STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055430	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Hills Health Care Ctr	10426 Bogardus Ave Whittier, CA 90603

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow physician's orders and care plan for two of three sampled residents (Resident 1 and Resident 2) by failing to:1. Follow Physician's Order to limit the resident's sitting to one to two hours at a time with gel cushion on the wheelchair for Resident 1.2. Follow Physician's Order to adjust Alternating Pressure Mattress Replacement System with Low Air Loss (APMRS, mattress that provided pressure redistribution by filling and un-filling air cells within the mattress so that contact points with the body were reduced) settings according to Resident 1's height and weight.3. Implement Resident 1's care plan to limit the resident's sitting to one to two hours at a time with gel cushion on the wheelchair and adjust the APMRS settings according to the resident's height and weight.4. Follow Physician's Order to adjust APMRS settings according to Resident 2's weight.5. Implement Resident 2's care plan to adjust APM settings according to the resident's weight.This deficient practice had the increased potential for Resident 1 and Resident 2 to develop new pressure ulcer (localized damage to the skin and/or underlying soft tissue, most often caused by prolonged pressure, but also by friction and shear) or injury and/or delay the resident's wound to heal. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities), and anemia (a condition where the body did not have enough healthy red blood cells). During a review of Resident 1's Braden Scale for Predicting Pressure Sore Risk (a simple tool used to predict a person's risk of developing a pressure sore [bedsore, a type of skin and tissue damage caused by constant pressure, friction, or shearing that cut off blood flow to an area, often on bony parts of the body] by rating six key factors: sensory perception, moisture, activity, mobility, nutrition, and friction/shear) dated 3/11/2024 at 6:20 PM, the Braden Scale indicated the resident's sensory perception was slightly limited, the resident's skin exposure to moisture was occasional, bedfast, slightly limited mobility, inadequate nutrition, and had a potential friction and shear problem. The Braden Scale indicated a score of 14, categorizing Resident 1 at moderate risk for pressure sore risk. During a review of Resident 1's Physician's Order dated 11/9/2024 at 11:50 AM, the Physician's Order indicated for the resident to have a low air loss mattress (an air-filled bed that prevented skin sores by using a gentle, continuous flow of air to keep the resident dry and cool, often combined with an alternating pressure feature that cycles air to redistribute pressure points) for skin management, setting according to resident weight and height and check function every shift. During a review of Resident 1's History and Physical (H&P) dated 3/11/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 1's Physician's Order dated 4/9/2025, the Physician's Order indicated for the resident to limit sitting to one to two hours at a time with gel cushion (a seat or pad made of a gel material, often combined with foam, that provided pressure relief and support by conforming to the body's shape) on the wheelchair every day and evening shift. During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 9/9/2025, the MDS indicated the resident had severe cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated that the resident was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries. The MDS indicated treatments for Resident 1's skin and ulcer/injury included pressure reducing device for chair, pressure reducing device for bed, and pressure ulcer/injury care. The treatment did not include a turning/repositioning program. During a review of Resident 1's Risk for Pressure Ulcer Development Care Plan revised 9/17/2025, the Care Plan indicated a goal for the resident to have no pressure ulcer development, show signs of healing, and remain free from infection. The Care Plan indicated interventions to limit sitting to one to two hours at a time with gel cushion on the wheelchair as per physician every day and evening shift; low air loss mattress for skin management setting according to resident height and weight and check function daily; and monitoring/reminding/assistance to turn/reposition. During a review of Resident 1's Turning Schedule Every 2 Hours dated 10/26/2025, the Turning Schedule had times listed in two-hour increments starting at 7:30 AM to 5:30 AM. The Turning Schedule did not have a staff signature from 7:30 AM to 1:30 PM and from 11:30 PM to 5:30 AM. During a review of Resident 1's Turning Schedule Every 2 Hours dated 10/29/2025, the Turning Schedule did not have a staff signature from 11:30 PM to 5:30 AM. During a review of Resident 1's Turning Schedule Every 2

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and secured environment for one of two sampled residents (Resident 1) who has a diagnosis of Dementia (loss of memory, language, problem-solving and other thinking abilities) by mistakenly sending Resident 1 without supervision to a Physicians (Orthopedic- a medical specialty that focuses on the musculoskeletal system, which includes bones, joints, ligaments, tendons, and muscles) appointment outside the facility that was scheduled for another resident (Resident 2) on 11/12/2025. This deficient practice resulted in Resident 1 leaving the facility, unsupervised, to the Orthopedic physician's office, which was eleven (11) miles away from the facility, and had the potential for Resident 1 to be at risk for accidents and/or injuries.FINDINGS:During a review of Resident 1's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE]. The AR indicated the resident's diagnoses including Cerebral infarction (when the blood supply to part of the brain is blocked or reduced.), Dementia (loss of memory, language, problem-solving and other thinking abilities). A review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 8/18/2025, indicated that Resident 1 had severe cognitive impairment. The MDS indicated Resident 1 requires maximal assistance (helper does more than the half the effort) in toileting, shower, lower body dressing and putting on and taking off footwear. The MDS indicated Resident 1 required partial assistance (helper does less than half the effort) in oral hygiene, upper body dressing and personal hygiene, chair to bed transfers. The MDS indicated Resident 1 had an active diagnosis of Dementia. A review of Resident 1's Progress Notes dated 11/06/2025, written by Social Service Director (SSD), indicated Orthopedic appointment with Physician 1 on 11/12/2025 at 10 AM. The Note indicated, Called transportation and confirmed. Pick up time in the facility at 9:05 AM. RP 1 made aware and will meet Resident 1 at the clinic. A review of Resident 1's Progress Notes dated 11/12/2025, timed at 9:48 AM and written by Social Service Director (SSD), indicated at 9:30 AM, SSD received a telephone call from Responsible Party (RP) 1 who stated RP 1 was informed via a text message informing RP 1 that Resident 1 was picked up by transportation, and that RP 1 was unaware that Resident 1 was leaving the facility. The Note indicated that SSD called the medical office to where Resident 1 was going to, and to watch over Resident 1 when she arrived at the medical office. The Note indicated SSD called the transportation to check on the status on Resident 1, and transportation stated Resident 1 was dropped off five (5 minutes) ago. The Note indicated SSD informed transportation to turn back around and pick up Resident 1 at the dropped off location (medical office). The Note indicated SSD called the medical office to confirm that Resident 1 arrived at the medical office. The Note indicated transportation arrived back to pick up Resident 1 at the medical office at approximately 9:55 AM, and returned to the facility at 10: 20 AM. A review of Resident 2's AR indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of fracture to the right femur and orthopedic aftercare. A review of Resident 2's MDS, dated [DATE], indicated Resident 2 had a BIMS of 15 (no cognitive impairment). The MDS indicated Resident 2 was independent with eating and oral hygiene. The MDS indicated Resident 2 required supervision with upper body dressing. The MDS indicated Resident 2 required maximum assistance with toileting. The MDS indicated Resident 2 was dependent with showers, lower body dressing, and putting on/taking off footwear. During a telephone interview on 11/12/2025 at 12:13 PM with RP 1, RP 1 stated this morning she received a text alert from a transportation company indicating Resident 1 was on-route. RP 1 stated she was able to see on the message the route began at the facility where Resident 1 resides to an unknown ending address for RP 1, which was a medical office. RP 1 stated she was confused and alarmed as she had not received any notification from the facility that Resident 1 was leaving the facility. RP 1 stated Resident 1 has Dementia and was very forgetful and should not go anywhere unaccompanied as she could get lost or hurt. RP 1 stated she immediately called the facility to ask where Resident 1 was going. RP 1 stated she spoke to Case Manager Assistant (CMA) who stated she was unaware that Resident 1 was not in the facility, and CMA transferred the call to SSD. RP 1 stated the facility staff was unaware Resident 1 was mistakenly sent to Resident 2's appointment, and that RP 1 stated there was no urgency from facility staff to locate Resident 1. RP 1 stated she hung up with facility and drove to the unknown medical office address to locate Resident 1 herself as she was afraid Resident 1 would be scared, anxious and confused, since Resident 1 was being taken to an unknown location by herself. RP 1 stated the facility was only alerted to their mistake when RP 1 called the facility to check on Resident 1's wellbeing