STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to accommodate needs for one of one sampled resident (Resident 1) who had a physician's order for a bariatric bed (specialized bed made specifically to accommodate larger and heavier patients) with bilateral 1/2 bed side rails (a structural support attached to the frame of a bed and intended to prevent a patient from falling) to maintain or achieve independent functioning and well-being. As a result of this deficient practice, Resident 1 was discovered on the floor, lying unconscious on [DATE]. The resident was later pronounced deceased , with the cause of death determined to be natural causes.Findings: During a review of Resident 1's admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included obesity due to excess calories, hyperlipidemia (an excess of lipids or fats in the blood), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life). During a review of Resident 1's History and Physical (H&P) dated [DATE] indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Order Summary dated [DATE] indicated a physician order for bariatric bed with bilateral 1/2 bed side rails. During a review of Resident 1's Weights and Vitals Summary dated [DATE] at 12:28 AM, Resident 1's weight was 265 pounds (lbs. A unit of measurement). During a review of Resident 1's care plans dated [DATE] indicated Resident 1 had self-care performance deficit related to respiratory failure with hypoxia (low levels of oxygen in the body tissues), chronic kidney disease (CKD, gradual loss of kidney function where damaged kidneys cannot properly filter waste and fluid from the blood), hypertension (HTN), pneumonia (inflammation , coronary heart failure (CHF), chronic obstructive pulmonary disease (COPD, ongoing lung condition caused by damage to the lungs), asthma, hyperlipidemia (HLD), presence of pacemaker, neuropathy, depression, impaired mobility, and incontinence. The care plan indicated an intervention for the use of a bariatric bed with bilateral 1/2 bed side rails. The care plan indicated Resident 1 required assistance from the bed side rails to assist with turning. During a review of Resident 1's active care plan dated [DATE] indicated Resident 1 was at risk for falls related to respiratory failure with hypoxia, CKD, HTN, pneumonia, CHF, COPD, asthma, HLD, presence of pacemaker, neuropathy, depression, impaired mobility, and incontinence. The fall risk care plan indicated Resident 1 needed a safe environment: floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; side rails as ordered, handrails on walls, and personal items within reach. During a review of Resident 1's nursing progress notes indicated on [DATE] timed at 12:16 AM, the progress note indicated Resident 1 refused to change her bed to a bariatric bed, stating I just want to rest and was endorsed to next shift. During a review of the nursing progress notes, on [DATE] timed at 6:35 AM, the progress note indicated Resident 1 was found resting in bed at 11:45 PM and licensed vocational nurse (LVN) 1 held a brief conversation with Resident 1 about the new room she (Resident 1) was in. The (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

Printed: 04/02/2026
Form Approved OMB
No. 0938-0391

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	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note further indicated, at 1:45 AM, Resident 1 was comfortable in bed with no acute distress. At 2:40 AM, Resident 1 was given a blanket per resident request. And at 3:50 AM, Resident 1 was found unresponsive on the floor by the resident's roommate in the Immediate assessment revealed no response to verbal or physical stimuli, no head trauma, lumps, or discoloration noted when assessed by the Registered Nurse Supervisor (RNS) 1. The note further indicated emergency protocol was initiated, charge nurse was notified, and emergency services were contacted. Cardiopulmonary resuscitation ((CPR a life-saving emergency procedure combining chest compressions and rescue breaths [or hands-only compressions] to circulate oxygenated blood when someone's heart stops or they aren't breathing)) was initiated even due to Resident 1's Do not resuscitate (DNR) status. The note indicated Resident 1 had no POLST to clarify DNR status. And at 4:28 AM, Resident 1 was pronounced dead by emergency medical technician (EMT). The note indicated at 6 AM, the coroner arrived, assessed Resident 1 and reported no head trauma. During an interview with Resident 3 (Resident 1's roommate) on [DATE] at 12:11 PM, Resident 3 stated she was getting up and saw Resident 1 on the floor in between Resident 1 and 3's bed. Resident 3 stated she did not hear Resident 1 fall Resident 3 stated she called for help and the nurses came right away and brought equipment (could not recall what equipment) and started CPR. Resident 3 stated she could not recall what happened after. During a telephone interview on [DATE] at 2:42 PM, LVN 1 stated Resident 1's bed from readmission to the facility on [DATE] did not have side rails. During an interview on [DATE] at 2:48 PM, the Director of Nursing (DON) stated Resident 1 had a bariatric bed prior to the recent hospitalization. Maintenance Supervisor (MS) kept track of beds and knew which bariatric beds were assigned to its respective residents. During a telephone interview on [DATE] at 3:18 PM, Licensed Vocational Nurse (LVN) 1 stated that around 11:30 PM on [DATE], while conducting rounds (systematic patient checks by nurses to assess patient's needs, comfort and safety), LVN 1 stated he had a spoke with Resident 1 about being in a new room. LVN 1 stated Resident 1 mentioned she needed a bigger bed and that the current bed she was laying in needed to be switched out. LVN 1 stated he could not recall what he said to Resident 1 since he was told by the previous shift that Resident 1 refused a bigger bed. LVN 1 stated he did not offer to switch Resident 1's bed to a bariatric bed nor did he switch the resident's bed to the bariatric bed upon the resident's request during his shift. LVN 1 then stated that at around 3:50 AM on [DATE], he heard a certified nursing assistant (CNA) calling for help and went to Resident 1's room. LVN 1 stated when he arrived at Resident 1's room, Resident 1 was found on the floor, between Resident 1's bed and her roommate's bed, lying on her left side. LVN 1 stated he immediately called for assistance since she was pretty big and LVN 1 needed help to turn Resident 1. LVN 1 stated Resident 1 was not breathing and had no pulse. LVN 1 stated he obtained Resident 1's vital signs and could not get any blood pressure, oxygen saturation (the percentage of hemoglobin [carries oxygen from the lungs to the body's tissues] in your red blood cells that is carrying oxygen), or a heart rate reading. LVN 1 stated multiple staff came into Resident 1's room to assist. LVN 1 stated a code blue (a critical, life-threatening medical emergency, usually a patient experiencing cardiac arrest [heart stops] or respiratory arrest [stops breathing], requiring immediate resuscitation) was and initiated CPR. During a telephone interview on [DATE] at 4:45 PM, LVN 2 stated during the 3 PM to 11 PM shift on [DATE] she was in the nursing station when Resident 1 arrived at the facility. LVN 2 stated Resident 1 arrived in a gurney with paramedics and placed into a regular sized bed. LVN 2 stated we noticed she was really big and barely fit in the bed. LVN 2 stated the bariatric bed was brought to the bedside by MS, but Resident 1 had already refused the bariatric bed when Registered Nurse Supervisor (RNS) 1 spoke to Resident 1. LVN 1 stated that Resident 1 used to have a bariatric bed prior to her most recent hospitalization on (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], but on this readmission, on [DATE], Resident 1 did not verbalize a request for a bariatric bed. LVN 1 stated regarding the regular size bed, that Resident 1 barely fit in the bed. During a telephone interview on [DATE] at 2:42 PM, LVN 1 stated Resident 1's bed from readmission did not have side rails. During a telephone interview on [DATE] at 3:01 PM, Family Member (FM) 1 stated prior to Resident 1's hospitalization, Resident 1 had a bariatric bed for comfort and safety. FM 1 stated Resident 1 was almost 300 pounds and a regular bed did not fit her at all. FM 1 stated Resident 1 was non-ambulatory and bed bound. During a telephone interview on [DATE] at 9:02 AM, RNS 1 stated when Resident 1 arrived at the facility for readmission on [DATE] she was brought in via gurney with the paramedics. RNS 1 stated Resident 1 was able to move from the gurney into a regular bed, in her room. RNS 1 stated Resident 1 was offered a bariatric bed but refused. RNS 1 stated Resident 1 said she wanted to rest. RNS 1 stated she could not recall if Resident 1's bed had side rails. During a concurrent observation and interview in Resident 1's room on [DATE] at 9:38 AM, MS stated the bed in the room was the same bed used when Resident 1 was readmitted to the facility. MS stated the bed was a regular bed and not a bariatric bed. During a concurrent interview and record review of Resident 1's Physician's Order for bariatric bed with 1/2 siderails on [DATE] at 11:53 AM The DON stated the purpose of Resident 1's 1/2 side rails were used as an enabler. The DON stated she could not recall why the bariatric bed was not ready prior to Resident 1's readmission. The DON stated the bed was readily available and she remembered seeing the bariatric bed in the hallway, but Resident 1 refused the bed. A review of Resident 1's County of Los Angeles Medical Examiner document, with a date of death of [DATE], the document indicated the manner of death was natural, caused by congestive heart failure and obesity. A review of the facility's policy and procedure (P&P) titled Admissions: Continuum of Care dated [DATE] indicated it was the policy of facility to have guidelines for processing the Resident's entry into the nursing facility. The P&P indicated the purpose was to provide the Resident with information and resources for his/her care and comfort. The P&P indicated the room and bedside unit will be checked for appropriate supplies. The P&P indicated the following procedures for the licensed nurse: initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders; note and initiate physician orders; address all care and services for identified diagnosis and health concerns; initiate medications and treatment. A review of the facility's P&P titled Safety, Resident, dated 9/2017 indicated it was the policy of the facility to create a safe environment for the resident. The P&P indicated to conduct room checks routinely by staff members to promote quality of life and ensure safety of resident residing in the facility. The P&P indicated room checks include but not limited to resident observations (wearing appropriate clothing, oral hygiene, assistive devices, alarms, etc) and bedside observation (call lights within reach).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one (1) of 1 sampled resident (Resident 1) was safely provided with her own routine medications from the pharmacy or cubex (automated medication management system to securely store, track, and dispense medications) as ordered by the physician and in accordance with the Policy and Procedure (P&P) titled, Six Rights of Medication Administration. This deficient practice resulted in Resident 1 to miss one dose of albuterol (bronchodilator medicine that relaxes airway muscles to treat and prevent wheezing, shortness of breath, and chest tightness) and to receive one dose of Heparin (an anticoagulant medication that prevents blood from clotting) that belonged to another resident (Resident 3). This had the potential to negatively impact Resident 1's medical conditions resulting in fall with injury, coma, or death. During a review of Resident 1's admission Record indicated Resident 1 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included obesity due to excess calories, hyperlipidemia (an excess of lipids or fats in the blood), and major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with daily life). During a review of Resident 1's History and Physical (H&P) dated 1/2/2026 indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Order Summary dated 1/2/2026 indicated the following physician orders: a. Ipratropium Albuterol Inhalation Solution 0.5-2,.5 (3) milligram (mg, unit of measure) per 3 milliliters (ml, unit of measure) 3 ml inhale orally via nebulizer (medical device that turns liquid medicine into a fine mist, allowing it to be inhaled directly into the lungs through a mouthpiece or mask) every 6 hours for respiratory failure, to be given routinely.b. Heparin Sodium (Porcine) Injection Solution 5000-unit (unit of measure) per milliliter (ml, unit of measure) inject 500 unit subcutaneously every 8 hours for deep vein thrombosis (DVT, a serious condition where a blood clot forms in a deep vein) prophylaxis, first dose to be taken from cubex. During a review of Resident 1's Medication Administration Record (MAR) dated 1/2026, the MAR indicated Resident 1 received the following medications: a. Heparin Injection Solution 5000 unit was last given on 1/2/2026 at 10 PM.b. Albuterol Inhalation Solution was last given on 1/3/2026 at 12 AM. During a review of the facility's Cubex receipts titled Transactions by Cabinet C6 and Controlled Subs, by Cab (cabinet), and bin, by time C81 dated 1/2/2026 to 1/3/2026 indicated no transactions were made for Resident 1. During a review of the Pharmacy Delivery Receipt dated 1/3/2026, the receipt indicated a delivery for Resident 1's medications on 1/3/2026 at 5:15 AM. The receipt indicated the following medications were delivered and returned back to pharmacy: a. Solifenacin (medication used to treat overactive bladder symptoms like urinary urgency, frequency, and incontinence) 5 mg tablet, Quantity: 14, 1 Package .b. Sertraline Hydrochloride (used to treat depression [mood disorder that causes persistent feeling of sadness and loss of interest]) 25 mg tablet, Quantity: 14, 1 Package.c. Isosorbide Mononitrate (medication used to prevent chest pain from coronary heart disease) 20 mg tablet, Quantity: 14, 1 Package.d. Isosorbide Mononitrate 10 mg tablet, Quantity: 14, 1 Packagee. Ondansetron Hydrochloride (medication to prevent nausea and vomiting) 4 mg tablet, Quantity: 30, 1 Package.f. Metoprolol Succinate Extended Release (ER) (used to treat chest pain [angina] and hypertension [high blood pressure]) 25 mg tablet, Quantity: 14, 1 Package g. Ipratropium Albuterol Inhalation Solution 0.5-3(2.5) mg/ 3 ml, Quantity: 90, 1 Packageh. Heparin Sodium 5000 unit/ml vial, Quantity: 21, 1 Packagei. Gabapentin (medication used to help control partial seizures [convulsions] in the treatment of epilepsy [brain condition that causes recurring seizures]) 100 mg capsule, Quantity: 84, 1 Packagej. Clopidogrel (antiplatelet medication that prevents blood platelets from sticking (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	together, reducing the formation of dangerous clots that can cause heart attacks and strokes) 75 mg tablet, Quantity: 14, 1 Packagek. Atorvastatin (medication that treats high cholesterol [waxy, fat-like substance throughout the body) 20 mg tablet, Quantity: 14, 1 Package During a telephone interview on 1/8/2026 at 10:49 AM, licensed vocational nurse (LVN) 2 stated and confirmed she administered Heparin to Resident 1 during her 3 PM t0 11 pm shift on 1/2/2026. LVN 2 stated going to the cubex to take out the Heparin but could not obtain it since it took too much time, because the cubex takes time to process with the pharmacy. LVN 2 stated she then used a vial of Heparin that belonged to another resident, Resident 3, who was receiving the same dose as Resident 1. LVN 2 stated she did not document that the dose of heparin administered to Resident 1 belonged to Resident 3. During an interview with the Director of Nursing (DON) at 1/8/2026 at 11:59 AM, the DON stated licensed nurses should never borrow medications from another resident. The DON stated when the cubex is used to take out medication, the licensed nurse would call the pharmacy, wait 5-10 minutes to remove the medication from the cubex. The DON stated LVN 2 should not have used medication that belonged to another resident, and she should have called the pharmacy and waited to get medication from the cubex. During a telephone interview on 1/8/2026 at 2:01 PM, LVN 1 stated he did not administer Albuterol to Resident 1. LVN 1 stated it was a mistake and might have just clicked yes on the MAR by accident. LVN 1 stated he does not remember administering Albuterol or any other medications to Resident 1. A review of the facility's policy and procedure (P&P) titled Six Rights of Medication Administration dated 5/2018 indicated the six rights of medication administration are followed in order to ensure safety and accuracy of administration. The P&P indicated the six rights of medication are as follows:a. Right Resident- Resident is identified prior to medication administration.b. Right Time- Medications are administered within prescribed time frames. c. Right Medication order- Medications are checked against the order before they are given.d. Right Dose - Medications are administered according to the dose prescribed.e. Right Route - Medications are administered according to the route prescribed.f. Right Documentation - Document administration or refusal of the medication after the administration or attempt and note any concerns