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	04/16/2026

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 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 observation, interview, and record review, the facility failed to properly manage and document medications for two of five sampled residents (Resident 1 and Resident 2) by failing to: 1.Document Resident 1's meropenem (intravenous [IV- into the vein] medication used to treat severe bacterial infections) dose on 4/13/2026 and 4/15/2026 at 10 PM. 2. Properly manage Resident 1's medications when three white pills were observed in a medicine cup on the resident's bedside table. 3. Assess Resident 1's ability to safely manage the residents' medications. 4. Document Resident 2's Zosyn (IV medication used to treat severe bacterial infections) dose on 4/15/2026 at 10 PM. This deficient practice placed Resident 1 and Resident 2 at risk for medication errors, including missed, duplicated, or incorrect doses, potential adverse drug reactions, and unsafe medication use.Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included cellulitis (potentially serious bacterial infection of the deeper layers of the skin and the tissue beneath) of corpus cavernosum (two sponge-like columns of tissue running along the shaft of the penis) and penis, specified polyneuropathies (a condition where many nerves outside the brain and spinal cord were damaged, causing widespread numbness, tingling, burning pain, and muscle weakness) and functional quadriplegia (complete immobility where a person could not move their arms or legs due to severe frailty or advanced disease, rather than a direct spinal cord injury). During a review of Resident 1's Initial admission Record dated 8/25/2025 at 10:13 PM, the Initial admission Record indicated the resident did not desire to self-administer drugs. The Initial admission Record indicated if the resident said yes a Self-administration of Medications IDT Determination Evaluation would have been triggered. During a review of Resident 1's History and Physical (H&P) dated 9/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 1's Physician's Order dated 10/9/2025 at 7:07 PM, the Physician's Order indicated for the resident to have methocarbamol (a prescription muscle relaxer used for short-term relief of acute muscle pain, spasms [a sudden, involuntary (uncontrollable) tightening or contraction of a muscle], strains, or sprains) oral tablet 500 milligram (mg, unit of measurement), give one tablet by mouth three times a day for spasms. During a review of Resident 1's Physician's Order dated 10/9/2025 at 9:58 PM, the Physician's Order indicated for the resident to have gabapentin (a prescription medication primarily used to treat neuropathic pain [nerve pain]) oral tablet 800 mg, give one tablet by mouth every six hours for neuropathy. Per nurse practitioner (NP, a registered nurse with advanced graduate education who provided high-quality primary, acute, and specialty care), okay to take together with Norco (prescription medication combining a strong opioid pain reliever [hydrocodone] and a common pain reliever [acetaminophen/Tylenol] used to treat moderate to severe pain) every six hours per resident's request. Hold if resident was sedated (being in a very calm, relaxed, or sleepy state caused by medication) or respiratory rate (RR, the number of breaths a person took per minute, usually measured at rest by counting how many times the chest rose). During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/16/2026, the MDS (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident's active diagnoses included cellulitis of corpus cavernosum and penis, specified polyneuropathies, and functional quadriplegia. During a review of Resident 1's Physician's Order dated 3/25/2026 at 1:48 PM, the Physician's Order indicated for the resident to have hydrocodone-acetaminophen oral tablet 10-325 mg, give one tablet by mouth every six hours for moderate to severe pain, pain level 4-10. During a review of Resident 1's Physician's Order dated 4/8/2026 at 4:35 PM, the Physician's Order indicated for the resident to have meropenem IV reconstituted (the process of adding a liquid [diluent] to a powered medication to turn the medication into a usable liquid solution for IV injection) 500 milligrams (mg- a unit of measurement). Use 500 mg intravenously every eight hours for positive Escherichia coli (E. coli, bacteria commonly found in the intestines of humans and animals) and extended-spectrum beta-lactamases (ESBL, enzymes produced by bacteria that make them resistant to many common antibiotics) to sacrococcyx wound (a pressure sore [bedsore] located on the tailbone or lower spine) for 10 days. During a review of Resident 1's IV Medication Administration Record (MAR) dated 4/1/2026 to 4/30/2026, the IV MAR indicated there was no documentation that the resident received meropenem on 4/13/2026 and 4/15/2026's 10 PM dose. During a concurrent observation and interview in Resident 1's room on 4/16/2026 at 12:40 PM, a medicine cup with three white pills were observed on the resident's bedside table. Resident 1 stated he knew what each pill was taken for; gabapentin for my nerves, Norco for my pain, and the other one was to relax my muscles. Resident 1 stated the three pills were his afternoon medications and were left on his bedside table because he was on the phone and asked the nurse to leave them there. During an interview on 4/16/2026 at 12:54 PM, Licensed Vocational Nurse (LVN) 1 stated when passing medications, the facility staff would need to wait until the residents took their medications completely and should not have left any medication at the resident's bedside before leaving their room. LVN 1 stated the facility staff needed to ensure the resident took the medication properly and if the facility staff left before the resident took the medication the resident might not have taken the medication or the medication could have been taken by another resident and that would not have been okay. During an interview on 4/16/2026 at 3:09 PM, Registered Nurse Supervisor (RNS) stated when providing IV medications, the facility staff should have documented the medication that was given after administration otherwise that would have meant the medication was not given. RNS stated if there was no documentation, that could have meant the resident missed the medication and infections required a certain level of antibiotics in their body to fight the infection and without the antibiotic the resident's body was not able to fight at the limit that was expected because the resident was underdosed. During a continued interview on 4/16/2026 at 3:09 PM, RNS stated she was unsure if she documented Resident 1's 10 PM meropenem dose for 4/15/2026 but should have been documented to prove the medication was given. During an interview on 4/16/2026 at 3:47 PM, Director of Nursing (DON) stated facility staff should have been documenting once a medication was given to know the medication was actually given and the resident's records were accurate. The DON stated if there was no documentation the medication was given, this could have been implied that the medication was missed. During a concurrent interview and record review of Resident 1's IV MAR on 4/16/2026 at 4:04 PM, the DON stated there was no documentation for the resident's meropenem on 4/13/2026 and 4/15/2026 at 10 PM but there should have been. The DON stated without documentation, this implied that the medication was not given and must be investigated. During an interview on 4/16/2026 at 4:07 PM, the DON stated the process for medication pass was to pour, pass, and sign and follow the six rights of medication administration (right resident, right medication, right dose, right route, right time, and right documentation). The DON stated medication should never have been left at the bedside and the facility staff should have made sure the resident took the medication before leaving the resident's room otherwise the resident might not have taken the medication or someone else could have taken the medication. During a continued interview on 4/16/2026 at 4:07 PM, the DON stated facility staff (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not have been documenting medications were administered before the resident actually took the medication because the facility staff would be saying the resident already took the medication when they did not and that was not the facility's process. During a concurrent interview and record review of Resident 1's Initial admission Record on 4/16/2026 at 4:15 PM, the DON stated the resident was not interested in taking his own medications therefore should not have been taking the medications on his own and the facility staff should have been watching him take his medications. The DON stated that without a proper evaluation done, Resident 1 might have forgotten to take the medication or someone else could have taken the medication if the medication was left at the bedside. 2. During a review of Resident 2's AR, the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus (DM, chronic metabolic disease that occurred when the body did not produce enough insulin or could not use insulin properly), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and chronic kidney disease (when the kidneys were damaged and could not filter blood the way they should have). During a review of Resident 2's H&P dated 6/12/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident's cognition was intact. The MDS indicated the resident's active diagnoses included type 2 DM, Parkinson's disease, and renal insufficiency (occurred when kidneys could not long adequately filter waste, toxins, and excess fluids from the blood), renal failure, or end-stage renal disease (ESRD, permanent kidney failure where kidneys could no longer filter waste or mange fluids well enough for survival). During a review of Resident 2's Physician's Order dated 4/10/2026 at 6:06 PM, the Physician's Order indicated for the resident to have Zosyn IV solution 3-0.375 gram (gm, a metric unit of weight and mass)/50 milliliters (ml, a metric unit used to measure small amounts of liquid volume), use 3.375 gm intravenously every eight hours for wound infection for seven days. During a review of Resident 2's IV MAR dated 4/1/2026 to 4/30/2026, the IV MAR indicated there was no documentation that the resident received Zosyn on 4/15/2026's 10 PM dose. During an interview on 4/16/2026 at 3:09 PM, RNS stated she was unsure if she documented Resident 2's 10 PM Zosyn dose for 4/15/2026 but should have been documented to prove the medication was given. During a concurrent interview and record review of Resident 2's IV MAR on 4/16/2026 at 4:05 PM, the DON stated there was no documentation for the resident's Zosyn on 4/15/2026 at 10 PM but there should have been. The DON stated without documentation, this implied that the medication was not given and must be investigated. During a review of the facility's undated policy and procedure (P&P) titled Self-Administration of Medications, the P&P indicated, Each resident will be informed of his/her right to self-administer medications. The Interdisciplinary Team will assess and determine if the practice is safe. Medications to be self-administered are specifically ordered and monitored by the facility nursing staff. Such orders will be periodically reassessed to assure that they may still be given safely. The P&P indicated If the resident requests to self-administer drugs the ID team will determine if the practice is safe before the resident may exercise this right. The Physician's Orders for such drugs will be clarified to include: May keep at bedside. The P&P indicated, Storage of non-legend drugs at the bedside shall meet the following conditions: The manner of storage shall prevent access by the other residents; lockable drawers or cabinets need to be used unless alternate procedures, including storage on a resident's person or in a lock drawer or cabinet are ineffective; the facility shall record in the resident's health record the bedside medications used by the resident, based on observation by the nursing staff and/or information supplied by the resident; the quantity of each drug supplied to the resident for bedside storage shall be recorded in the health record each time the drug is so supplied. During a review of the undated P&P titled, Specific Medication Administration Procedures, the P&P indicated for General Procedures to Follow for All Medications: After administration, return to card and document administration in Medication Administration Record (MAR); these guidelines refer to all medications. The P&P indicated for Oral Medication Administration (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procedure: Pour the correct number of tablets or capsules into the medication cup. Administer medication and remain with resident while medication is swallowed. After administration, return to cart and document administration in Medication Administration Record (MAR). During a review of the facility's P&P titled Six Rights of Medication Administration revised May 2019, the P&P indicated The six rights of medication administration are as follows in order to ensure safety and accuracy of administration. 1. Right Resident - Resident is identified prior to medication administration. 2. Right Time - Medications are administered within prescribed time frames. 3. Right Medication order - Medications are checked against the order before they are given. 4. Right Dose - Medications are administered according to the dose prescribed. 5. Right Route - Medications are administered according to the route prescribed. 6. Right Documentation - Document administration or refusal of the medication after the administration or attempt.