STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055168	A. Building B. Wing	01/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Socal Post-Acute Care	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to ensure that Resident 53's Advance Directive Acknowledgment Form (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law [whether statutory or as recognized by the courts of the State], relating to the provision of health care when the individual is incapacitated) was completed upon admission to the facility on [DATE]. This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident's wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: During a review of Resident 53's Admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included hemiplegia (paralysis that affects only one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following other nontraumatic intracranial hemorrhage (a type of stroke) affecting left non-dominant side, dysphagia (difficulty swallowing), and abnormalities of gait and mobility. During a review of Resident 53's History and Physical (H&P), dated 1/9/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 53's Advance Directive Acknowledgement form dated 11/29/2024, the form indicated the form was incomplete. The form was not signed by the resident/responsible party. During a concurrent interview and record review of Resident 53's Advance directive Acknowledgment form on 1/12/2025 at 9:43 AM, the Social Services Designee (SSD) verified Resident 53's form was not completed and signed by Resident 53's responsible party. The SSD stated Resident 53 was readmitted last week and could not recall if she had followed up with resident's family regarding the Advance Directive Acknowledgment form. The SSD stated the form should be filled out to its entirety, so that in the case of an emergency, if the nurses find resident unresponsive, they will know what the resident ' s wishes were. The SSD stated it the form was also for the family to be fully aware of the decisions and what the decisions mean. (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

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 01/12/2025
NAME OF PROVIDER OR SUPPLIER Socal Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 S. Sorenson Ave. Whittier, CA 90606	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy Advance Directive, revised September 2022, indicated The resident has the right to formulate and Advance Directive, including the right to accept or refuse medical or surgical treatment. Advance Directives are honored in accordance with state law and facility policy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interviews and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the facility's policy for one of one sampled resident (Resident 53) with a diagnosis of diabetes mellitus (a disease in which the blood sugar levels are too high). The facility failed to ensure all appropriate discharge orders from General Acute Care Hospital (GACH) 1 were verified with the attending physician (Physician 1) upon readmission to the facility on [DATE]. This deficient practice resulted to Resident 53 not receiving the care and services to continue diabetic management and/or medications for the resident ' s diagnosis of diabetes mellitus, while in the facility from 12/8/2024 to 1/12/2024 (36 days). Cross Referenced to F641, F657, and F692 Findings: During a review of facility's Admission Record indicated Resident 53 was initially admitted on [DATE] but readmitted back to the facility from GACH 1 on 12/8/2024, with diagnoses that included acute pulmonary edema (condition caused by excess fluid in the lungs), Type 2 diabetes mellitus, and end stage renal disease (ESRD- condition in which the kidneys lose the ability to remove waste and balance fluids). During a review of Resident 53's Facility Medication Administration Record (MAR) from 10/25/2024 to 11/27/2024, the MAR indicated insulin aspart injection as per sliding scale was previously being administered to Resident 53 prior to readmission on 12/8/2024. The MAR indicated the resident had received insulin on the following days: On 10/26/2024 timed at 9 PM, 2 units given for a blood sugar level of 155 milligrams per deciliter (mg/dL). On 10/27/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL. On 10/29/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 152 mg/dL. On 10/30/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 179 mg/dL. On 10/31/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 169 mg/dL. On 11/1/2024 timed at 9 PM, 3 units given for a blood sugar level of 208 mg/dL On 11/2/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL On 11/3/2024 timed at 9 PM, 2 units given for a blood sugar level of 159 mg/dL (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/5/2024 timed at 9 PM, 2 units given for a blood sugar level of 178 mg/dL On 11/7/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 155 mg/dL On 11/7/2024 timed at 9 PM, 2 units given for a blood sugar level of 167 mg/dL On 11/12/2024 timed at 11:30 AM, 3 units given for a blood sugar level of 230 mg/dL On 11/14/2024 timed at 6:30 AM, 2 units given for a blood sugar level of 154 mg/dL On 11/14/2024 timed at 9 PM, 3 units given for a blood sugar level of 212 mg/dL On 11/15/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 160 mg/dL On 11/20/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 164 mg/dL On 11/20/2024 timed at 9 PM, 3 units given for a blood sugar level of 234 mg/dL On 11/21/2024 timed at 9 PM, 2 units given for a blood sugar level of 198 mg/dL On 11/22/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 190 mg/dL On 11/22/2024 timed at 9 PM, 2 units given for a blood sugar level of 166 mg/dL On 11/24/2024 timed at 9 PM, 2 units given for a blood sugar level of 156 mg/dL On 11/25/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 11/26/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 177 mg/dL On 11/27/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL During a review of Resident 53's Physician Progress Notes from GACH 1, dated 12/1/2024, the indicated a diagnosis of Diabetes Mellitus with blood sugar control per protocol. During a review of Resident 53's Facility History and Physical Assessment (H&P) dated 12/16/24, the H&P indicated Resident 53 had the capacity to understand and make decisions. During a review of Resident 53's Facility Order Summary Report prior to readmitted d 10/25/2024 indicated Insulin (a hormone of the pancreas that is essential for allowing your body to use sugar for energy) Aspart Injection Solution (Insulin Aspart) inject as per sliding scale: if 0-149 mg/dL = 0 units; 150-199 mg/dL = 2 units; 200-249 mg/dL= 3 units; 250-299mg/dL = 4 units; 300-349 mg/dL = 6 units; 350-399 mg/dL= 8 units notify Physician 1 if over 400 mg/dL, subcutaneously before meals and at bed time for Diabetes Mellitus (DM). During a review of Resident 53's Facility Order Summary Report dated 1/12/2025, the Order Summary Report did not indicate medications or treatment orders were ordered for Resident 53 such as insulin sliding scale for Resident 53's DM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/14/2024, the MDS indicated Resident 53 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 53 had an active diagnosis of DM. The MDS also indicated Resident 53 was receiving Insulin medication. During a review of Resident 53's Facility care plans indicated an active DM care plan initiated 10/26/2024 with a revision on 11/6/2024, and target date of 1/25/2025. The care plan indicated the following interventions: (1) to administer medications as ordered, (2) monitor blood sugar as ordered by Physician 1, (3) monitor for signs and symptoms of hypoglycemia and hyperglycemia and notify Physician 1 if any; (4) monitor skin status every week and as needed and notify Physician 1 if any changes are noted; (5) notify Physician 1 if blood sugar is less than 60 or over 400; and (6) provide diet as ordered. During a review of Resident 53's Facility Custom Interdisciplinary Team (IDT) Care Conference form dated 12/8/2024, the form indicated the areas reviewed with Physician 1 were Resident 53 ' s diagnoses, care plans. The Custom IDT Care Conference form indicated there was no new diagnosis(es) since last assessment. The Custom IDT Care Conference form indicated a diet of 80 grams (gm, unit of measure), low potassium, low salt and regular texture. During a review of Resident 53's Facility Nutritional Initial Screener dated 12/15/2025, the document indicated admitting diagnoses that included status post left below the knee amputation, chronic obstructive pulmonary disease (COPD- condition caused by damage to the airways or other parts of the lung), ESRD, and pressure injury stage 2. The nutritional initial screener indicated the following diet: consistent carbohydrate diet (CCHO- Diet for people with diabetes to manage their blood sugar levels and weight), no added salt, mechanical soft (diet designed for people who have trouble chewing and swallowing), thin. During a concurrent interview and record review of Resident 53's medical chart on 1/12/2025 at 10:37 AM, the Director of Nursing (DON) verified Resident 53 had a diagnosis of DM on the Admission Record. The DON verified there were no physician orders for diabetic management like insulin or blood sugar checks on the Order Summary Report. The DON stated she and the Minimum Data Set Nurse (MDSN) check admission documentation and will conduct an IDT with the resident and the resident ' s family/responsibly party to go over medications and what transpired at the GACH 1. The DON stated the purpose of clarifying orders and diagnosis with Physician 1 was to ensure if Resident 53 needed insulin. The DON stated if there are no orders for diabetic management, the resident can experience hyperglycemia (high blood sugar) and have uncontrolled blood sugar. At 10:55 AM, the DON stated when verifying the orders as the admitting nurse, she would have clarified with Physician 1. The DON stated Physician 1 reviews the medications on admission, and sign electronically. During a concurrent interview and record review of Resident 53's Order Summary Report prior to readmitted d 10/25/2024 on 1/12/2025 at 11:24 AM, the DON stated Resident 53 had an order for Insulin at the facility before she was transferred to GACH 1. The DON stated when Resident 53 was readmitted back to the facility on [DATE] there were no orders to continue Insulin. The DON stated she would have clarified with Physician 1, and she would expect the nurses to question and clarify with Physician 1 as well. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse (RN) 1 on 1/12/2025 at 2:35 PM, RN 1 stated when she admits a resident, she would review the admission and medication orders from the GACH. RN 1 stated she would call the physician in charge of the resident to verify and go over each medication with the orders from the hospital. RN 1 stated she would ask the physician if they wanted any blood work done and confirm the resident ' s diet. RN 1 stated the orders she inputs for the facility is what she reviews from the GACH records and the nurse from the hospital who was giving report. RN 1 stated with Resident 53 was a resident at the facility before. RN 1 stated during admission verification of hospital orders and diagnosis with Physician 1, she did not bring up to Physician 1 of no orders for Insulin for DM. RN 1 stated Resident 53 was not using insulin in previous admissions which was why she did not bring it up to the physician. RN 1 stated she should have clarified diabetic management with Physician 1, but did not think about it at that moment. RN 1 stated if the missing Insulin order was mentioned to Physician 1 on admission and if he agreed to not continue insulin, RN 1 would have documented on progress notes. During a telephone interview with Physician 1 on 1/12/2025 at 3 PM, Physician 1 stated he was notified of Resident 53 ' s readmission to the facility but could not recall the details of the phone call with the admitting nurse. Physician 1 stated when verifying orders with the admitting nurse, they would verify each medication. Physician 1 stated he would have expected the licensed nurse to let him know about the change, but it was nothing unusual to him because Resident 53 did not require too much insulin. Physician 1 stated if Resident 53 ' s hemoglobin A1C (HbA1C- blood test that shows what the average blood sugar level was over the past 2 to 3 months) was normal she would not require anymore checking for blood sugar or insulin. Physician 1 stated he could not recall if there were any orders for diabetic management for Resident 53 ' s recent readmission. During a review of the facility ' s policy and procedure (P&P) titled Admissions- From the Community dated 3/2017 indicated prior to, or at the time of admission, a resident admitted from the community to the facility will have the following information available to assure that the immediate care needs of the resident can be met: admitting diagnosis and prognosis; current medical status; and physician orders for immediate care. During a review of the facility ' s P&P titled Diabetes- Clinical Protocol dated 11/2020 indicated the physician and staff will summarize factors that are contributing to, or conditions that are affected by the resident ' s diabetes or glucose intolerance and will assess the impact of diabetes on the individual ' s function and quality of life.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a federally mandated resident assessment tool) was accurate for one of one sampled resident (Resident 53) who had a diagnosis of diabetes mellitus (a disease in which the blood sugar levels are too high) with no physician orders for Diabetes Management. This deficient practice had the potential to result in Resident 53 not to receive appropriate treatment and/or services. Cross Referenced to F635, F657, and F692 Findings: During a review of Resident 53's Facility Physician Progress Notes from GACH 1 dated 12/1/2024 indicated a diagnosis of Diabetes Mellitus with blood sugar control per protocol. During a review of facility's Facility Admission Record indicated Resident 53 was initially admitted on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included acute pulmonary edema (condition caused by excess fluid in the lungs), Type 2 diabetes mellitus, and end stage renal disease (ESRD- condition in which the kidneys lose the ability to remove waste and balance fluids). During a review of Resident 53's Facility History and Physical Assessment (H&P) dated 12/16/24, the H&P indicated Resident 53 had the capacity to understand and make decisions. During a review of Resident 53's Facility Order Summary Report prior to readmitted d 10/25/2024 indicated Insulin (a hormone of the pancreas that is essential for allowing your body to use sugar for energy) Aspart Injection Solution (Insulin Aspart) inject as per sliding scale: if 0-149 milligrams per deciliter (mg/dL).= 0 units; 150-199 mg/dL= 2 units; 200-249 mg/dL= 3 units; 250-299 mg/dL= 4 units; 300-349 mg/dL= 6 units; 350-399 mg/dL= 8 units notify Physician 1 if over 400 mg/dL, subcutaneously before meals and at bed time for Diabetes Mellitus (DM). During a review of Resident 53's Facility Order Summary Report dated 1/12/2025, did not indicate medications or treatment orders were ordered for Resident 53 such as insulin sliding scale for Resident 53's DM. During a review of Resident 53's MDS, indicated Resident 53 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 53 had an active diagnosis of DM. The MDS also indicated Resident 53 was receiving Insulin medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's Facility care plans indicated an active DM care plan initiated 10/26/2024 with a revision on 11/6/2024, and target date of 1/25/2025. The care plan indicated the following interventions: (1) to administer medications as ordered, (2) monitor blood sugar as ordered by Physician 1, (3) monitor for signs and symptoms of hypoglycemia and hyperglycemia and notify Physician 1 if any; (4) monitor skin status every week and as needed and notify Physician 1 if any changes are noted; (5) notify Physician 1 if blood sugar is less than 60 or over 400 mg/dL; and (6) provide diet as ordered. During a review of Resident 53 ' s Facility Custom Interdisciplinary Team (IDT) Care Conference form dated 12/8/2024 indicated the areas reviewed with Physician 1 were Resident 53's diagnoses, care plans. The Custom IDT Care Conference form indicated there was no new diagnosis(es) since last assessment. The Custom IDT Care Conference form indicated a diet of 80 grams (gm, unit of measure), low potassium, low salt and regular texture. During a review of Resident 53's Facility Nutritional Initial Screener dated 12/15/2025, the document indicated admitting diagnoses that included status post left below the knee amputation, chronic obstructive pulmonary disease (COPD- condition caused by damage to the airways or other parts of the lung), ESRD, and pressure injury stage 2. The nutritional initial screener indicated the following diet: consistent carbohydrate diet (CCHO- Diet for people with diabetes to manage their blood sugar levels and weight), no added salt, mechanical soft (diet designed for people who have trouble chewing and swallowing), thin. During a review of Resident 53's Facility Medication Administration Record (MAR) from 10/25/2024 to 11/27/2024, the MAR indicated insulin aspart injection as per sliding scale was previously being administered to Resident 53 prior to readmission on 12/8/2024. The MAR indicated the resident had received insulin on the following days: On 10/26/2024 timed at 9 PM, 2 units given for a blood sugar level of 155 mg/dL On 10/27/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 10/29/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 152 mg/dL On 10/30/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 179 mg/dL On 10/31/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 169 mg/dL On 11/1/2024 timed at 9 PM, 3 units given for a blood sugar level of 208 mg/dL On 11/2/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL On 11/3/2024 timed at 9 PM, 2 units given for a blood sugar level of 159 mg/dL On 11/5/2024 timed at 9 PM, 2 units given for a blood sugar level of 178 mg/dL On 11/7/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 155 mg/dL On 11/7/2024 timed at 9 PM, 2 units given for a blood sugar level of 167 mg/dL (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/2024 timed at 11:30 AM, 3 units given for a blood sugar level of 230 mg/dL On 11/14/2024 timed at 6:30 AM, 2 units given for a blood sugar level of 154 mg/dL On 11/14/2024 timed at 9 PM, 3 units given for a blood sugar level of 212 mg/dL On 11/15/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 160 mg/dL On 11/20/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 164 mg/dL On 11/20/2024 timed at 9 PM, 3 units given for a blood sugar level of 234 mg/dL On 11/21/2024 timed at 9 PM, 2 units given for a blood sugar level of 198 mg/dL On 11/22/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 190 mg/dL On 11/22/2024 timed at 9 PM, 2 units given for a blood sugar level of 166 mg/dL On 11/24/2024 timed at 9 PM, 2 units given for a blood sugar level of 156 mg/dL On 11/25/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 11/26/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 177 mg/dL On 11/27/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL During a concurrent interview and record review of Resident 53's medical chart on 1/12/2025 at 10:37 AM, the Director of Nursing (DON) verified Resident 53 had a diagnosis of DM on the Admission Record. The DON verified there were no physician orders for diabetic management like insulin or blood sugar checks on the Order Summary Report. The DON stated she and the Minimum Data Set Nurse (MDSN) check admission documentation and will conduct an IDT with the resident and the resident ' s family/responsibly party to go over medications and what transpired at the GACH. The DON stated the purpose of clarifying orders and diagnosis with Physician 1 was to ensure if Resident 53 needed insulin. The DON stated if there are no orders for diabetic management, the resident can experience hyperglycemia (high blood sugar) and have uncontrolled blood sugar. At 10:55 AM, the DON stated when verifying the orders as the admitting nurse, she would have clarified with Physician 1. The DON stated Physician 1 reviews the medications on admission, and they will sign electronically. During a concurrent interview and record review of Resident 53's Order Summary Report prior to readmitted d 10/25/2024 on 1/12/2025 at 11:24 AM, the DON stated Resident 53 had an order for Insulin at the facility before she was transferred to GACH 1. The DON stated when Resident 53 was readmitted back to the facility on [DATE] there were no orders to continue Insulin. The DON stated she would have clarified with Physician 1 and she would expect the nurses to question and clarify with Physician 1 as well. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 53 ' s MDS dated [DATE] on 1/12/20254 at 1:58 pm, the Minimum Data Set Nurse (MDSN) verified Resident 53 had an active diagnosis of DM. The MDSN stated she must have miscoded. The MDSN stated for the 5-day MDS she would review the facility's MAR and the resident ' s hospital records. The MDSN stated the lookback for the 5-day MDS would be 7 days prior to Assessment Reference Date (ARD) which for Resident 53 would be 12/7/2024 to 12/14/2024. The MDS also indicated Resident 53 was receiving Insulin medication. The MDSN stated she must have miscoded the MDS. During the same interview and concurrent record review of Resident ' s MAR for 12/2024 on 1/12/2025 at 2:07 PM, the MDSN verified Resident 53 did not receive insulin during the assessment reference period of 12/7/2024 to 12/14/2025. During the same interview on 1/12/2025 at 2:09 PM, the MDSN stated it was important for the MDS assessment to be accurate for reimbursement purposes. During a review of the facility ' s policy and procedure (P&P) titled Accuracy of Assessments dated 3/2018 indicated the facility ensures each resident receives an accurate assessment, reflective of the resident ' s status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident ' s status, needs, strengths, and areas of decline. The P&P indicated the assessment must represent an accurate picture of the resident ' s status during the observation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to ensure the care plan was revised for one of one sampled resident (Resident 53) who had an active care plan for a diagnosis diabetes mellitus (a disease in which the blood sugar levels are too high) with no physician orders for Diabetes Management. This deficient practice had the potential to result in Resident 53 not receiving appropriate treatment and/or services for the Diabetes. Cross Referenced to F635, F641, and F692 Findings: During a review of Resident 53's Physician Progress Notes from GACH 1 dated 12/1/2024 indicated a diagnosis of Diabetes Mellitus with blood sugar control per protocol. During a review of facility's Admission Record (AR), the AR indicated Resident 53 was initially admitted on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included acute pulmonary edema (condition caused by excess fluid in the lungs), Type 2 diabetes mellitus, and end stage renal disease (ESRD- condition in which the kidneys lose the ability to remove waste and balance fluids). During a review of Resident 53's History and Physical Assessment (H&P) dated 12/16/24, the H&P indicated Resident 53 had the capacity to understand and make decisions. During a review of Resident 53's Order Summary Report prior to readmitted d 10/25/2024 indicated Insulin (a hormone of the pancreas that is essential for allowing your body to use sugar for energy) Aspart Injection Solution (Insulin Aspart) inject as per sliding scale: if 0-149 = 0 milligrams per deciliter (mg/dL) units; 150-199 mg/dL= 2 units; 200-249 mg/dL= 3 units; 250-299 mg/dL= 4 units; 300-349 mg/dL= 6 units; 350-399 = 8 units notify Physician 1 if over 400mg/dL, subcutaneously before meals and at bed time for Diabetes Mellitus (DM). During a review of Resident 53's Order Summary Report dated 1/12/2025, the Report did not indicate medications or treatment orders were ordered for Resident 53 such as insulin sliding scale for Resident 53's DM. During a review of Resident 53's MDS, the MDS indicated Resident 53 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 53 had an active diagnosis of DM. The MDS also indicated Resident 53 was receiving Insulin medication. (continued on next page)

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 01/12/2025
NAME OF PROVIDER OR SUPPLIER Socal Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 S. Sorenson Ave. Whittier, CA 90606	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's care plans indicated an active DM care plan initiated 10/26/2024 with a revision on 11/6/2024, and target date of 1/25/2025. The care plan indicated the following interventions: (1) to administer medications as ordered, (2) monitor blood sugar as ordered by Physician 1, (3) monitor for signs and symptoms of hypoglycemia and hyperglycemia and notify Physician 1 if any; (4) monitor skin status every week and as needed and notify Physician 1 if any changes are noted; (5) notify Physician 1 if blood sugar is less than 60 or over 400; and (6) provide diet as ordered. During a review of Resident 53's Custom Interdisciplinary Team (IDT) Care Conference form dated 12/8/2024, the form indicated the areas reviewed with Physician 1 were Resident 53's diagnoses, care plans. The Custom IDT Care Conference form indicated there was no new diagnosis(es) since last assessment. The Custom IDT Care Conference form indicated a diet of 80 grams (gm, unit of measure), low potassium, low salt and regular texture. During a review of Resident 53's Nutritional Initial Screener dated 12/15/2025, the document indicated admitting diagnoses that included status post left below the knee amputation, chronic obstructive pulmonary disease (COPD- condition caused by damage to the airways or other parts of the lung), ESRD, and pressure injury stage 2. The nutritional initial screener indicated the following diet: consistent carbohydrate diet (CCHO- Diet for people with diabetes to manage their blood sugar levels and weight), no added salt, mechanical soft (diet designed for people who have trouble chewing and swallowing), thin. During a review of Resident 53's Facility Medication Administration Record (MAR) from 10/25/2024 to 11/27/2024, the MAR indicated insulin aspart injection as per sliding scale was previously being administered to Resident 53 prior to readmission on 12/8/2024. The MAR indicated the resident had received insulin on the following days: On 10/26/2024 timed at 9 PM, 2 units given for a blood sugar level of 155 mg/dL On 10/27/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 10/29/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 152 mg/dL On 10/30/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 179 mg/dL On 10/31/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 169 mg/dL On 11/1/2024 timed at 9 PM, 3 units given for a blood sugar level of 208 mg/dL On 11/2/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL On 11/3/2024 timed at 9 PM, 2 units given for a blood sugar level of 159 mg/dL On 11/5/2024 timed at 9 PM, 2 units given for a blood sugar level of 178 mg/dL On 11/7/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 155 mg/dL On 11/7/2024 timed at 9 PM, 2 units given for a blood sugar level of 167 mg/dL (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/2024 timed at 11:30 AM, 3 units given for a blood sugar level of 230 mg/dL On 11/14/2024 timed at 6:30 AM, 2 units given for a blood sugar level of 154 mg/dL On 11/14/2024 timed at 9 PM, 3 units given for a blood sugar level of 212 mg/dL On 11/15/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 160 mg/dL On 11/20/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 164 mg/dL On 11/20/2024 timed at 9 PM, 3 units given for a blood sugar level of 234 mg/dL On 11/21/2024 timed at 9 PM, 2 units given for a blood sugar level of 198 mg/dL On 11/22/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 190 mg/dL On 11/22/2024 timed at 9 PM, 2 units given for a blood sugar level of 166 mg/dL On 11/24/2024 timed at 9 PM, 2 units given for a blood sugar level of 156 mg/dL On 11/25/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 11/26/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 177 mg/dL On 11/27/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL During a concurrent interview and record review of Resident 53's medical chart on 1/12/2025 at 10:37 AM, the Director of Nursing (DON) verified Resident 53 had a diagnosis of DM on the Admission Record. The DON verified there were no physician orders for diabetic management like insulin or blood sugar checks on the Order Summary Report. The DON stated she and the Minimum Data Set Nurse (MDSN) check admission documentation and will conduct an IDT with the resident and the resident's family/responsibly party to go over medications and what transpired at the GACH. The DON stated the purpose of clarifying orders and diagnosis with Physician 1 was to ensure if Resident 53 needed insulin. The DON stated if there are no orders for diabetic management, the resident can experience hyperglycemia (high blood sugar) and have uncontrolled blood sugar. At 10:55 AM, the DON stated when verifying the orders as the admitting nurse, she would have clarified with Physician 1. The DON stated Physician 1 reviews the medications on admission, and they will sign electronically. During a concurrent interview and record review of Resident 53's Order Summary Report prior to readmitted d 10/25/2024 on 1/12/2025 at 11:24 AM, the DON stated Resident 53 had an order for Insulin at the facility before she was transferred to GACH 1. The DON stated when Resident 53 was readmitted back to the facility on [DATE] there were no orders to continue Insulin. The DON stated she would have clarified with Physician 1 and she would expect the nurses to question and clarify with Physician 1 as well. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 53's care plans with the Minimum Data Set Nurse (MDSN) on 1/12/2025 at 3:14 PM, the MDSN verified Resident 53 had an active care plan in place for Resident 53's Diabetes. The MDSN stated the interventions on the care plan did not indicate Resident 53's current physician orders. The MDSN stated the care plan should have been revised at when Resident 53 was readmitted on [DATE] because there was no order for insulin and blood sugar checks. The MDSN stated the importance of revising the care plan was for staff to know what to do to manage Resident 53 ' s diabetes. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 12/2016 indicated assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. The P&P indicated the IDT must review and update the care plan when the resident has been readmitted to the facility from a hospital stay.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on interview and record review, the facility failed to ensure a comprehensive approach in regard to resident's diet for one of one sampled resident (Resident 53) by failing to ensure an accurate nutritional assessment was completed for Resident 53 ' s diagnosis for diabetes mellitus (DM- a disease in which the blood sugar levels are too high). This deficient practice had the potential to result in Resident 53 to not receive the appropriate diet and nutritional needs that addressed her DM. Cross Referenced to F635, F641, and F657 Findings: During a review of Resident 53's Physician Progress Notes from GACH 1 dated 12/1/2024 indicated a diagnosis of Diabetes Mellitus with blood sugar control per protocol. During a review of facility's Admission Record indicated Resident 53 was initially admitted on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included acute pulmonary edema (condition caused by excess fluid in the lungs), Type 2 diabetes mellitus, and end stage renal disease (ESRD- condition in which the kidneys lose the ability to remove waste and balance fluids). During a review of Resident 53's History and Physical Assessment (H&P) dated 12/16/24 indicated Resident 53 had the capacity to understand and make decisions. During a review of Resident 53's Order Summary Report prior to readmitted d 10/25/2024 indicated Insulin (a hormone of the pancreas that is essential for allowing your body to use sugar for energy) Aspart Injection Solution (Insulin Aspart) inject as per sliding scale: if 0-149 mg/dL= 0 units; 150-199 mg/dL= 2 units; 200-249 mg/dL= 3 units; 250-299 mg/dL= 4 units; 300-349 mg/dL= 6 units; 350-399 mg/dL= 8 units notify Physician 1 if over 400, subcutaneously before meals and at bed time for Diabetes Mellitus (DM). During a review of Resident 53's Order Summary Report dated 1/12/2025, did not indicate medications or treatment orders were ordered for Resident 53 such as insulin sliding scale for Resident 53's DM. During a review of Resident 53's Minimum Data Set (MDS - a federally mandated resident assessment tool), indicated Resident 53 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS indicated Resident 53 had an active diagnosis of DM. The MDS also indicated Resident 53 was receiving Insulin medication. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's care plans indicated an active DM care plan initiated 10/26/2024 with a revision on 11/6/2024, and target date of 1/25/2025. The care plan indicated the following interventions: (1) to administer medications as ordered, (2) monitor blood sugar as ordered by Physician 1, (3) monitor for signs and symptoms of hypoglycemia and hyperglycemia and notify Physician 1 if any; (4) monitor skin status every week and as needed and notify Physician 1 if any changes are noted; (5) notify Physician 1 if blood sugar is less than 60 or over 400; and (6) provide diet as ordered. During a review of Resident 53's Custom Interdisciplinary Team (IDT) Care Conference form dated 12/8/2024 indicated the areas reviewed with Physician 1 were Resident 53's diagnoses, care plans. The Custom IDT Care Conference form indicated there was no new diagnosis(es) since last assessment. The Custom IDT Care Conference form indicated a diet of 80 grams (gm, unit of measure), low potassium, low salt and regular texture. During a review of Resident 53's Nutritional Initial Screener dated 12/15/2025 indicated admitting diagnoses that included status post left below the knee amputation, chronic obstructive pulmonary disease (COPD- condition caused by damage to the airways or other parts of the lung), ESRD, and pressure injury stage 2. The nutritional initial screener indicated the following diet: consistent carbohydrate diet (CCHO- Diet for people with diabetes to manage their blood sugar levels and weight), no added salt, mechanical soft (diet designed for people who have trouble chewing and swallowing), thin. During a review of Resident 53 ' s Facility Medication Administration Record (MAR) from 10/25/2024 to 11/27/2024, the MAR indicated insulin aspart injection as per sliding scale was previously being administered to Resident 53 prior to readmission on 12/8/2024. The MAR indicated the resident had received insulin on the following days: On 10/26/2024 timed at 9 PM, 2 units given for a blood sugar level of 155 mg/dL On 10/27/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 10/29/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 152 mg/dL On 10/30/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 179 mg/dL On 10/31/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 169 mg/dL On 11/1/2024 timed at 9 PM, 3 units given for a blood sugar level of 208 mg/dL On 11/2/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL On 11/3/2024 timed at 9 PM, 2 units given for a blood sugar level of 159 mg/dL On 11/5/2024 timed at 9 PM, 2 units given for a blood sugar level of 178 mg/dL On 11/7/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 155 mg/dL On 11/7/2024 timed at 9 PM, 2 units given for a blood sugar level of 167 mg/dL (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/12/2024 timed at 11:30 AM, 3 units given for a blood sugar level of 230 mg/dL On 11/14/2024 timed at 6:30 AM, 2 units given for a blood sugar level of 154 mg/dL On 11/14/2024 timed at 9 PM, 3 units given for a blood sugar level of 212 mg/dL On 11/15/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 160 mg/dL On 11/20/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 164 mg/dL On 11/20/2024 timed at 9 PM, 3 units given for a blood sugar level of 234 mg/dL On 11/21/2024 timed at 9 PM, 2 units given for a blood sugar level of 198 mg/dL On 11/22/2024 timed at 4:30 PM, 2 units given for a blood sugar level of 190 mg/dL On 11/22/2024 timed at 9 PM, 2 units given for a blood sugar level of 166 mg/dL On 11/24/2024 timed at 9 PM, 2 units given for a blood sugar level of 156 mg/dL On 11/25/2024 timed at 9 PM, 2 units given for a blood sugar level of 154 mg/dL On 11/26/2024 timed at 11:30 AM, 2 units given for a blood sugar level of 177 mg/dL On 11/27/2024 timed at 9 PM, 3 units given for a blood sugar level of 209 mg/dL During a concurrent interview and record review of Resident 53's medical chart on 1/12/2025 at 10:37 AM, the Director of Nursing (DON) verified Resident 53 had a diagnosis of DM on the Admission Record. The DON verified there were no physician orders for diabetic management like insulin or blood sugar checks on the Order Summary Report. The DON stated she and the Minimum Data Set Nurse (MDSN) check admission documentation and will conduct an IDT with the resident and the resident ' s family/responsibly party to go over medications and what transpired at the GACH. The DON stated the purpose of clarifying orders and diagnosis with Physician 1 was to ensure if Resident 53 needed insulin. The DON stated if there are no orders for diabetic management, the resident can experience hyperglycemia (high blood sugar) and have uncontrolled blood sugar. At 10:55 AM, the DON stated when verifying the orders as the admitting nurse, she would have clarified with Physician 1. The DON stated Physician 1 reviews the medications on admission and they will sign electronically. During a concurrent interview and record review of Resident 53 ' s Order Summary Report prior to readmitted d 10/25/2024 on 1/12/2025 at 11:24 AM, the DON stated Resident 53 had an order for Insulin at the facility before she was transferred to GACH 1. The DON stated when Resident 53 was readmitted back to the facility on [DATE] there were no orders to continue Insulin. The DON stated she would have clarified with Physician 1 and she would expect the nurses to question and clarify with Physician 1 as well. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of Resident 53's Nutritional Initial Screener dated 12/15/2025 with the Consultant Dietitian (CD) on 1/12/2025 at 2:15 PM, the CD verified the admitting diagnoses that included status post left below the knee amputation, chronic obstructive pulmonary disease (COPD- condition caused by damage to the airways or other parts of the lung), ESRD, and pressure injury stage 2. The CD stated when she completes the Nutritional Initial Screener for each resident she would review the resident's medical diagnosis and H&P. The CD stated she must have missed resident ' s diagnosis of Diabetes Mellitus when completing the Nutritional Initial Screener. The CD verified the following diet on the Nutritional Initial Screener: consistent carbohydrate diet (CCHO- Diet for people with diabetes to manage their blood sugar levels and weight), no added salt, mechanical soft (diet designed for people who have trouble chewing and swallowing), thin. The CD stated the diet was incorrect because there was no diagnosis of diabetes. The CD stated Resident 53's blood sugar at the time was normal. The CD could not recall what Resident 53's blood sugar was at the time of her assessment. The CD stated the Nutritional Initial Screener should be completed and accurate to match the resident ' s current orders. During the same interview and concurrent record review of Resident 53's Order Summary dated 12/30/2024 on 1/12/2024 at 2:25 PM, the CD stated Resident 53's dialysis diet took precedence over a CCHO diet which was why Resident 53 had current orders of 80 gm Renal, Low potassium, low salt diet, mechanical soft texture, thin liquids consistency. During a review of the facility's policy and procedure (P&P) titled Nutritional assessment dated ,d+[DATE] indicated the dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. The P&P indicated the nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: current clinical conditions and recent events that may have affected a resident ' s nutritional status and risk factors.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observations, interviews and record reviews, the facility failed to ensure one (1) of 1 sampled resident (Resident 15) was receiving the appropriate oxygen flow rate in liters per minute (LPM; measurement of volume delivered, used to measure delivery of oxygen) for chronic respiratory failure (when not enough oxygen passes from your lungs to your blood) as ordered by the attending physician and in accordance with the resident's plan of care. This deficient practice had the potential for Resident 15 not to receive enough oxygen or receive too much oxygen which can lead to oxygen toxicity (a condition that occurs when someone breathes in too much oxygen, damaging the lungs and other organs). Findings: During a review of Resident 15's Admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included chronic respiratory failure and pulmonary embolism (PE; when a blood clot blocks and stops blood flow to an artery in the lung). During a review of Resident 15's History and Physical (H&P) dated 3/31/2024, the H&P indicated Resident 15 had the capacity to make needs known but can not make medical decisions. During a review of Resident 15' s Order Summary Report dated 1/8/2024, the Report indicated Resident 15 had a physician order to monitor oxygen saturation every shift to maintain oxygen saturation (measurement of how much oxygen is in the body) greater than 92 percent. During a review of Resident 15's Order Summary Report dated 10/23/2024, the Report indicated Resident 15 had a physician order to receive oxygen at two (2) to four (4) liters per minute continuously via nasal cannula (NC; a small plastic tube, which fits into the person ' s nostrils for providing supplemental oxygen) every shift for chronic respiratory failure. During a review of Resident 15's Minimum Data Set (MDS; a care assessment and screening tool) dated 10/27/2024, the MDS indicated the resident was assessed to have severely impaired cognition (capable of remembering, learning new things, concentrating, or making decisions that affect everyday life) and required: Maximal assistance (helper does more than half the effort) for putting on footwear. Moderate assistance (helper does less than half the effort) for toileting, showering, personal hygiene and lower body dressing. Supervision (helper provides verbal cues) for upper body dressing Set up assistance (helper sets up or cleans up) for eating, and oral hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's Care Plan (CP) dated 3/25/2023 and revised on 3/18/2024, the CP indicated Resident 15 required the use of oxygen therapy due to PE. The CP interventions included to administer oxygen therapy as ordered and oxygen therapy at 2 LPM via NC continuously. During a review of Resident 15 ' s Medication Administration Record (MAR; record of medications given to resident) dated 1/1/2025 to 1/31/2025, the MAR indicated Resident 15 was ordered oxygen at 2 to 4 LPM via NC every shift for chronic respiratory failure. During a review of Resident 15's Progress Notes dated 1/10/2025 at 9:04 PM, Progress Notes indicated, Resident 15 ' s oxygen was documented at 4.5 LPM via NC, current order is for 2 to 4 LPM via NC. During a concurrent observation and interview on 1/10/2025 at 8:18 PM with Licensed Vocational Nurse (LVN) 2, Resident 15's oxygen machine was observed to be set at 4.5 LPM. LVN 2 stated the oxygen setting is at 4.5 LPM. It was not at 2 to 4 L as ordered by the physician. LVN 2 stated the resident can get hyperoxygenation (a condition where the body is exposed to too much oxygen) if the oxygen is not at the right dose. During a concurrent interview and record review on 1/12/2025 at 10:30 AM with the director of nursing (DON), the facility's policy and procedure (P&P) titled, Oxygen Administration dated 10/2010 was reviewed. The P&P indicated: The purpose of this procedure is to provide guidelines for safe oxygen administration. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 LPM. Adjust the oxygen delivery device so that the proper flow of oxygen is being administered. The DON stated, It is important to give the correct dose of oxygen to keep the resident oxygenated. The DON stated the residents can get hyperoxygenation if they are given too much oxygen. They can get seizures and possibly get injured as a result.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview and record review, the facility failed to ensure that the attending physician responded to a recommendation made by the consultant pharmacist (CP) regarding laboratory monitoring for one of four residents (Residents 18) sampled for medication regimen review between 1/9/2024 and 1/9/2025. This deficient practice had the potential to cause a negative impact on the resident ' s overall physical, mental, and psychosocial well-being. Findings: During a review of facility's Admission Record indicated Resident 18 was initially admitted on [DATE] and readmitted back to the facility on [DATE], with diagnoses that included Type 2 diabetes mellitus (a disease that occurs when there are high levels of sugar in the blood)with unspecified diabetic retinopathy(a complication of diabetes that damages the blood vessels in the eyes), Major depressive disorder(a mood disorder that consist of feelings of sadness, hopelessness and loss interest) During a review of Resident 18 ' s History and Physical Assessment (H&P) dated 2/24/2024, the H&P indicated Resident 18 had the capacity to understand and make decisions. During a review of the Consultant Pharmacist ' s Medication Regimen Review, dated 10/09/2024, the Medication Regimen Review indicated the Contracted Pharmacist (CP) made a recommendation to clarify with Resident 18 ' s Primary Physician if it was clinically indicated/appropriate for Resident 18 to have labs performed for: Basic Metabolic Panel (BMP- a blood test that checks the levels of different substances in your blood). During a review of Resident 18's clinical record from 10/09/2024 to 1/11/2025, the record indicated there was no response from Resident 18's attending physician regarding the pharmacist ' s recommendation listed above and order for BMP labs as recommended by the CP. During an interview and concurrent record review on 1/11/2025 at 3:15 PM with the Director of Nurses (DON), the DON confirmed there was no documented clinical record from 10/09/24 to 1/11/2025 indicating the facility had informed Resident 18's physician of the consultant pharmacist recommendation. The DON stated it was important to communicate the CP's recommendations to Residents Primary Physician as soon as they are received to make sure residents are receiving the appropriate care. During a review of the facility's policy Medication Regimen Reviews, revised August 2019, indicated Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medical director and or the administrator

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NAME OF PROVIDER OR SUPPLIER Socal Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 7931 S. Sorenson Ave. Whittier, CA 90606	

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on observation, interview, and record review, the facility failed to ensure that PRN (as needed - not given on a regular schedule) orders for psychotropic (medications that affects mood and behavior) Ativan (a medication used to treat anxiety-the fear of the unknown) are limited to a duration of 14 days and evaluated for the continued use of for one of three sampled residents (Resident 5) taking psychotropic medications. Resident 5's physician order for Ativan did not indicate a stop date since the medication was ordered on 12/17/2024. This deficient practice increased the risk of Resident 5 to experience adverse effects (undesired effect) of psychotropic medication therapy including, but not limited to, dizziness, drowsiness, leading to an overall negative impact to their physical, mental and psychosocial well being. Findings: During a review of Resident 5's Admission Record (AR) indicated a readmission to the facility on [DATE] with diagnoses that included Hemiplegia (paralysis that affects one side of your body) and Hemiparesis (one sided muscle weakness) following a cerebral infraction (when the blood supply to a part of the brain is blocked), Type 2 Diabetes Mellitus(high levels of sugar in the blood) without complications. During a review of Resident 5's History and Physical [H&P] dated 10/11/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 5's Order Summary Report, dated 1/11/2025, the Report indicated a physician order for: Ativan oral tablet 0.5 milligrams (mg-a unit of measurement), give one tablet by mouth every 4 hours as needed for anxiety manifested by agitation, shortness of breath, climbing out of bed, crying, yelling or hitting, with a start date of 12/17/2025 and no end date indicated. During an interview and concurrent record review of Resident 5's medical record on 1/12/2025 at 10:22 AM, with the Director of Nursing (DON), the DON stated Resident 5 ' s order for Ativan 0.5 mg PRN ordered on 12/17/2024, did not include a stop date or rationale why the medication should be extended past the 14 day prescription. The DON stated Ativan like other psychotropic medication ordered as PRN need to be renewed every 14 days and must be seen and evaluated by resident ' s attending physician before renewing the PRN psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Psychotropic Medications Use dated with a revised date of 4/08/2022 indicated 2. Psychoactive can only be prescribed if there is an appropriate indication: diagnosis and behavior. E. PRN (as needed) orders for anti-psychotic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond the 14 days,

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	055168	A. Building B. Wing	01/12/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48903 Based on observation, interview and record review, the facility failed to put an opening date on an open pack of ground beef in the facility's one of one freezer. These deficient practices had the potential to cause food-borne illnesses to 54 residents residing in the facility who receives their daily meals prepared in the facility's kitchen. Findings: During a concurrent observation and interview on [DATE] at 6:25 PM with the Dietary Director (DD) an open pack of ground beef was observed without an opening date. The DD stated, We don't know how long something has been opened if there is no opening date. This pack of ground beef does not have an opening date on it. It might be old and cause a resident to get sick if they eat it. During a concurrent interview and record review on [DATE] at 10:28 AM with the Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled, Labeling and Dating of Foods dated 2023, indicated, All food items in the storeroom, refrigerator and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date. The DON stated, It is important to label opened food items so that we know when things are opened and for how long they are good for. We might not know when something expires or how long it has been opened if it's not labeled. Old or expired food can potentially be served to residents if it is not labeled and there can be some health issues if they eat bad food like food poisoning and vomiting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854 Based on observation, interview, and record review, the facility failed to maintain a safe, sanitary environment to help prevent the spread of transmission of infections to residents, staff members, visitors in accordance with the facility's policy and procedure on infection control by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 1 was aware when to wear personal protective equipment (PPE) in an Enhanced Barrier Precaution (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) room for one of one sampled resident (Resident 49) who had an EBP. 2. Ensure LVN 1 disposed of soiled PPE in a disposable bin inside of Resident 49 ' s room. These deficient practices had the potential to increase the risk of the spread of infection to the residents, staff, and other visitors in the facility. Findings: 1. During a review of Resident 49's Admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included hemiplegia (paralysis that affects only one side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, aphasia (loss of ability to understand or express speech, caused by brain damage) following cerebral infarction, and gastrostomy status (G-tube, an opening into the stomach from the abdominal wall, made surgically for the introduction of food). During a review of Resident 49's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/21/2024, the MDS indicated Resident 49 had moderately impaired cognitive (thought process) skills for daily decision making. During a review of Resident 49's Order Summary Report Indicated the following physician orders: On 8/25/2024, the physician prescribed ENTERAL (food or drug administration via the human gastrointestinal tract) administer all medications via g-tube unless otherwise specified. On 11/29/2024, the physician prescribed enhanced barrier precautions. During a medication administration observation and concurrent interview with LVN 1 on 1/11/2025 at 9:05 AM, Resident 49's room was observed with an EBP signage by the entrance of the door. LVN 1 stated PPE was only to be worn for EBP resident when providing high contact care. The EBP signage indicated to wear PPE when using the feeding tube. No isolation cart with PPE was observed around the resident room ' s entrance. LVN 1 found an isolation gown, donned PPE and continued with medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same observation and concurrent interview on 1/11/2025 at 9:27 AM, LVN 1 was observed doffing the isolation gown and could not find a disposal bin for the soiled gown inside Resident 49's room. LVN 1 proceeded to exit Resident 49's room and into the hallway to dispose of the soiled gown in a soiled linen bin across the hall near another resident's room. LVN 1 stated it was important to wear the correct PPE to protect the resident from infection. LVN 1 stated the disposal of the gown should be closer to the room and there was nowhere in Resident 49's room to dispose the soiled gown. During an interview with the Director of Nursing (DON) on 1/11/2025 at 2:56 PM, the DON stated the importance of wearing PPE in an EBP room was to protect the facility staff and the residents. The DON stated the gown should be worn during high risk activities dealing with any g-tube, foley catheter (a device that drains urine from urinary bladder into collection bag outside of the body), wound dressings (materials applied to wounds to promote healing, protect from infection and prevent further injury), or administering medications via g-tube. During an interview with the infection prevention nurse (IPN) on 1/12/2025 at 11:52 AM, the IPN stated PPE should be worn during high contact care activity because Resident 49 had a g-tube. The IPN stated PPE should be worn to make sure the staff were not spreading infection, because the resident was at risk for infection. The IPN stated soiled PPE should be disposed in resident room to prevent the spread of infection. During a review of the facility's policy and procedure (P&P) titled Enhanced Barrier Precautions updated 1/11/2025 indicated EBP to include the use of glove and gown during high-contact care activities for residents with chronic wounds, or indwelling medical devices, regardless of their MDRO status. The P&P indicated the safest practice would be to wear a gown and gloves for any care (dressing changes) or use (injecting or infusing medications or tube feeds) of the indwelling medical device. The P&P indicated to position a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. During a review of the facility's undated enhanced barrier precautions signage indicated STOP, everyone must clean their hands, including before entering and when leaving the room. The signage indicated providers and staff must also wear gloves and gown for the following high contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting; the device care or use of central line, urinary catheter, feeding tube, tracheostomy (a surgical procedure in which the surgeon creates a hole through the neck and into the trachea [trachea]), and wound care: any skin opening requiring a dressing.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48903 Based on observation, interview and record review, the facility failed to ensure the facility's trash bin was not overflowing. The facility disposed trash in a bin with overflowing trash and the trash was on the ground of the facility's parking lot. These deficient practices had the potential to attract pest and rodents, that could spread infection and create an uncomfortable environment for residents, staff and the public. Findings: During a concurrent observation and interview on 1/10/2025 at 7:56 PM with the Dietary Director (DD), a variety of trash (open boxes, broken containers, wooden pallets, broken decorations and other scattered items) was observed within the view of residents ' windows in the facility ' s parking lot. The DD stated, The trash should be disposed in the trash can, not on the parking lot floor (ground). We don't know if it's hazardous, it can attract animals, bugs. During a concurrent observation and interview on 1/10/2025 at 8:35 PM with the Maintenance Director (MNTD) a variety of trash (open boxes, broken containers, wooden pallets, broken decorations and other scattered items) was observed within the view of several residents ' rooms windows adjacent to the facility's parking lot. The MNTD stated trash should not be outside of the facility ' s parking lot floor. MNTD stated trash should be in the trash container. During a concurrent interview and record review on 1/12/2025 at 10:32 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Homelike Environment dated 2/2021 was reviewed, the P&P indicated: Residents are provided with a safe, clean, comfortable and homelike environment. The characteristics of the facility that reflect a personalized homelike setting include a clean, sanitary and orderly environment. The DON stated, It is not a homelike environment to see trash outside the window or to have trash scattered in the facility ' s parking lot. It may make me feel like the facility is dirty if I was a resident and saw that.