

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 11/06/2025
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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and records reviews, the facility failed to ensure certified nursing assistants (CNA) were competent in providing appropriate care and services during resident transfers, to and from the bed, for two of three sampled residents (Resident 1 and Resident 2) who underwent orthopedic surgery (a procedure on the musculoskeletal system [a complex of network of bones, muscles, joints, tendons, and ligaments that work together to provide support, movement, and protection to the body]) This deficient practice had the potential to place residents at risk for further injury and delay healing process. A review of Resident 1's general acute care hospital (GACH) records, dated 10/13/24, prior to the admission to the facility, indicated Resident 1 was status post fall with left femur fracture, status post (s/p) surgery on 10/10/24. The record indicated the diagnosis was open femur fracture. A review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 10/23/2024 with diagnoses that included fracture of lower end of left femur (a break in the lower part of the left thigh bone near the knee joint) and Type II diabetes mellitus (a disorder in which the amount of sugar in the blood is elevated). A review of Resident 1's history & Physical (H&P), dated 10/24/24, indicated Resident 1 did not have the capacity to understand or make decisions. A review of Resident 1's Care Plan (CP) for Recent fracture of left femur secondary to s/p fall, dated 10/25/2024, indicated interventions was to immobilize the affected distal (farther away to the point of attachment to the body) and proximal (closer to the point of attachment to the body) joints as indicated. The interventions also indicated to assist with transfers and ambulation as needed. A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/28/2024, indicated Resident 1 had intact memory and cognition (ability to think and reason). The MDS also indicated Resident 1 required partial/moderate assistance with personal hygiene, substantial/maximal assistance with eating and oral hygiene, and dependent with shower/bathe self and chair/bed-to-chair transfer. A review of Resident 1's Progress Notes-Situation, Background, Assessment and Recommendation (SBAR, a communication tool) Summary, dated 11/10/2024, indicated Resident 1's oxygen saturation (a measure of how much oxygen in the blood) was 86 percent and pulse was 125. Resident 1 was noted with chronic pain to left leg. The SBAR indicated 911 (emergency services) was called and Resident 1 was sent out for further evaluation. A review of Resident 1's Progress Notes, dated 11/10/2024 at 12:20 PM, indicated Resident 1 complained of pain to left leg prior to transferring Resident 1 to the general acute care hospital (GACH). The Note indicated charge nurse administered pain medication that was ineffective, with minimal relief. A review of Resident 1's GACH 1's Emergency Department Note, dated 11/10/2024, indicated Resident 1 had respiratory distress and complained severe pain to the left leg. A review of Resident 1's GACH 1's Consultation, dated 11/11/2024 at 10:03 AM, indicated left periprosthetic femur fracture (a break of thigh bone). A review of Resident 1's GACH 1's Operative Report, dated 11/14/2024, indicated Resident 1 underwent the surgery of open reduction internal fixation (a surgical procedure to repair a broken bone) to the left femur fracture with a hardware removal. A review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 10/2/2025 with diagnoses that included aftercare following joint replacement surgery and presence of right artificial knee joint. A review of Resident 2's H&P, dated 10/9/25, indicated Resident 2 was able to make needs known but could not make medical decisions. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had intact memory and cognition. The MDS also indicated Resident 2 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene and chair/bed-to-chair transfer, and substantial/maximal assistance with toileting hygiene and shower/bathe self. A review of Resident 2's Order Summary Report, dated 11/6/2025, indicated the physician ordered two folded pillows under the heel while in bed. A review of the Facility Assessment, dated from 7/1/2025 to 10/31/2025, indicated the facility admitted and cared for residents with fractures. During an interview on 11/6/2025 at 9:20 AM with Family Member 1 (FM) 1, FM 1 stated Resident 1 had surgery on her left leg and stayed in the facility for rehabilitation. FM 1 stated the physical therapist provided specific instructions on how to transfer Resident 1 to prevent injury to her left leg. FM 1 stated on 11/10/2025, one of the FMs was visiting the resident and observed two nurses transferring Resident 1 from the bed to chair, and Resident 1's left leg was twisted. FM 1 stated the FM heard a crack, then, Resident 1 yelled They broke my leg. FM 1 stated Resident 1 was transferred to the hospital and found out she sustained a fracture on her left leg, then, Resident 1 underwent a second surgery on her left leg. FM 1 stated the nurses in the facility did not have the proper training on how</p>		