

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/09/2026
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)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive resident specific care plan for one out of three sampled residents (Resident 1) by failing to ensure to implement a care plan for Resident 1, who had a gastrostomy tube (G-tube, a device surgically inserted through the abdominal wall directly into the stomach to provide long-term nutrition, hydration, and medication to individuals unable to eat enough by mouth) and had a behavior of refusing tube feedings. This deficient practice had the potential to result in confusion of resident's care and negatively affect the residents psychosocial wellbeing. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the resident was readmitted on [DATE] with anoxic brain damage (occurs when the brain is completely deprived of oxygen, leading to widespread brain cell death within minutes), expressive language disorder (a communication condition where individuals have difficulty putting thoughts into words, resulting in a limited vocabulary, improper grammar, and trouble forming complex sentences), encounter for attention to gastrostomy (surgical procedure that creates a small opening through the abdominal wall into the stomach). During a review of Resident 1's History and Physical Assessment (H&P) dated 8/15/2026 indicated resident was alert and oriented by name, followed commands, anxious, and non-verbal. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screen tool) dated 3/3/2026, indicated Resident 1's cognition was intact. The MDS indicated resident had unclear speech and had the ability to express ideas and wants and understood verbal content. The MDS indicated Resident 1 had a feeding tube. During a review of Resident 1's Order Summary Report dated 3/4/2024 indicated a physician order was made for Enteral Feed Order every 4 hours Glucerna 1.5 at 237 milliliters (ml, unit of measure) via G-tube bolus (a single, relatively large dose of a substance administered rapidly into the body to quickly achieve an effective concentration) every 4 hours, 1422 ml total volume, 2136 calories (kcal), 117 grams (g, unit of measure) protein, 1090 ml water. During a review of Resident 1's Medication Administration Record dated 4/2026 to 6/2026 indicated Resident 1 refused her Enteral Feed of Glucerna on the following dates: On 4/1/2026 at 4 [NAME] 4/2/2026 at 12 AM and 4 [NAME] 4/6/2026 at 12 AM and 4 [NAME] 4/29/2026 at 4 [NAME] 5/9/2026 to 5/11/2026 at 12 AM and 4 [NAME] 5/16/2026 to 5/18/2026 at 12 AM and 4 [NAME] 5/21/2026 at 12 AM and 4 [NAME] 6/3/2026 to 6/5/2026 at 12 AM and 4 AM. During a review of Resident 1's care plans, no care plan was indicated for resident's refusal of enteral feeding for Glucerna. During a telephone interview on 6/9/2026 at 3:09 PM, Licensed Vocational Nurse (LVN) 1 stated she would usually document on progress notes when Resident 1 refuses her feeding bolus. LVN 1 stated Resident 1 was on monitoring for refusing because it was a common behavior for her and everyone was aware. LVN 1 stated when Resident 1 refuses anything she would document and inform Registered Nurse Supervisor (RNS). During an interview on 6/9/2026 at 2:21 PM, Resident 1 stated that she sometimes refuses her feeding between the hours of 12 AM to 4 AM. During an interview on 6/9/2026 at 3:43 PM, the Director of Nursing (DON) stated she has heard from the staff that Resident 1 wants specific staff assigned to her and refuses care. The DON stated when a resident refuses any care she expects her staff to document when they are refusing care, try using (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	different staff, attempting to provide care multiple times, and to update the care plan. The DON stated she also expects her staff to notify the resident's family/responsible party and the Physician. During a concurrent interview and record review of Resident 1's care plans on 6/9/2026 at 3:48 PM, the DON confirmed no care plan was created for Resident 1's refusal of enteral feeding. The DON stated it was important to have a care plan for Resident 1's refusal of tube feeding to make sure staff knows the plan of care of resident's history of refusing. The DON stated if the interventions are not working the staff can try different interventions and add more interventions to the care plan. A review of the facility's policy and procedure (P&P) titled Comprehensive Resident Centered Care Plan dated 12/2023 indicated the resident has the right to refuse or discontinue treatment. The P&P indicated in the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk.		