

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854</b></p> <p>Based on interview and record review, the facility failed to ensure the physician was notified for one of two sampled residents (Resident 1), who had a history of self-decannulation (process to remove tracheostomy [procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck] tube).</p> <p>This deficient practice had the potential for residents to not receive appropriate care, treatment and/or services.</p> <p>As a result, Resident 1 self-decannulated three times while a resident at the facility.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated a readmission to the facility on [DATE] with diagnoses that included cerebral infarction (also called ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), aphasia (language disorder that affects how you communicate), respiratory failure (condition that makes it difficult to breathe on your own), and encounter for surgical aftercare following surgery on the respiratory system.</p> <p>A review of Resident 1 ' s History and Physical assessment dated [DATE], indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s latest comprehensive Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/10/2024, indicated the resident had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) for cognitive skills for daily decision making.</p> <p>A review of Resident 1 ' s Physician Order Summary indicated for the following with corresponding order dates:</p> <p>1) On 6/6/2024, the physician prescribed Trach Tube type: Shiley XLT 8 every shift.</p> <p>2) On 6/6/2024, the physician prescribed change Trach tube as needed and every day shift stating on the 6th and ending on the 6th every month</p> <p>(continued on next page)</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3) On 6/6/2024, the physician prescribed suction to maintain patent airway and indicate: oral removal of saliva (Yes/No), Tracheostomy tie secure (Y), Change of Condition (Yes/No)- if yes, document in respiratory progress note 8 times/day</p> <p>4) On 6/9/2024, the physician prescribed to monitor episode/s of anxiety manifested by trying to pull out life sustaining tubing causing harm and tally by hashmarks for the use of Ativan (medication used to treat anxiety, also known as Lorazepam) every shift.</p> <p>5) On 6/9/2024, the physician prescribed Ativan Oral Tablet 1 MG (Lorazepam) *Controlled Drug* Give 1 tablet via gastrostomy (G-tube, tube inserted through the belly that brings nutrition directly to the stomach) every 6 hours as needed for Anxiety manifested by attempting to pull out life sustaining tubing for 14 Days.</p> <p>6) On 6/14/2024, the physician prescribed Freedom Splint (multipurpose soft splints that help restrict elbow and knee movement) of left arm for daily prevention of pulling out of life sustaining tubes. Obtained consent from family member (Family 1), after education of the risks, benefits, and verified with physician.</p> <p>A review of Resident 1 ' s General Acute Care Hospital (GACH) Physician Orders Report on 6/5/2024 timed at 8:17 AM, indicated Resident 1 had a soft wrist restraint on left wrist for repeated attempts to remove life sustaining tubing (intravenous (IV soft flexible tube placed inside a vein, usually in the hand or arm), nasogastric (NG, thin, flexible plastic tube from nose to stomach that ' s used for temporary medical purposes] or other tubing).</p> <p>A review of Resident 1 ' s care plan initiated on 6/7/2024 indicated Resident 1 receives special treatments for tracheostomy tube care with risk for accidental decannulation and associated respiratory distress. The care plan interventions indicated if decannulation occurs to notify physician/responsible party of change of condition.</p> <p>A review of Resident 1 ' s Change of Condition (COC)/Interact Assessment form (SBAR [situation, background, assessment, recommendation]) dated 6/9/2024 timed at 10:27 AM indicated Resident 1 was found with tracheostomy pulled out and respiratory therapist was called into the room and was successful in re-inserting tracheostomy.</p> <p>A review of Resident 1 ' s Licensed Nurses Note on 6/23/2024 timed at 3:57 AM indicated at 3:30 AM Resident 1 pulled life sustaining tracheostomy, registered nurse and respiratory therapist responded, and respiratory therapist reinserted tracheostomy.</p> <p>A review of Resident 1 ' s COC/Interact Assessment form (SBAR) on 6/23/2024 timed at 11:30 AM indicated Resident 1 pulled out tracheostomy. Resident 1 managed to take off the left arm freedom splint, respiratory therapist and registered nurse were notified and tracheostomy was re-inserted by respiratory therapist.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review of Resident 1 ' s Licensed Nurses Notes and COC/Interact Assessment Forms on 7/31/2024 at 6:26 PM, the Director of Nursing (DON) stated the facility could not find documented evidence of a change of condition, physician or family notification when Resident 1 self-decannulated her tracheostomy on 6/23/2023 at 3:30 AM. The DON stated the licensed nurses should have documented a change of condition. The DON stated the physician and family should have been notified. The DON stated the physician should have been notified to receive new orders for Resident 1 ' s care. The DON stated the family should have been notified to update them of Resident 1 ' s status.</p> <p>During a telephone interview with licensed vocational nurse (LVN) 1 on 8/1/2024 at 4:08 PM, LVN 1 confirmed and stated Resident 1 decannulated herself at 3:30 AM on 6/23/2024. LVN 1 stated Resident 1 wore a freedom splint on the left side but was able to take it off herself. LVN 1 stated neither her or the registered nurse (RN) notified the physician during that shift. LVN 1 stated Resident 1 ' s oxygen saturation (oxygen levels in the blood, normal range 96-100%) was above 95% so she did not document a change of condition, notify the physician or family.</p> <p>During a telephone interview with Family 1 on 8/1/2024 at 4:22 PM, Family 1 stated she was not notified that Resident 1 decannulated herself on 6/23/2024 at 3:30 AM.</p> <p>During an interview with the DON on 8/1/2024 at 4:35 PM, the DON stated each new occurrence of complication should require a new change in condition, update in care plan and physician and family notification.</p> <p>A review of facility ' s policy and procedure (P&amp;P) titled Change in Resident ' s Condition or Status dated 3/2023 indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition and/or status. The P&amp;P indicated prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication form.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42854</b></p> <p>Based on interview and record review, the facility failed to implement a care plan consistent with professional standards of practice for a resident with tracheostomy (procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck), that included specific behaviors and interventions to monitor tracheostomy self-decannulation (process to remove tracheostomy tube) for one of two sampled residents (Resident 1) who had a history of self-decannulation.</p> <p>This deficient practice had the potential for residents to not receive appropriate care, treatment and/or services. Resident 1 had self-decannulated three times while a resident at the facility on 6/9/2024 at 10:15 AM, 6/23/2024 at 3:30 AM and 11:30 AM.</p> <p>Findings:</p> <p>A review of Resident 1 ' s Admission Record indicated a readmission to the facility on [DATE] with diagnoses that included cerebral infarction (also called ischemic stroke, occurs when the blood supply to part of the brain is blocked or reduced), aphasia (language disorder that affects how you communicate), respiratory failure (condition that makes it difficult to breathe on your own), and encounter for surgical aftercare following surgery on the respiratory system.</p> <p>A review of Resident 1 ' s History and Physical assessment dated [DATE] indicated Resident 1 did not have the capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s latest comprehensive Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 6/10/2024, indicated the resident had moderately impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) for cognitive skills for daily decision making.</p> <p>A review of Resident 1 ' s Physician Order Summary indicated for the following:</p> <ol style="list-style-type: none"> <li>1) On 6/6/2024, the physician prescribed Trach Tube type: Shiley XLT 8 every shift.</li> <li>2) On 6/6/2024, the physician prescribed change Trach tube as needed and every day shift stating on the 6th and ending on the 6th every month</li> <li>3) On 6/6/2024, the physician prescribed suction to maintain patent airway and indicate: oral removal of saliva (Yes/No), Tracheostomy tie secure (Y), Change of Condition (Yes/No)- if yes, document in respiratory progress note 8 times/day</li> <li>4) On 6/9/2024, the physician prescribed to monitor episode/s of anxiety manifested by trying to pull out life sustaining tubing causing harm and tally by hashmarks for the use of Ativan (medication used to treat anxiety, also known as Lorazepam) every shift.</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5) On 6/9/2024, the physician prescribed Ativan Oral Tablet 1 MG (Lorazepam) *Controlled Drug* Give 1 tablet via gastrostomy (G-tube, tube inserted through the belly that brings nutrition directly to the stomach) every 6 hours as needed for Anxiety manifested by attempting to pull out life sustaining tubing for 14 Days.</p> <p>6) On 6/14/2024, the physician prescribed Freedom Splint (multipurpose soft splints that help restrict elbow and knee movement) of left arm for daily prevention of pulling out of life sustaining tubes. Obtained consent from family member (Family 1), after education of the risks, benefits, and verified with physician.</p> <p>A review of Resident 1 ' s General Acute Care Hospital (GACH) Physician Orders Report on 6/5/2024 timed at 8:17 AM, indicated Resident 1 had a soft wrist restraint on left wrist for repeated attempts to remove life sustaining tubing (intravenous (IV soft flexible tube placed inside a vein, usually in the hand or arm), nasogastric (NG, thin, flexible plastic tube from nose to stomach that ' s used for temporary medical purposes] or other tubing).</p> <p>A review of Resident 1 ' s care plan initiated on 6/7/2024, indicated Resident 1 receives special treatments for tracheostomy tube care with risk for accidental decannulation and associated respiratory distress. The care plan indicated if decannulation occurs to notify physician/responsible party of change of condition.</p> <p>A review of Resident 1 ' s Change of Condition (COC)/Interact Assessment form (SBAR [situation, background, assessment, recommendation]) dated 6/9/2024 timed at 10:27 AM indicated Resident 1 was found with tracheostomy pulled out and respiratory therapist was called into the room and was successful in re-inserting tracheostomy.</p> <p>A review of Resident 1 ' s Licensed Nurses Note on 6/23/2024 timed at 3:57 AM indicated at 3:30 AM Resident 1 pulled life sustaining tracheostomy, registered nurse and respiratory therapist responded, and respiratory therapist reinserted tracheostomy.</p> <p>A review of Resident 1 ' s COC/Interact Assessment form (SBAR) on 6/23/2024 timed at 11:30 AM indicated Resident 1 pulled out tracheostomy. Resident 1 managed to take off the left arm freedom splint, respiratory therapist and registered nurse were notified and tracheostomy was re-inserted by respiratory therapist.</p> <p>During a concurrent interview and record review of Resident 1 ' s care plans on 7/31/2024 at 4:24 PM, the Director of Nursing (DON) stated there was no documented evidence of a care plan initiated or updated regarding Resident 1 ' s self-decannulation on 6/9/2024 and twice on 6/23/2024. The DON stated the importance of updating the care plan was to look at what interventions to provide the resident to prevent further decannulation to herself. The DON stated what we were doing was not enough.</p> <p>During an interview with the DON on 8/1/2024 at 4:35 PM, the DON stated each new occurrence of complication should require a new change in condition, update in care plan and physician and family notification.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of facility ' s policy and procedure (P&amp;P) titled Care Plans, Comprehensive Person-Centered dated 03/2023 indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implement for each resident. The P&amp;P indicated care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making.</p> <p>A review of facility ' s P&amp;P titled Tracheostomy Tube, Reserve Tube for Emergency Use dated 5/2013 indicated to maintain a tracheostomy tube of the appropriate size at the bedside of all intubated residents and to be used in the case of accidental extubation/decannulation or other emergencies.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>48481</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary care and services to one of 3 residents (Resident 3) with Gastrostomy tube (G-tube a soft plastic tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) by ensuring an abdominal binder (fitted elastic material that goes around abdomen to support muscle and or keep bandage in place) was in use as ordered by the physician order to prevent from pulling out or dislodge ( accidental removal).</p> <p>This deficient practice had the potential to result in G-tube dislodgement that can lead to complications including trauma, infection of G-tube site and delayed nutritional feeding.</p> <p>Findings:</p> <p>During an observation on 7/31/24 at 10:35 AM in Resident 3 ' s room, Resident 3 was awake, able to make some eye contact and talks in incomprehensible sounds, G-tube was not anchored (device to secure device) and without an abdominal binder in use.</p> <p>During an interview on 7/31/24 at 10:45 AM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated, His (Resident 3) abdominal binder was very soiled, so we sent it to the laundry this morning. LVN 5 stated there was no other abdominal binder to be used when the binder is laundered since the resident only had one abdominal binder.</p> <p>During a review of Resident 3 ' s admission record, dated 6/11/24, indicated Resident 2 was admitted to the facility initially on 5/10/24 with diagnoses include but not limited to cardiac arrest ( heart functions stops) anoxic brain damage (damage to the brain due to lack of oxygen for a period of time) , respiratory failure ( failure of the lungs to meet the oxygen demand of the body), tracheostomy ( a tube surgically inserted into the neck and trachea used to deliver oxygen) status, gastrostomy status.</p> <p>During a review of Resident 3 ' s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 5/23/24, indicated the resident was severely impaired with cognitive (very limited mental action or process of acquiring knowledge and understanding) patterns for daily decision making and required extensive assistance from staff for activities of daily living; MDS also indicated the resident ' s nutritional approaches was feeding tube while and while not a resident of the facility.</p> <p>During a review of Resident 3 ' s physician order report, dated 5/24/24 indicated to place an abdominal binder to Resident 3 for prevention of G-tube dislodgement.</p> <p>During a review of Resident 3 ' s physician order report, dated 7/30/24, indicated [Restraint] Abdominal binder daily for prevention of pulling out life-sustaining tubing every shift for pulling out life-sustaining tubing, assess for skin breakdown and adequate circulation then reapply.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0693  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	During a review of Resident 3 ' s Care Plan, dated 5/24/24, indicated, Focus: Abdominal binder. Resident utilizes an abdominal binder to reduce the risk of having the G-tube pulled out secondary to resident pulling on G-tube causing dislodgement. Intervention: Apply abdominal binder as ordered.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48481</p> <p>Based on observation, interview, and record review, the facility failed to provide sufficient staffing to the residents by ensuring the Restorative Nursing Assistant (RNA-a certified nursing assistant (CNA) with specialized training in rehabilitation skills who assists the restorative team with supervised and delegated restorative programs) was not assigned to perform Certified Nursing Assistant duties ( to perform Activities of Daily Living- such as bathing, feeding and repositioning residents) instead of performing range of motion (ROM) exercises (Movement of joint exercise) to 19 to 19 of residents on RNA program, including Resident 6.</p> <p>This deficient practice had the potential to for the resident with a physician's order to receive RNA assisted exercises to not receive services and result in a decrease the residents' range of motion and mobility which could result in contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).</p> <p>Findings:</p> <p>During an interview on 8/1/2024 at 12:55 p.m. with Resident 6, Resident 6 stated he did not receive RNA services at all in the past two months, and only once around 3 months ago. Resident 6 stated he needed the exercises to maintain his range of motions and prevent permanent joint stiffness.</p> <p>During a review of Resident 6 ' s Admission Record, indicated Resident 6 was readmitted to the facility on [DATE] with diagnoses including muscle weakness(generalized), history of functional quadriplegia (paralysis or unable to move both arms and legs) and acquired absence of left leg below knee.</p> <p>During a review of Resident ' s Minimum Data Set (MDS) dated [DATE], indicated that Resident 6 ' s cognitive status is intact; his mobility/ functional ability is dependent or maximal assistance.</p> <p>During a review of Resident 6 ' s physician order summary, dated 5/9/24 and 5/10/24, the physician order summary indicated RNA to do Active Range of Motion (AROM-a resident move a particular body part along a joint) exercises to bilateral upper extremities (BUE) for everyday (QD) 3 times/week or as tolerated; RNA to do stand using FWW (front-wheeled walker) for QD 3 times/ weekly or as tolerated with 2 person assist for safety.</p> <p>During an interview on 8/1/2024 at 2:37 p.m. with Certified Nurse Assistant (CNA) 4, CNA 4 stated if there was no scheduled RNA, he would provide RNA exercises for his own residents because he knew his resident ' s physician order for RNA exercises. CNA 4 stated did not provide RNA exercise to other residents because CNA 4 did not know the physician ' s order of other residents.</p> <p>During an interview on 8/1/24 at 2:47 p.m. CNA 5, she and other CNA provided RNA exercise for the residents if there was no assigned RNA available on that day. She stated the CNAs provided RNA exercise when providing the ADLs activities to the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility ' s census and staffing assignment for residents at Subacute Station, dated 7/2/24 to 7/6/24, indicated no RNA assigned for Subacute Station from 7/3/24 to 7/9/24 and 7/11/24 to 7/13/24. On 7/31/24 CNA 4 was assigned as both RNA and as a CNA with 9 residents to take care of during the day shift.</p> <p>During an interview on 8/1/24 at 3:55p.m. with DSD (Director of Staff Development), the DSD stated when CNAs providing care to the resident, they turned the resident, and when they cleaned the resident ' s arm, hand, they moved the arms and the finger joints, she stated all these ADL activities were considered as part of RNA exercise to the residents. The DSD stated she and the Rehab director (Director of Rehabilitation) oversee the RNA program in the facility. The DSD stated she did not have the list of the residents who were in the RNA program and she did not know which resident was scheduled to receive RNA program each day. She stated she solely relied on the RNAs to report to her if there was any abnormal changes regarding the resident ' s condition.</p> <p>During an interview on 8/1/24 at 4:06 p.m., with Rehab Director (RD), the RD stated each resident ' s RNA program was different and was specific to that resident, such as what task to perform and its frequency, so random turning and moving the resident when the CNA was providing ADLs activities to the resident was not considered as part of the RNA activities. The RD stated there were two RNAs in SNF, one RNA in the subacute. She stated RNAs are specifically trained and assigned to provide exercise for the resident who required RNA program and they should focus on it, not be pulled to perform regular ADLs tasks for the CNAs.</p> <p>During an interview on 8/1/24 at 4:52 p.m with DON, the DON stated the RNA was dedicated to provide RNA activities to the residents who required RNA program. She stated each resident had specific order for RNA program and required specific amount of time to receive the specific RNA activities. The DON stated she was not aware of that RNAs were assigned to do CNAs ' work instead of focusing providing RNA activities to the resident. The DON stated she doesn ' t have a list of the residents who were in the RNA program and she did not know which resident was scheduled to receive RNA program each day, she stated solely relies on report from the RNAs if there ' s any issue with their tasks or with residents.</p> <p>During a review of the facility ' s policy and procedure, Restorative Nursing Services, dated July 2017, indicated Policy Statement: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Restorative goals and objectives are individualized and resident-centered and are outlined in the resident ' s plan of care.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>48481</p> <p>Based on observation, interview and record review, the facility failed to ensure staffing information was posting was updated and placed in a visible and prominent place daily that indicated the total number of staff and the actual hours worked by the staff was not readily accessible to residents and visitors to. On 7/31/24 the nursing posting was not observed for residents, responsible party to review if the facility had adequate staffing for the day.</p> <p>This deficiency had the potential to result in the lack of the staff providing care to the facility without the responsible party and resident ' s awareness and result in the resident ' s not receiving quality of care.</p> <p>Findings:</p> <p>During an observation on 7/31/24 at 1:32 PM, the daily staffing information posting in front of the Subacute ( an area of nursing care that require a lower level than acute care hospital and higher level than a skilled nursing care) Nursing Station (Station and area divided from Skilled Nursing [SNF] in the facility) dated 7/25/24, verified with Registered Nurse (RN) 1.</p> <p>During an interview and record review on 7/31/18 at 1:35 PM with RN 1, RN 1 stated it was not posted in the morning because there was a change in RN staffing assignment. Another RN called off for SNF Station, so my RN was pulled to replace that staff at the last minute, so we had to update the posting. RN 1 stated posting the staffing information should have been done this morning at beginning of shift and should be posted right away after changes were done to ensure the visitor and residents are able to determine the staffing numbers in the facility.</p> <p>A review of the facility's policy and procedure titled Staffing, Sufficient and Competent Nursing, revised August 2022, indicated Direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46779</p> <p>Based on interview and record review, the facility failed to maintain accurate clinical records in accordance with acceptable professional standards and practices for one of three sampled residents (Resident 6). Restorative Nurse Assistant (RNA-a Certified Nursing Assitant with specialised training in providing range of motion exercises) 1 admitted that she willfully documented in Survey Report for RNA tasks for Resident 6 ' s that RNA exercises were provided to Resident 6 on 7/10/24 and 7/22/24 even though she was not at the facility, off duty and did not provide the exercises to Resident 6.</p> <p>The deficient practice had the potential for the resident and other residents not to receive necessary RNA assisted exercised to improve or maintain range of motion of the extremities and the body that results in the deterioration of rehabilitative condition.</p> <p>Findings:</p> <p>During a review of Resident 6 ' s Admission Record indicated the facility originally admitted Resident 6 on 2/20/24 and readmitted him on 4/25/24 with diagnoses that included diabetes mellitus (a disease of inadequate control of blood level of glucose [sugar]) and acquired absence of left leg below knee amputation (removal of the leg below the knee).</p> <p>During a review of Resident 6 ' s Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/24/24, indicated Resident 6 had intact memory and cognition (ability to think and reasonably). The MDS indicated Resident 6 required substantial/maximal assistance with oral hygiene, upper body dressing, lower body dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and dependent with toilet hygiene, shower/bathe self, and tub/shower transfer.</p> <p>During a review of Resident 6 ' s Order Summary Report, dated 8/1/24, indicated the physician ' s ordered Resident 6 to receive RNA assisted AROM exercises to both upper extremities daily three times a week or as tolerated and sit to stand using front wheel walker (FWW) daily three times a week or as tolerated with two-person assist for safety.</p> <p>During a review of Resident 6 ' s Documentation Survey Report, dated 7/2024, indicated RNA 1 documented that she provided AROM exercises to Resident 6 on 7/10/24 and 7/22/24 by signing her initials for on the form for the RNA to do AROM exercises to bilateral upper extremities daily three times a week or as tolerated do sit to stand using FWW for daily three times a week or as tolerated with two- person assist for safety.</p> <p>During a review of facility ' s Daily Staffing Assignment, dated 7/10/24, indicated RNA 1 was not signed in and scheduled to work at the facility, and no documented evidence RNA 1 was on duty on 7/10/24.</p> <p>During a review of Subacute-[NAME] Pacific Care Center Daily Staffing Assignment, dated 7/22/24, no documented evidence indicated RNA 1 was on duty on 7/22/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055764	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  7716 S Pickering Avenue Whittier, CA 90602	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Punch Detail the document where residents punched in and out, dated 8/1/24, no documented evidence indicated RNA 1 punched in to work on 7/10/24 and 7/22/24.</p> <p>During an interview on 8/1/24, at 2:20 PM, with RNA 1, RNA 1 stated she did not work on 7/10/24 and 7/22/24 and she did not provide RNA tasks for the resident. RNA 1 stated CNA 4 was the one to provide RNA tasks for the residents in the subacute unit on the days that she was not working. RNA 1 stated she documented Resident 6 ' s RNA tasks as completed for 7/10/ and 7/22 when she returned to work and CNA 4 asked her to document it for him. She stated if other CNAs asked her to document for other resident ' s RNA tasks as completed on the residents ' record, she would document for the CNAs even though she was not working in the facility on those days.</p> <p>During an interview on 8/1/24, at 2:37 PM, with CNA 4, CNA 4 stated he had never provided care to Resident 6. CNA 4 stated when there was no assigned RNA on the floor, he would complete the RNA tasks for his assigned residents, then, he would ask RNA 1 to document for him in despite of knowing RNA 1 was not working on those days. CNA 4 stated RNA 1 was the regular RNA in the subacute unit and she documented the RNA tasks as completed for the CNAs. CNA 4 stated that was the practice they were doing in the facility sometimes. CNA 4 stated each staff should document their own work and should not ask someone else to document for him or her.</p> <p>During an interview on 8/1/24, at 3:55 PM, with the Director of Staff Development (DSD), the DSD stated RNA 1 did not work on 7/10/24 and 7/22/24. The DSD stated RNA 1 should not document on Resident 6 ' s clinical record on 7/10/24 and 7/22/24 for other staff because RNA 1 did not know if the staff provided the care to Resident 6 or not.</p> <p>During an interview on 8/1/24, at 4:52 PM, with the Director of Nursing (DON), the DON stated it was not the standard of practice that RNA 1 document on Residents ' RNA tasks as completed for other staff if she did not provide the care to the residents, and she would not know if other staff provided the care or not. The DON stated the staff should document for their own work and should not ask other staff to sign for them.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Charting and Documentation, dated 7/2017, the P&amp;P indicated Documentation of procedures and treatments will include care-specific details, including: .the name and tile of the individual(s) who provided the care .</p>		