. There was no physician's order for the administration of Glytrol cans. According to the plan of care developed on admission for the resident's dependency on GT for feeding, the approaches included to provide the feeding formula amount as ordered. The plan of care did not address the bolus feeding administered by the resident's husband. A review of the Therapeutic Home Visits record from 9/16/11 to 10/14/11, revealed the resident went out of the facility 11 times for six to eight	F 322		

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	056709	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12365 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 16	F 322		

hours each time. However, on the same days the resident was out, the medication administration record (MAR) did not reflect the number of hours the resident did not receive the continuous feeding and the actual amount of Fibersource HN the resident received. The MAR did not reflect the use of Glytrol cans.

On 10/15/11, at 8 a.m., during an interview, the RN supervisor acknowledged that the information related to the resident's feeding while out on a pass was not in the clinical record and the registered dietitian and the physician had been informed and new orders were obtained.

2. On 10/16/11, at 7:15 a.m., Resident 16 was observed in her room sitting in a wheelchair, by the window and next to her bed. There was a GT pole with a feeding formula, Fibersource HN, hanging, however, the formula was not connected to the resident and the enteral pump was turned off. The resident was unable to participate in an interview due to her mental condition.

Another observation at 8 a.m., revealed the GT feeding was still disconnected and turned off.

A review of the clinical record indicated the resident was readmitted to the facility on 8/10/11, with diagnoses that included GT, paralysis agitans, and hypertension.
The MDS assessment dated 7/15/11, indicated the resident was severely impaired in cognitive skills for daily decision-making, had difficulty with communication, was non-ambulatory, required extensive to total assistance with all ADLs, and was dependent on a GT for feeding.
A physician's order dated 8/16/11, indicated

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	056706	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12365 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322	Continued From page 17 continuous feeding with Fibersource HN at 60 cc/hr via GT for 20 hours to provide a total volume of 1200 cc and 1440 kilocalories in 24 hours via enteral pump. Start infusion at 12 p.m. until dose is completed. A current plan of care with a re-evaluation date of 11/2011, developed for the resident's dependency on GT for feeding. Included in the approaches to provide the feeding amount as ordered. On 10/15/11, at 8:55 a.m., an observation with LVN 1 present, revealed the resident's GT remained disconnected, LVN 1 checked the pump to see if the dosage was completed, however, the reading indicated a total of 1068 cc infused out of 1200 cc ordered in 24 hours. LVN 1 stated she would ask the charge nurse (LVN 2) if there was a reason for the GT to be disconnected. At 9 a.m., LVN 2 came into the room and stated she started her shift at 7 a.m., and had not touched the resident's GT. LVN 2 stated it was probably the licensed nurse from the 11 p.m. to 7 a.m. who disconnected the GT for the certified nursing assistant (CNA) to get the resident up in the wheelchair. LVN 2 stated the nobody notified her the GT was off and disconnected.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	A. IMMEDIATE CORRECTIVE ACTION: F323 Resident# 18 Plan of care was reviewed updated promptly including the use of tab alarm for safety.	

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	068705	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12365 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 323	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 24 sample residents (18). For Resident 18, the plan of care did not include the use of the tab alarm and its effectiveness had not been evaluated. The deficient practice had potential for fall and injury. Findings: On 10/15/11, at 8:35 a.m., Resident 18 was observed walking with unsteady gait by her bedside with an alarm device on her hand and was noted confused. The alarm device did not sound to alert the staff when the resident tried to get out of bed. The Evaluator called for assistance, and a licensed nurse who arrived to the room explained the alarm did not sound because the resident had removed the alarm device from the holder. The resident was assisted back in bed and the alarm was placed on the holder. However, at 9:45 a.m., the resident was observed again walking by her bedside with the alarm device on her hand. The alarm did not sound. At the time of the observation, a registered nurse (RN) supervisor stated the resident needed another device to alert the staff from getting out of bed, since she was able to remove it. The RN nurse supervisor indicated the resident was at risk for falls and frequently got out of bed without assistance or supervision.	F 323	B. <u>IDENTICATION OF OTHERS AT RISK:</u> All residents have the potential to be affected. C. <u>PROCESS TO PREVENT RECURRENCE:</u> DON/ADON and/or designee in-service the License Nurses on assessment and formulating a proper plan of care for resident who are highly at risk for fall. RN Supervisor, License Nurses and Staff Developer will frequently perform rounds and identify residents who are high risk for fall and intervene. D. <u>MONITORING PROCESS:</u> QAA/CQI will report findings by quarterly review "Incidents and Accidents" necessary correction will be made.	11/08/11

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	055708	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	13255 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 A review of the clinical record revealed the resident was admitted to the facility on 9/30/11, with diagnoses that included osteoporosis and psychosis. The Minimum Data Set (MDS-standardized assessment and care planning tool) dated 10/7/11, indicated the resident was alert, disoriented, and required extensive assistance with activities of daily living (ADLs), including walking and transfers. The resident had a physician's order since admission for the use of a tab alarm for safety. A plan of care dated 9/30/11, indicated the resident had a potential for injury/fall related to limited mobility, poor balance, lack of awareness, sensory deficits, gait disturbances/unsteady gait, not calling or waiting for assistance, and inconsistent use of the call light. The approaches included frequent visual checks to monitor and assist. The approaches did not include the use of the tab alarm. There clinical record lacked documentation addressing the effectiveness of the tab alarm device.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	F 328	A. IMMEDIATE CORRECTIVE ACTION: F328 Resident# 11 was re-assessed for long toe nails over growth and blackish discoloration. Podiatrist was called right away to examine the resident.	

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	055795	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12565 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 328	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate podiatry (foot) care for 1 of 24 sample residents (11). Resident 11 was not provided with podiatric care. This failure had the potential for foot complications. Findings: During observation with two licensed nurses on 10/16/11, at 10:30 a.m., Resident 11's toenails were long, thick, and had rugged end. The left great toenail had blackish discoloration. One of the licensed nurses stated they would request for a podiatrist (a health care provider who specializes in the care of the feet) consultation. A review of clinical record indicated the resident was admitted to the facility on 8/1/11, with diagnoses that included diabetes mellitus. The Minimum Data Set (MDS-standardized assessment and care planning tool) 8/8/11, indicated the resident was alert, disoriented, could not recall, and required extensive to total assistance with activities of daily living (ADLs). A physician's order dated 8/1/11, indicated podiatry care every two months as needed for mycotic/hypertropic (overgrowth) nails. However, there was not documented evidence of a referral or that the resident was seen by the podiatrist since admission.	F 328	A. IDENTIFICATION OF OTHERS AT RISK: All residents have the potential to be affected. B. PROCESS TO PREVENT RECURRENCE: License Nurses and CNA's were in-service to report over growth toe nails that are identify during body check. Social Services will be given residents list that are needing of Podiatry consult and treatment C. MONITORING PROCESS: QAA/CQI will report findings by quarterly review "Treatment and Special Needs". Necessary corrections will be made.	10/18/11
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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	065706	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12365 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 329	Continued From page 21 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the residents' medication regimen is free from unnecessary drugs when used for excessive duration and without adequate monitoring of possible side/adverse effects for two of 24 sample residents (1, 6). Resident 1 was on the antipsychotic medication Risperdal since 4/6/11, had no documentation to justify the continued use and had no gradual dose reduction. For Resident	F 329	A. IMMEDIATE CORRECTIVE ACTION: F329 Resident# 1 MD was called and notified and ordered to discontinue Celexa. Risperdal was decreased to .25mg at QHS. Orders carried out promptly. Resident# 6 Orders were verified and reviewed regarding the use of Risperdal. An Orthostatic Blood pressure monitoring was started right away. B. IDENTIFICATION OF OTHERS AT RISK: All residents have the potential to be affected. C. PROCESS TO PREVENT RECURRENCE: Pharmacist will continue to review residents on Psychotropic medications monthly and recommend for reduction. License Nurses and Social Services conduct to monthly and quarterly review for residents who are on Psychotropic medications and discuss behavior manifestations. A gradual dose reduction is being carried out together with MDs approval including risk and benefits is no reduction is indicated.	

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	055705	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 22 8, who was receiving Risperdal, there was no monitoring of the side effect of orthostatic blood pressure for the month of 10/2011, as ordered by the physician. This deficiency had the potential for residents to have complications from psychotropic use. Findings: 1. On 10/13/11, at 6:40 p.m., during an observation with Licensed Vocational Nurse 1 (LVN 1), Resident 1 was in bed, able to communicate her needs, and spoke with a low tone of voice. The resident had a sad facial expression. At 6:45 p.m., during an interview with LVN 1, who was also MDS (Minimum Data Set) coordinator, she stated the resident had usually a sad affect and had no behavioral problem. On 8/14/11, at 7 p.m., the resident was again observed sitting up in her bed and asking, in a low tone of voice, to be repositioned. The resident stated she remembered the Evaluator visiting the prior evening. The resident had a sad facial expression. On 8/14/11, a review of the clinical racors revealed the resident was admitted to the facility on 3/4/10, with diagnoses that included secondary Parkinsonism, diabetes mellitus, skin cancer, anxiety state, and hypertension. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 8/25/11, indicated the resident had memory recall problems, was able to communicate with clear speech, had no mood or behavioral symptoms, was unable to walk and required extensive	F 329	D. MONITORING PROCESS: QAA/CQI will report findings by quarterly review "Pharmacy regimen review" necessary correction will be made.	

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	056706	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12286 E. WASHINGTON BLVD WHITTIER, CA. 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 23 assistance with bed mobility, transfers, toilet use and personal hygiene. A review of the medication regimen revealed the resident was receiving two daily anti-depressant medications (Celexa and Trazodone), one hypnotic medication as needed for sleep (Ambien), one anti-anxiety medication as needed for restlessness (Ativan) and daily antipsychotic medication Risperdal. According to the physician's orders and psychiatric progress notes, the resident was evaluated by a psychiatrist on 4/6/11. The psychiatrist assessed the resident to have paranoid thought that people are doing something bad to her. The psychiatrist diagnosed Alzheimer's dementia and psychotic stressors, and ordered Risperdal 0.5 milligrams (mg) every night for behavior manifested by restlessness, yelling and screaming. Another psychiatrist evaluation dated 8/23/11, documented the resident had no more behavioral disturbances. The Risperdal order remained unchanged. According to the Behavior Management Committee-Psychotropic Drug Review form dated 9/15/11, the resident had no behavior manifestation of restlessness, yelling and screaming for the months of 6/2011 and 7/2011. For the month of 8/2011, the resident manifested the behaviors seven times. The interdisciplinary team recommended to continue the psychotropic medications as ordered. A review of the nursing notes from 10/1/11 to 10/14/11, revealed no manifestation of behavior for which the Risperdal was given. There was no documented evidence that	F 329		

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	065784	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12386 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 24 non-pharmacological interventions were ineffective when the resident manifested restlessness, yelling and screaming behavior. There was no documented evidence that since 4/5/11, there were attempts of gradual dose reduction for Risperdal. The physician did not document a rationale for not attempting dose reduction and how the risks from the use of antipsychotic outweighed the benefits. On 10/15/11, at 10 a.m., during an interview, Registered Nurse 1 and LVN 1, could not provided evidence the interdisciplinary team discussed with the physician and/or the psychiatrist the continued need of Risperdal. 2. A review of Resident 6's clinical record indicated the resident was admitted to the facility on 9/8/11, with diagnoses that included dementia (loss of cognitive function) with psychosis. The admission MDS assessment dated 9/15/11, indicated the resident was severely impaired in cognitive skills for daily decision-making, did not walk, and was totally dependent on staff for activities of daily living (ADLs). A physician's order dated 9/8/11, indicated to administer the antipsychotic medication Risperdal 1 mg by mouth every night at 9 p.m., for psychosis manifested by continuous yelling out names and numbers. The physician also ordered to monitor the orthostatic (postural) blood pressure every seven days due to the use of Risperdal. According to the care plan developed on 9/8/11, the resident had an alteration on behavior pattern related to dementia with psychosis and was on	F 329		

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	055706	A. BUILDING _____ B. WING _____	10/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12395 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 329	Continued From page 25 Risperdal. One of the approaches was to monitor for the side effects of Risperdal which included postural (orthostatic) hypotension. On 10/15/11, at 9:40 a.m., during an interview, LVN 3 stated that according to the medication administration record (MAR), the orthostatic blood pressure was scheduled to be taken on 10/5/11 and 10/13/11. However, there was no documentation the orthostatic blood pressure was taken on those days. On 10/15/11, at 9 a.m., LVN 4 explained that in orthostatic blood pressure monitoring, the blood pressure should be taken while the resident changes position from lying/sitting to sitting/standing. Orthostatic hypotension is a drop in blood pressure with position change; results in dizziness, blurred vision, confusion, and possible syncope which may result in injuries secondary to falls; and the elderly are at special risk (Pathophysiology/Lee-Ellen C. Copstead, Jacquelyn L. Banasik. - 4th ed. p. 390-391).	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 364	A. IMMEDIATE CORRECTIVE ACTION: F364 Administrator place an order to repair food warmer including new menu. B. IDENTIFICATION OF OTHERS AT RISK: All resident have the potential to be affected.	

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THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 384	Continued From page 26 review, the facility failed to ensure prepared food conserved proper temperatures. Hot food was not maintained at safe temperatures above 140 degrees Fahrenheit (F). This deficient practice caused residents to get cold food that was not palatable and had a potential for foodborne illnesses. Findings: On 10/14/11, at 6:30 p.m., during a group meeting interview with 10 residents present, all 10 residents complained the warm food was usually served cold. The residents stated they have complained about the cold food but the problems continues and they wished to have appetizing warm food. On 10/15/11, at 12:25 p.m., during a tray line observation with the dietary supervisor, the final cooking internal temperature of the chicken and the zucchini was 160 degrees Fahrenheit. A test tray was requested to be prepared for the Evaluator to check the temperature at the time the last tray was distributed to the residents in two different areas of the facility. The test tray checked at 12:42 p.m., in Nursing Station 3, revealed the temperature of the hot food items, the chicken and the zucchini, was 130 degrees F. The test tray checked at 1 p.m., in Nursing Station 4, revealed the temperature of the hot food items, the chicken and the zucchini, was 130 degrees F. At 1:10 p.m., during an interview, dietary supervisor stated the food temperatures should be 140 degrees F and above when being served	F 384	C. PROCESS TO PREVENT RECURRENCE: Registered Dietician in-service Dietary Supervisor and Kitchen personnel in preparing food on a timely manner and proper distribution of food to maintain acceptable temperature and palatability of food. D. MONITORING PROCESS: QAA/CQI will report findings by quarterly review "Nutritive value/Palatable/Preferred Temperature of food" necessary corrections will be made.	11/10/11

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	055705	A. BUILDING _____ B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12345 E. WASHINGTON BLVD WHITTIER, CA. 90606

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F 384	Continued From page 27 to the residents to preserve the quality and safety of the food. She further stated that the facility will order hot plates to preserve the hot temperature. The facility's undated dietary policy and procedure titled "Hot Holding," stipulated that foods shall be kept warm while served in a manner which preserves food quality and safety. The policy further stated that food's standard temperature at point of service must be 140 degrees F.	F 384		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	A. IMMEDIATE CORRECTIVE ACTION: F441 Resident# 3 was re-assessed. No rashes but has scattered brown discoloration on the back area no itchiness noted. Resident# 12 is no longer in the facility. Resident# 15 was re-assessed and examine. No new rashes noted with few brown spots on chest area no itchiness noted. A. IDENTIFICATION OF OTHERS AT RISK: All resident have the potential to be affected.	

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	056709	A. BUILDING _____ B. WING _____	10/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA. 90606

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F 441	Continued From page 28 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement infection control policies on communicable diseases to control and prevent the spread of scabies (parasitic infestation that causes intense itching and a rash) infection for three sample residents with rashes in a sample of 24 residents (3, 15, 12) out of a total of 13 residents in the facility with rashes that were treated with Elimite cream (indicated for infestation with Sarcoptes scabiei). Residents 3, 12, and 15 had rashes with itchiness and receive treatment with Elimite cream for prophylaxis (prevention) of scabies There was no evidence of contact isolation precautions when the treatment was administered, possible contacts and roommates were not treated within the same time period, and there was no environmental disinfection. For Resident 12, there was no contact identification list. This deficient practice had the potential for the spread of scabies. Findings:	F 441	B. PROCESS TO PREVENT RECURRENCE: Infection control designee/DON conducted an in-service to License Nurses and CNA's to report immediately if there's any changes on residents' skin condition specially skin rashes and presence of itchiness and demonstration of proper hand washing technique. Infection control designee/DON formulate and revised plan for infection control program which includes but not limited to a). Assessment & Treatment b). Isolation c). Skin scraping d). Line listing and contact listing of resident and staff e). Environmental sanitation and control f). Laundry and cleaning g). Universal Precautions h). Proper plan of care I). Evaluation & reporting. C. MONITOING PROCESS: QAA/CQI will report findings by quarterly review "Infection Control Program" necessary correction will be made.	11/08/11

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12286 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 441	Continued From page 29	F 441		

1a. On 10/14/11, at 8:50 p.m., during an observation with Licensed Vocational Nurse 1 (LVN 1), Resident 3 was resting in bed with a GT (a tube which is surgically inserted into the stomach for purposes of feeding and medication administration), receiving Fibersource HN feeding formula. The resident was observed to have skin eruptions (rash) throughout her arms and chest area.
The resident was unable to communicate and could not be interviewed.
The resident shared the room with Resident 16 and another non-sample resident.
The non-sample resident, who was able to communicate and was alert and oriented, stated she had rashes all over her body that was itchy and was observed on 10/15/11, at 7 p.m., to have scattered rashes on both arms and trunk.

A review of the clinical record indicated Resident 3 was readmitted to the facility on 9/30/11, with diagnoses that included dysphagia (difficulty swallowing), GT and diabetes mellitus.
The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/7/11, indicated the resident was severely impaired in cognitive skills for daily decision-making, was totally dependent on staff for all activities of daily living (ADLs), and was dependent on a GT for feeding.

A review of the physician's orders and nursing notes revealed the resident was identified with rashes (skin eruptions) to the right flank (side of the trunk) to 9/8/11, and a dermatological evaluation dated 9/26/11, documented body rashes and ordered scabies prophylaxis

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THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 441	Continued From page 30 treatment and a repeat treatment in seven days. 1b. A review of the clinical record revealed Resident 16 (Resident 3's roommate) was admitted to the facility on 12/16/92, with diagnoses that included hypertension, aphasia (an impairment of language ability), catatonic schizophrenia (involve disturbances in movement) and joint contractures. The MDS assessment dated 7/20/11, indicated the resident was not able to communicate, had memory problems and required total care. The resident was under hospice care since 7/13/11. Further record review revealed the resident was given Elimite cream treatment one time application on 7/14/11 for prophylaxis and to repeat in seven days. On 8/16/11, the resident was ordered Triamcinolone 0.1 % cream daily for back rashes. A consultation record dated 8/8/11, indicated the resident had rashes on the back and the right flank and an antifungal powder (Nystatin) was ordered. On 10/3/11, a dermatological evaluation was done and ordered Elimite cream and a repeat treatment in seven days for prophylaxis. 1c. According to the Management of Scabies Outbreaks in California Health Care Facilities, by California Department of Public Health, Division of Communicable Disease Control in Consultation with Licensing and Certification dated 8/2008, the diagnosis of typical scabies can be specifically difficult in elderly persons living in long-term care facilities. The skin is generally dry and scaly and there may be preexisting, chronic dermatological conditions for which oral or topical	F 441		

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	055706	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12355 E. WASHINGTON BLVD WHITTIER, CA 90606

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F 441	Continued From page 31	F 441		

steroids have been prescribed. Outbreak definition included at least two clinically suspect cases identified in patients, healthcare workers, volunteers and/or visitors during a two-week period of time. Control of outbreak involves a choice between treating only symptomatic cases and their known contacts or treating all possible contacts including asymptomatic patients, healthcare workers, volunteers, and visitors. Only patients who have symptoms or positive skin scrapings need to be placed on isolation. To prevent silent transmission of scabies, all those included in the treatment schedule should be treated in the same 24-hour treatment periods. Following bathing to remove the first application of scabicide, discontinue isolation precaution. Isolation precautions are not necessary for prophylactic treatments (e.g., follow-up treatments or treatment of asymptomatic patients).

The facility's infection control policy and procedure on Communicable Diseases, Identifying and Treatment of Scabies, revised 9/2007, indicated the purpose of the policy was to control and prevent the spread of scabies in the facility. The procedures included to place symptomatic residents on isolation precautions. Restrict residents to their rooms for the duration of the first treatment period (8 - 12 hours). Following bathing to remove the first application of scabicide, discontinue isolation precautions. Place all clean clothing from each resident's closet in red plastic bags and take them to the laundry. All soiled linen and clothing is to be placed in an infectious waste bag to be taken to the laundry. Place all non-washable personal cloths such as shoes, coats, jackets, and scarves

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12888 E. WASHINGTON BLVD WHITTIER, CA. 90606

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F 441	Continued From page 32 worn by the resident during the preceding week in a plastic bag. Place them in plastic for five days. On 10/15/11, at 10:30 a.m., during an interview with the infection control nurse and a review of a Contact Identification List, it was revealed the facility had a total of 12 resident who received prophylactic treatment with Elimite cream between 9/14/11 and 10/4/11, including Residents 3, 12, 15 and the roommate for Residents 3 and 15. According to the form, six residents had onset of symptoms between the two-week period from 8/26/11 to 10/9/11. Four residents had onset of symptoms between the two-week period from 8/20/11 to 9/3/11. The form also indicated there were 13 residents with unresolved rashes. Further record review revealed that for Residents 3 and 15, there was no plan of care developed for the scabies prophylactic treatment and there was no evidence isolation precaution was implemented during the initial treatment and that environmental disinfection was done. On 10/15/11, at 11 a.m., an interview with the infection control nurse and the director of nursing revealed they did not implement isolation precautions during Elimite treatment because there were no residents with a positive scraping for scabies and none of the residents treated with Elimite were diagnosed as having scabies. Both nurses stated there was no scabies outbreak in the facility. 2. During an observation with two licensed nurses on 10/15/11, at 3:30 p.m., Resident 12 was noted	F 441		

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F 441	Continued From page 39 with rashes on his back and left leg. On 10/14/11, at 10:30 a.m., during an an interview, the resident stated he had itchiness on the area affected by the rashes. A review of clinical record revealed the resident was readmitted to the facility on 8/21/11, with diagnoses that included diabetes. The MDS assessment dated 8/28/11, indicated the resident was able to communicate, had memory problems, and required extensive assistance with ADLs. A plan of care dated 8/22/11, indicated the resident had rashes on the back, the abdominal area, the left lower leg, and the left upper extremity. According to a dermatology consultation dated 8/25/11, the diagnoses included treatment failure for scabies and pruritus (itching). The treatment included prophylaxis with Elimite cream and to repeat it in seven days, and Atarax (indicated for itchiness) 10 milligram every 12 hours orally. However, there was no documented evidence the resident was placed on isolation precaution during the first Elimite treatment. The facility's infection control policy and procedure on Scabies, indicated to place symptomatic residents on isolation precautions in their assigned rooms. According to the Prevention and Control of Scabies in California Long-Term Care Facilities by California Department of Public Health, Division of Communicable Disease Control in Consultation with Licensing and Certification dated 3/2008, as soon as a possible case of scabies is identified, the infection control nurse practitioner should develop a contact identification list. The list should identify every	F 441		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12395 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 resident, health care worker, visitor, and volunteer who may have had a direct, physical contact with the case within the previous month. However, the Contact Identification List provided by the director of nursing on 10/18/11, did not include healthcare workers who had contact with Resident 12. On 10/18/11, at 4:40 p.m., during an interview, the infection control nurse confirmed no isolation precaution was implemented during the duration of the first treatment with Elimite and there was no contact identification list developed for healthcare workers who have had contact with the resident within the previous month.	F 441		
F 500 SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 500	A. IMMEDIATE CORRECTIVE ACTION: F500 Hospice Agency was contacted promptly and informed regarding coordination of plan of care. Physician's communication and other related services should be integrated. B. IDENTIFICATION OF OTHERS AT RISK: All residents have the potential to be affected.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056706	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12366 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 500	Continued From page 35 Based on observation, interview, and record review, the facility failed to ensure services furnished by outside resources under written arrangement pertaining to the services are followed for one of 24 sample residents (15). For Resident 15, who was on hospice care, the agreement that hospice and the facility staff will have a coordinated care was not fulfilled, there was no integrated plan of care, there was no evidence the hospice physician was informed of the orders given by the attending physician, who was not a hospice physician, and the hospice nurses did not document presence of rashes for which the resident had received multiple treatment and was seen by a dermatologist. This deficient practice had the potential for not meeting the resident's needs and provide uncoordinated care. Findings: On 10/13/11, at 8:45 p.m., Resident 15 was observed in bed able and unable to communicate needs. A review of the clinical record revealed the resident was admitted to the facility on 12/16/92, with diagnoses that included hypertension, aphasia (an impairment of language ability), catatonic schizophrenia (involve disturbances in movement) and joint contractures. The Minimum Data Set (MDS - standardized assessment and care planning tool) dated 7/20/11, indicated the resident was not able to communicate, had memory problems and required total care. On 7/8/11, the attending physician referred the resident to hospice care and on 7/13/11, the	F 500	C. PROCESS TO PREVENT RECURRENCE: Administrator conducted an in-service to the Admission Coordinator on communicating with License Nurses if residents is under Hospice Care to ensure coordination and integration of proper plan of care. Hospice Case Manager will report to DON and/or designee on a timely manner. D. MONITORING PROCESS: QAA/CQI will report findings by quarterly review "Outside Professional Resources and Agreement" necessary correction will be made.	11/04/11

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	055705	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12365 E. WASHINGTON BLVD WHITTIER, CA 90606

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 500	Continued From page 56 resident was admitted to hospice care. The hospice admission orders included registered nurse (RN) visits one to three times a week, certified home health aide (CHHA) visits two times a week and to call hospice for changes of condition and to obtain authorization for medications, laboratory, treatment and other order changes. A review of the contract agreement signed by the facility and the hospice agency and dated 3/4/11, revealed the two parties (hospice and the facility) agreed to fulfill the responsibilities stated in the document. Among the responsibilities, it was indicated the plan of care for the resident reflects the participation of the hospice, facility, and the resident and family. The facility will no make modifications to the plan of care without consulting with hospice. Hospice shall retain professional management responsibility. Hospice physician along with the attending physician (if any), is responsible for the palliation and management of the hospice resident's terminal illness and related conditions. However, a review of the clinical record revealed the facility had one plan of care and the hospice had another plan of care and there was no documentation of an integrated plan of care with input from both, the facility and the hospice staff. There was no documented evidence of interdisciplinary team meetings held with hospice and facility staff participation. A review of the physician's orders revealed multiple orders from the attending physician (not a hospice physician) and consultant physicians (wound care specialist and dermatologist).	F 500		

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	050706	A. BUILDING _____ B. WING _____	10/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ORCHARD - POST ACUTE CARE	12356 W. WASHINGTON BLVD WHITTIER, CA 90606

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F 500	Continued From page 37 However, there was no evidence this orders were relayed to the hospice physician and the hospice interdisciplinary group. A review of the hospice nursing documentation revealed the hospice nursing staff did not address the resident's unresolved ongoing rashes since 7/14/11, which required treatment with Elimite cream for scabies (parasitic infestation that causes intense itching and a rash). On 10/16/11, at 12 p.m., during an interview and further record review, Licensed Vocational Nurse 1 (LVN 1) who was also the MDS coordinator, could not provide evidence of coordination of care between the hospice and the facility.	F 500		