

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Socal Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 S. Sorenson Ave. 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>46779</p> <p>Based on observation, interview and record review, the facility failed to provide care and services as ordered by the physician and as indicated in the facility's policy and procedure for one of three sampled residents (Resident 1) after experiencing a fall on 4/4/25 and reported having pain on 4/6/25.</p> <p>Resident 1's x-ray (a medical imaging test that creates images of the inside of the body) that was ordered by the physician 4/6/25 at 7:48 AM due to the resident's complaint of pain on the ankle and x-ray was taken on 4/7/25 at 10:59AM. The facility did not follow up to with the Radiology (company that specialize in x-rays) company of the resident's x-ray to obtain the x-ray result.</p> <p>As a result of this deficient practice the X-ray result was not received until 4/9/25 that showed ankle fracture (broken bone) which delayed Resident 1's care and hospitalization after a fall to receive care which could potentially result in long term functional limitation, persistent pain, and limited of range of motion affecting the resident's quality of life negatively.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/25/2023 with diagnoses that included dementia (a term for a range of conditions that affect the brain's ability to think, remember, and function normally) and osteoarthritis (a degenerative joint disease, affecting joints over time, leading to pain, stiffness, and swelling).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 1/17/2025, the MDS indicated Resident 1 had moderately impaired memory and cognition (ability to think and reason). The MDS indicated Resident 1 required setup or clean-up assistance with eating and oral hygiene, and partial/moderate assistance with shower/bathe self, and personal hygiene and chair/bed-to-chair transfer.</p> <p>During a review of Resident 1's SBAR (Situation, Background, Assessment, and Recommendation, a structured communication tool, particularly common in healthcare) Communication Form, dated 4/4/2025, the SBAR indicated Resident 1 had a witnessed fall on 4/4/2025.</p> <p>During a review of Resident 1's Progress Notes, dated 4/6/2025 at 7:48 AM, Resident 1 continued with to experience pain after the fall, the physician ordered an x-ray of left ankle.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's X-ray Report of left ankle, dated 4/7/2025 at 7:54 PM, from an x-ray that was taken on 4/7/2025 at 10:59 AM, indicated the resident had nondisplaced complete transverse fracture (a clean and straight break across the bone) of medial malleolus (a bone located on the inner side of the ankle) is noted and complete transverse fracture of distal fibula diaphysis (a lower end of the bone at ankle area) is noted with lateral angulation of distal fractured fragment (in fractures refers to the tilt of the lower end of the fractured fragment of the broken bone away from its normal alignment).</p> <p>During a review of Resident 1's SBAR Communication Form, dated 4/9/2025, the SBAR indicated abnormal x-ray showing fracture to ankle. The SBAR indicated the physician was notified on 4/9/2025 at 5 PM.</p> <p>During a concurrent observation and interview on 4/18/2025 at 1:29 PM, Resident 1 was lying on the bed with her left ankle and foot stabilized with the splints and wrapped in the elastic bandages. Resident 1 stated she was having pain at level 10/10 pain when she tried to move her left foot, and she could not get up of bed or stand anymore.</p> <p>During an interview on 4/18/2025 at 1:25 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1's x-ray of left ankle was done by an outside radiology company on 4/7/2025 around 11 AM. LVN 1 stated the nurse who worked in the evening shift and the nurse who worked on the next day did not follow up the X-ray result did not report to the physician within 24 hours after the x-ray of left ankle was done to prevent a delayed treatment to Resident 1.</p> <p>During an interview on 4/18/2025 at 4:02 PM with Registered Nurse (RN) 1, RN 1 stated she worked the evening shift on 4/7/2025 and she did not receive a phone call or a fax of Resident 1's x-ray result on the left ankle. RN 1 stated she did not follow up with the result with the radiology company.</p> <p>During an interview on 4/18/2025 at 4:15 PM with LVN 1, LVN 1 stated she worked the morning shift on 4/8/2025, but she did not get any endorsement to follow up with Resident 1's x-ray report on the left ankle, so she did not follow up with the radiology company for the result. LVN 1 stated, someone notified the physician on 4/9/25, but she did not know when and who received Resident 1's x-ray report and reported to the physician. LVN 1 stated the physician called back and ordered to transfer the resident to the hospital in the afternoon on 4/9/2025.</p> <p>During an interview on 4/18/2025 at 4:38 PM with LVN 2, LVN 2 stated when she started to work the evening shift on 4/8/2025 and she noticed Resident 1's x-ray of left ankle report was blank. LVN 2 stated she asked LVN 1 why the report was blank and LVN 1 said she did not know the reason. LVN 2 stated she called the radiology company, and the representative of the radiology company told her that the radiology company was having issues of sending out the reports for the past two days and the representative did not have the report available to provide a verbal report to the nurse at that time. LVN 2 stated she did not report this issue to the Director of Nursing (DON) immediately.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/18/2025 at 4:40 PM with the DON, the report of Resident 1's x-ray of left ankle, dated 4/7/2025, and Resident 1's SBAR, dated 4/9/2025, were reviewed. The DON stated the time stamp of the received fax of the x-ray report indicated the report was received on 4/9/2025 at 5 PM. The DON stated the nurse notified the physician on 4/9/2025 at 5 PM. The DON stated he did not know the facility was having issues of obtaining the x-ray report from the radiology company because the staff did not report it to him. The DON stated the nurse should report the issue to him, so he could reach out to the supervisor of the radiology company to escalate the request and make sure they obtained the report and notified the physician within 24 hours once the x-ray was taken to prevent any delayed care for Resident 1. The DON stated any delay treatment could lead to the functional limitation, pain, and the loss of motion of Resident 1' left ankle because of the fractured ankle. The DON stated it was the facility's standard of practice to obtain a x-ray result and report to the physician within 24 hours when the test was done to prevent any delayed care and potential adverse complication for the residents.</p> <p>During a review of the facility's policy and procedure (P&P), dated 5/2017, the P&P indicated Prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider and except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.</p>