

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 03/26/2026
NAME OF PROVIDER OR SUPPLIER Whittier Hills Health Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide and explain the process for obtaining a copy of resident's medical records upon request for one of two sampled residents (Resident 1) in accordance with the facility's policy and procedure titled Protected Health Information (information in the medical record that can be used to identify an individual). This deficient practice resulted in violation of Resident 1's and Responsible Party's (RP 1) right to obtain a copy of the resident medical records, in accordance with facility policy. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses that included Type 2 Diabetes Mellitus (in which your blood glucose, or blood sugar, levels are too high), dementia (diseases that affect memory, thinking, and the ability to perform daily activities). During a review of Resident 1's Interdisciplinary Team- (IDT) Care plan review with effective date 2/10/2026 authored by Social Service Assistant (SSA) and attended by Registered Nurse (RN) 1, Rehabilitation Staff (RS) 1 and Activity Director (AD), an IDT conference was conducted. The care plan review also listed Resident 1 and RP 1 as attendees. The IDT record did not include topics that were discussed during the IDT care plan review with the IDT and Resident 1's RP. The IDT record was not signed and dated by the SSA who authored the IDT care plan review. During an interview on 3/26/2026 at 1:15 PM with Resident 1's RP 1, RP 1 stated she had requested an IDT meeting in February 2026 to request Resident 1's medical records. RP 1 stated SSA told her during the meeting she would take care of the request. RP 1 stated after weeks of waiting for the records she called to follow up with SSA, but the facility receptionist would just tell her the SSA was unavailable and would not get anyone else to assist her. RP 1 stated after more attempts to speak to the SSA, RP 1 was eventually transferred to Medical Records Director (MRD) who informed RP 1 that MRD was not aware of her request from February 2026 and that she needed to fill out a form for the request. RP 1 stated she was not informed by the SSA when she made her initial request during the IDT meeting in February 2026. During an interview with MRD on 3/26/2026 at 2:20 PM, MRD stated a few days ago she received a phone call from RP 1 asking why she had not received Resident 1's medical records she had previously requested. MRD stated she had not received or informed that a request from RP 1 was communicated to the SSA. MRD stated she explained to RP 1 that she needs to come in and fill out a request form. MRD stated SSA no longer worked in the facility and had not communicated to her that RP 1 had requested Resident 1's medical records during their IDT meeting in February 2026. MRD stated if she had known she would have contacted RP 1 and explained the facility process to acquire the medical records. During an interview on 3/26/2026 at 2: 42 PM with the AD, the AD stated she was present during Resident 1's IDT care plan review on 2/10/2026 and remembered Resident 1's RP asking SSA for Resident 1's medical records. The AD stated she remembered SSA stating she would get the records for RP 1. During a review of the facility's policy and procedure (P&P) titled Protected Health Information with a revision date of 11/2024 indicated, 7. A resident may have access to his or her records within twenty-four (24) hours (excluding weekends or holidays) of the resident's written or oral request.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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