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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Pacific Care Center	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 50203 Based on interview and record review, the facility failed to notify the physician after one of three sample residents (Resident 1) fell from a shower chair (a plastic chair with wheels used for resident to shower) on 8/1/2024. This deficient practice had the potential for the resident not to receive the necessary care, monitoring and supervision need to prevent recurrent fall. In addition this had the potential for the resident not to receive or receive delayed interventions after a fall. Cross reference to F689 Findings: During a review of Resident 1's Admission Record (Face Sheet), indicated the facility admitted Resident 1 on 1/25/2019 and readmitted her on 8/9/2024 with diagnoses that included muscle weakness, osteoarthritis (tissue in the joints break down over time) of the left ankle and foot, and unspecified dementia (a decline in mental function that affects a person's ability to think, remember, make decisions, and can interfere with their daily activities). During a review of Resident 1's History Physical Examination (HPE, a comprehensive physician's note regarding the assessment of the resident's health status), dated 11/30/2023, Resident 1 does not have the capacity to understand and make decision. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/3/2024, indicated Resident 1 was moderately impaired cognitively (ability to think and reason). The MDS indicated Resident 1 required supervision (a helper who provides verbal cues or contact guard assistance as resident completes the activity) when showering, set up assistance (a helper who set ups or cleans up; resident completes the activity) with personal hygiene, upper and lower body dressing, and personal hygiene, and independent when eating and putting on/taking off footwear. The MDS indicated that Resident 1 did not have any falls since admission. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's electronic medical chart, the electronic medical chart did not show any documented evidence of Resident 1's fall on 8/1/2024 and no record to indicate the physician or the responsible party was notified of the resident's fall from a shower chair with wheels. During an interview on 8/15/2024 at 2:51PM with the Assistant Director of Nursing (ADON), the ADON stated he was not aware of Resident 1's latest fall on 8/1/2024 and only became aware of it today [8/15/2024]. The ADON stated there was no documented evidence a Change of Condition (CoC) assessment, an SBAR [Situation, Background, Assessment, and Recommendation] Communication Form (communication tool to provide essential and concise information, usually during crucial situationsno skin assessment, a 72 hour neurological (mental condition) checks, or no interdisciplinary team (IDT) meeting (a collaborative meeting of healthcare providers from different specialties to improve patient care) was conducted after the resident fall on 8/1/24. The ADON stated, there was no documented evidence that the physician was informed of Resident 1's fall on 8/1/24. The ADON stated, a COC report completed and notify the physician of a resident's change in status. The ADON stated, a physician must be notified to determine if a resident needs to be transferred to the hospital for further care. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, dated March 2023, indicated, the facility will promptly notify the resident, their attending physician, and the resident representative of changes in the resident's medical/mental and/or status. The P&P indicated the nurse will notify the resident's attending physician or physician on call when there has been an accident or incident involving the resident. The P&P indicated the nurse will make detailed observations and father relevant information for the provider, including information prompted by the Interact SBAR communication Form.

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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** 50203 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for two of two sampled residents: 1. For Resident 1 with history of falls by ensuring interventions are deveopled to prevent recurrent fall. Resident 1 had a fall on 8/1/24 and there was no documented evidence the incident was documented Resident 1's clinical record. These failures had the potential to result in Residnet 1 to have a recurrent fall due to the lack knowledge of the staffs to know the interventions needed to prevent Resident 1 from falsl that could result in injuries and death. Cross reference to F689 2, For Resident 5 a care plan was not developed to ensure the resident was monitored for the behavior or opening and closing curtains and keeping the television volume loud, including the intervention to have the nursing supervisor conduct rounds to ensure safety measures are being followed and noise levels are within an adequate range in Resident 4 and 5 ' s room. This deficient practice had the potential to result in continued conflict between Resident 4 and Resident 5 ' s conflict that could lead to disturbance of peace of the residents. Findings: 1. During a review of Resident 1 ' s Admission Record (Face Sheet), indicated the facility admitted Resident 1 on 1/25/2019 and readmitted her on 8/9/2024 with diagnoses that included muscle weakness, osteoarthritis (tissue in the joints break down over time) of the left ankle and foot, and unspecified dementia (a decline in mental function that affects a person ' s ability to think, remember, make decisions, and can interfere with their daily activities). During a review of Resident 1 ' s History Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 11/30/2023, Resident 1 does not have the capacity to understand and make decision. During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/3/2024, indicated Resident 1 had moderately impaired cognition (ability to think and reason). The MDS indicated Resident 1 required supervision (the helper provided verbal cues or contact guard assistance as resident completes the activity) when showering, set up assistance (the helper set ups or cleans up; resident completes activity) with personal hygiene, upper and lower body dressing, and personal hygiene, and independent when eating and putting on/taking off footwear. The MDS indicated that Resident 1 did not have any falls since admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Resident 1 on 8/15/2024 at 10:28 AM, Resident 1 stated she fell off the shower chair after taking a shower while reaching for her clothes in the closet when she stood up from the shower chair (a plastic seat with wheels to move residents around easily and safe to place in water) and she slipped on the floor because she was not wearing shoes. During an Interview with the Certified Nursing Assistant (CNA)1 on 8/16/2024 at 11:11 AM, CNA 1 stated she move the wheelchair between bed A and B and turned her back away from Resident 1. CNA 1 then heard Resident 1 say AHH and she found Resident 1 on the floor next to the shower chair. During a review of Resident 1 ' s last quarterly Fall Risk assessment, dated 5/3/2024, indicated Resident 1 was at risk for falls due to inability to stand without assistance and having an unsteady gait and. This fall assessment indicated that Resident 1 takes more than 1 medication and has more than 1 predisposing condition that may affect her ability to walk and maintain her balancer regulations). During a review of Resident 1 ' s care plan (a document that outlines the facility ' s plan to provide personalized resident care based on the resident ' s needs), revised on 8/12/2023, indicated Resident 1 was at risk for falls/injury because of: difficulty walking, lack of coordination, muscle weakness, used of psych [psychiatric] medications, poor safety awareness, history of falls 5/15/2023. The care plan interventions included, to assess resident ' s fall risk upon admission, quarterly, annual, and when there is a change of condition. The interventions indicated the staff will provide frequent supervision, and the staff will remind Resident 1 of safety instructions regarding ambulation, transfers, and ADLs [Activities of Daily Living] when appropriate. During a review of Resident 1 ' s care plans, the care plans did not show any documented evidence of Resident 1 ' s latest fall on 8/1/2024 to indicate appropriate interventions related to the cause of fall. During a review and concurrent interview on 8/15/2024 at 2:51PM with the Assistant Director of Nursing (ADON), The ADON stated the care plan for Resident 1 was not updated or revised after Resident 1 fell on [DATE] from the shower chair. The ADON stated the plan must be revised to determine what happened and to prevent a fall from happening again. 2. During a review of Resident 5 ' s Face Sheet, indicated the facility admitted Resident 5 on 8/21/2023 and readmitted him on 2/12/2024 with diagnoses that included acute respiratory failure (conditions where the lungs are unable to provide enough oxygen to the rest of the body) with hypoxia (there is not enough oxygen in the body ' s tissues to maintain normal function), cerebral palsy (a group of neurological disorders that affect a person ' s movement and muscle coordination), and Type 2 Diabetes Mellitus (chronic condition that the body does not respond to insulin [body ' s hormone to process glucose]). During a review of Resident 5 ' s HPE, dated 2/13/2024, indicated Resident 5 does not have the capacity to understand and make decisions. During a review of Resident 5 ' s MDS, dated [DATE], indicated Resident 5 was unable to make decisions regarding tasks for daily life. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s document Concern Record (Theft/Loss and Grievance Report), indicated on 7/22/2024, FM 1 expressed grievance regarding FM 2 for allowing the television volume to be too loud inside the room, disrupting the peaceful environment of Resident 4 and Resident 5. The document indicated FM 2 allowed Resident 5 to play with the privacy curtain by pulling it from one side of the room to another. During a review of the facility ' s document Concern Record (Theft/Loss and Grievance Investigation Record), dated 7/23/2024, indicated the Social Services Director (SSD) and the ADON spoke with FM 2 on 7/25/2024 about the grievance. The document indicated SSD and the ADON informed FM 2 about the safety concerns of allowing Resident 5 to play with the privacy curtains and the television volume being too loud. The document indicated the facility recommendations for nursing supervisor to conduct rounds to ensure safety measures are being followed and noise levels are within an adequate range. During a review of Resident 5 ' s care plans, the care plans did not show any documented evidence of the grievance recommendations for the nursing supervisors to conduct rounds to ensure safety and noise levels within adequate range. During an interview on 8/16/2024 at 12:50 PM with the Registered Nurse (RN) 1 and the Licensed Vocational Nurse (LVN) 2, the RN 1 and LVN 2 stated they were unaware of monitoring FM 2 ' s behavior regarding the television volume and the privacy curtain. RN 1 and LVN 2 stated they were not aware of documenting the conduct rounds to ensure safety measures are being followed and noise levels are within an adequate range. During an interview on 8/16/2024 at 2:43 PM with the ADM, the ADM stated the nursing staff was aware of the grievance and situation between FM 1 and FM 2 which should had been addressed in the resident ' s care plan to monitor Resident 5 ' s behavior and assess the noise level in the room to prevent conflict between two family members. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, date March 2023, indicated assessments of residents are ongoing and care plans are revised as information about the resident and residents ' conditions changes. The P&P indicated the interdisciplinary team reviews and updates the care plan when there has been a significant change in the resident ' s condition.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48661

Based on observation, interview, and record review the facility failed to provide services to promote wound healing by failing to follow the facility ' s policies and procedures on Prevention of Pressure Injuries, and Wound Care, when providing incontinent care to residents with a pressure ulcers in the Sacrococcyx (the fused sacrum and coccyx, or tailbone) and Coccyx (the small bone at the bottom of the spine) area for two of four sampled residents (Resident 1 and Resident 2).

This deficient practice had the potential to place the residents at risk for poor wound healing and discomfort.

Findings:

A review of Resident 1 ' s Admission Record indicated the facility admitted the resident on 5/10/2024 and readmitted the resident on 6/11/2024, with diagnoses including pressure ulcer of sacral region (skin injuries that occur in the sacral region of the body, near the lower back and spine) - stage 4 (involves full-thickness skin loss that extends through the fascia and into the muscle, tendon, or bone), anoxic brain damage (occurs when the brain was completely deprived of oxygen), gastrostomy status (a surgical procedure that involves placing a feeding tube through the skin and into the stomach wall).

A review of Resident 1 ' s Sacrococcyx wound Care Plan dated 5/10/2024, indicated a goal for the resident ' s wound to have proper healing and resolve without complications. The Care Plan interventions included administer treatment as ordered, monitor for any signs and symptoms of infection and progress of the wound, and provide pressure relieving devices as appropriate.

A review of Resident 1 ' s H&P dated 5/12/2024, indicated the resident did not have capacity to understand and make decisions.

A review of Resident 1 ' s MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS indicated the resident had one stage four pressure ulcer that presented upon admission.

A review of Resident 1 ' s Incontinent Care Plan dated 5/23/2024, indicated a goal that the resident would be clean, dry, and odor-free daily and to minimize the risk of skin breakdown daily. The Care Plan interventions included to monitor for bowel incontinence, change brief promptly when soiled/soaked, and good incontinent care with each episode.

A review of Resident 1 ' s Physician ' s Order dated 6/27/2024, indicated treatment to Sacrococcyx to left and right buttock pressure injury: cleanse with NS (normal saline - a solution of 0.9% sodium chloride in water, or 9 grams of salt per liter of water), pat dry, apply Santyl ointment (removes dead tissue from wounds so they could start to heal), sprinkle collagen powder (a concentrated protein supplement made from animal collagen that had been processed into a flavorless powder), apply calcium alginate (a gelatinous, cream-colored substance that was insoluble in water), and cover with foam dressing (wound coverings made from polyurethane or silicone foam that absorb wound exudate and keep the wound moist to promote healing).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s MDS dated [DATE], 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 had one or more unhealed pressure ulcers. A review Resident 2 ' s Admission Record indicated the facility admitted the resident on 7/17/2024, with diagnoses including pressure ulcer of sacral region - stage 3 (a deep, cavity-like wound that occurs when the skin loses all of the skins thickness, including the subcutaneous tissue, but did not extend through the fascia beneath it), hemiplegia (one-sided muscle paralysis or weakness), and muscle weakness (decrease in muscle strength). A review of Resident 2 ' s History and Physical (H&P) dated 7/17/2024, indicated the resident was able to make decisions for activities of daily living. A review of Resident 2 ' s Physician Order dated 7/25/2024, indicated treatment coccyx pressure injury: cleanse with NS, pat dry, apply Santyl and cover with dry dressing every day shift. A review of Resident 2 ' s Coccyx Pressure Injury Care Plan dated 7/31/2024, indicated a goal to minimize the risk of complications and decline and would show signs or symptoms of improvement. The Care Plan interventions included to administer treatment as ordered, assess for signs or symptoms of pain or discomfort, and to assess skin integrity during care. A review of Resident 2 ' s Incontinent Care Plan dated 7/31/2024, indicated a goal the resident would be clean, dry, and odor-free daily and would minimize the risk of skin breakdown daily. The Care Plan interventions included monitoring incontinent episodes, change brief promptly when soiled/soaked, and observe for redness or any skin breakdown. A review of the Supply Order Invoice dated 10/10/2023, indicated the facility ordered disposable wipes for the facility ' s Central Supply Department for a quantity of three total, containing 68 wipes per pack. During a concurrent observation and interview in the Storage Room on 8/16/2024 at 7:40 AM, two 12 pack boxes were observed containing disposable personal cleansing wipes. The Central Supply (CS) staff stated the facility usually would have five boxes on site but used three boxes when the facility had to shut off the water recently. The CS staff stated the facility would be counting inventory on Friday and would be ordering more cleansing wipes on the coming Tuesday. The CS stated if the water was shut off again, the facility would not have enough wipes to accommodate all the residents in the building. During an observation on 9/16/2024 at 9:25 AM, Certified Nursing Assistant (CNA) 2 was changing Resident 2 ' s incontinent diaper. CNA 2 had a reusable wash cloth (made from similar materials to bath towels) in the bathroom sink under running water and drained the water to clean the resident ' s bowel movement. CNA 2 cleaned Resident 2 with the wet reusable wash cloth and placed the now dirty wash cloth into the linen hamper. CNA 2 removed Resident 2 ' s dry dressing from the coccyx because the dressing was soiled and cleaned around the wound with another reusable wash cloth. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/16/2024 at 12:19 PM, CNA 2 stated the wash cloth could be kind of rough because of washcloths were re-usable. CNA2 stated she was unaware where to find the facility ' s disposable personal cleansing wipes within the facility. CNA 2 stated because the wash cloth is rough, the wash cloth could cause redness or a skin tear to the resident and around the area of the wound. CNA 2 stated the resident would be agitated. During an interview on 8/16/2024 at 12:30 PM, the Treatment (TLVN) LVN stated the TLVNs were responsible for wound care and would use gauze (thing often transparent fabric) and Normal Saline solution and the CNAs would clean around the wound. The TLVN stated CNAs should not have used a reusable wash cloth to clean around the wound because the reusable wash cloth was rougher than what the TLVN would use, and the reusable wash cloth could irritate the resident ' s skin especially around the wound area. The TLVN stated if the resident ' s skin was irritated, the irritation could cause bleeding and could be painful for the resident. During an interview on 8/16/2024 at 2:53 PM, the Director of Nursing (DON) stated if a resident had a bowel movement the CNAs would use a reusable wash cloth to clean the resident. The DON stated the CNA would not touch the wound but would inform the treatment nurses to re-dress the resident ' s wound. The DON stated if the bowel movement were to get on the wound, the facility would use gauze and NS to clean the wound, not the reusable wash cloth. A review of the facility ' s policy and procedure (P&P) titled Prevention of Pressure Injuries dated March 2023, indicated Prevention: clean promptly after episodes of incontinence, use a barrier product to protect skin from moisture, and do not rub or otherwise cause friction on skin that is at risk of pressure injuries. A review of the facility ' s P&P titled Activities of Daily Living (ADL), Supporting dated March 2023, indicated Resident who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The P&P indicated Appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: elimination (toileting). A review of the facility ' s P&P titled Wound Care dated March 2023, indicated The purpose of this procedure was to provide guidelines for the care of wounds to promote healing. The P&P indicated The following equipment and supplies would be necessary when performing this procedure. Dressing material, as indicated (i.e. gauze) and disposable cloths. The P&P indicated steps in the procedure include Remove dry gauze. Apply treatments as indicated. Dress wound. Pick up sponge and apply directly to area. Be certain all clean items were on a clean field. Remove the disposable cloth next to the resident and discard into the designated container.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 50203 Based on observation, interview, and record review, the facility failed to ensure one of two sampled resident (Resident 1) with a history of fall and had a recurrent fall on 8/1/24 was investigated for cause of fall and implemented interventions that addresses resident ' s risk factors for falls to prevent recurrent fall. This failure had the potential for Resident 1 to have a recurrent fall and have a significant change in condition that is not monitored and result in delayed or not receive the necessary care and interventions to prevent a recurrent fall that could lead to injury and death. Findings: During a review of Resident 1 ' s Admission Record (Face Sheet), indicated the facility admitted Resident 1 on 1/25/2019 and readmitted her on 8/9/2024 with diagnoses that included muscle weakness, osteoarthritis (tissue in the joints break down over time) of the left ankle and foot, and unspecified dementia (a decline in mental function that affects a person ' s ability to think, remember, make decisions that interfere with the daily activities). During a review of Resident 1 ' s History and Physical Examination (HPE, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 11/30/2023, indicated Resident 1 does not have the capacity to understand and make decision. During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/3/2024, indicated Resident 1 was moderately impaired in cognition (ability to think and reason). The MDS indicated Resident 1 required supervision (the helper provided verbal cues or contact guard assistance as resident completes the activity) when showering, set up assistance (the helper set ups or cleans up; resident completes activity) with personal hygiene, upper and lower body dressing, and personal hygiene, and independent when eating and putting on/taking off footwear. The MDS indicated that Resident 1 did not have any falls since admission. During a review of Resident 1 ' s Change of Condition (CoC) Assessment, dated 5/13/2023, resident was found lying on the floor complaining of bilateral knee, bilateral elbow, and bilateral upper arm pain. The CoC indicated prior to resident being found on the floor, resident was seated at the edge of the bed, and the CNA instructed the resident not to stand up. The CoC indicated Resident 1 was known to ambulate without assistance for short and long distances. The CoC indicated Resident 1 stood up to reach for something in her closet, fell on her knees, and fell backwards into the room door. During a review a Resident 1 ' s care plan, last revised on 8/23/2023, indicated Resident 1 had an actual fall related to poor safety awareness/judgement, unsteady gait on 5/15/2023. The care plan interventions included administering pain medication as needed, neurological checks for 72 hours, and assess for changes in LOC [level of consciousness, a person ' s awareness and understanding of their surroundings], skin integrity, pain, and notify physician. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/15/2024 at 10:28AM with Resident 1 on the outdoor patio, Resident 1 was sitting in her wheelchair describing her fall while gesturing to her bilateral arms and lower legs. Resident 1 stated she felt pain in her bilateral lower legs and right hand a couple weeks ago. Resident 1 stated, two weeks ago, she was in her room after a shower sitting in a shower care, and she was covered with towels and blankets. Resident 1 stated, she wanted to wear regular clothes, so she stood up from the shower chair and slipped. Resident 1 stated she was not wearing shoes. Resident 1 stated she hit her head on the floor and a Certified Nurse Assistant (CNA) helped her off the floor. During an interview on 8/16/2024 at 11:11 AM with CNA 1, CNA 1 stated she took Resident 1 back to her room after her shower by the shower chair. CNA 1 stated there was a wheelchair blocking the path to Resident 1 ' s bed. CNA 1 stated she told Resident 1 to please wait for me while I move the wheelchair. CNA 1 stated she turned her back on the resident to move the wheelchair three to four feet further into the room when she suddenly heard a noise hit the ground and Resident 1 let out a soft yell. CNA 1 stated she turned around and found Resident 1 sitting on the floor upright. CNA 1 stated she ran to her right way and called for the Licensed Vocational Nurse (LVN) 1 right away. CNA 1 stated LVN 1 asked Resident 1 what happened, and Resident 1 responded that she had slipped. During a review of Resident 1 ' s electronic medical chart, the electronic medical chart did not show any documented evidence of Resident 1 ' s fall on 8/1/2024, and there was no documented evidence the cause of the fall was investigated. During an interview on 8/15/2024 at 2:51PM with the Assistant Director of Nursing (ADON), the ADON stated he was not aware of Resident 1 ' s latest fall on 8/1/2024 and only became aware of it today [8/15/2024]. The ADON stated there was no documented evidence Resident 1 ' s fall was documented in the resident ' s clinical record, it was not investigated for the root cause, there was no CoC assessment, no SBAR [Situation, Background, Assessment, and Recommendation] Communication Form (communication tool to provide essential and concise information) no care plan developed, no skin assessment, no 72 hour neurological (mental capacity) checks, and no interdisciplinary team (IDT) meeting (a collaborative meeting of healthcare providers from different specialties to improve patient care) was done after the resident fall on 8/1/24. The ADON stated the facility ' s fall protocol included completing an incident report to determine what caused a resident to fall, notify the physician and family about the fall, assess resident skin, pain, and conduct a resident post-fall assessment. and update the care plan, and post-fall assessment done. During a review of the facility ' s policy and procedure, dated 3/2023, titled Accidents and Incident-Investigating and Reporting indicated, all accidents and incidents involving a resident must be reported to the Administrator the physician and responsible party. The nurse supervisor/charge nurse should promptly initiate and document an investigation that included time, date, circumstances surrounding the incident, nature of the injury if any and follow up information and the safety committee will review trends of accidents and safety hazards. During a review of the facility ' s policy and procedures (P&P) titled Falls - Clinical Protocol, last revised March 2018, indicated the following: 1. The nurse shall document and report the following: a. Vital signs, recent injury, especially fracture or head injury/ (continued on next page)

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	055764	A. Building B. Wing	08/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Pacific Care Center	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.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. observing for change in normal range of motion, weight bearing, etc.; d. Change in cognition or level of consciousness; e. Neurological status; f. Pain; g. Frequency and number of falls since last physician visit; h. Precipitating factors, details on how fall occurred; i. All current medications, especially those associated with dizziness or lethargy; and j. All active diagnoses 2. The staff will evaluate and document falls that occur while the individual is in the facility; for example, when and where they happened, any observations of the events, etc.appened, any observations of the events, etc.

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 08/16/2024
NAME OF PROVIDER OR SUPPLIER Whittier Pacific Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S Pickering Avenue Whittier, CA 90602	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based an interview, and record review the facility failed to follow infection prevention and control practices and implement interventions to prevent and control the spread of infections in the facility by failing to transport and store dirty linen in accordance with the facility ' s policy and procedure for six of six sampled residents (Resident 3, 4, 5, 6, 7, and 8). This deficient practice had the potential to result in an increased spread of infection in the facility leading to serious illness and death. Findings: A review of Resident 3 ' s Admission Record indicated the facility admitted the resident on 1/17/2024 and readmitted the resident on 7/23/2024, with diagnoses including candidiasis (a fungal infection caused by an overgrowth of a type of yeast that lives on your body), carrier of carbapenem-resistant enterobacterales (CRE - a group of bacteria that were resistant to one or [NAME] carbapenems, a class of antibiotics), and personal history of other infectious and parasitic (an organism that lives on a host, taking what the organism needs to stay alive while often injuring the host) disease. A review of Resident 3 ' s History and Physical (H&P) dated 7/26/2024, indicated the resident did not have capacity to understand and make decisions. A review of Resident 3 ' s Minimum Data Set (MDS - a standardized resident assessment and care screening tool) dated 7/25/2024, indicated the resident had severe cognitive impairment (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent on facility staff with oral/toileting/personal hygiene and transfers. A review of Resident 3 ' s Physician ' s Order dated 7/23/2024, indicated contact isolation diagnosis: CRE (Carbapenem-resistant Enterobacterales - type of bacteria that could cause serious infections and were difficult to treat), C. Auris (Candida Auris - a yeast that could cause severe illness and spread easily in healthcare facilities), and chronic wounds. A review of Resident 4 ' s Admission Record indicated the facility admitted the resident on 9/13/2021 and readmitted the resident on 10/21/2022, with diagnoses including extended spectrum beta lactamase (ESBL - enzymes produced by some bacteria that could cause infections that were difficult to treat) resistance, candidiasis, and klebsiella pneumoniae (a type of bacteria that was normally found in the human gut and was generally harmless). A review of Resident 4 ' s H&P dated 3/13/2024, indicated the resident had capacity to understand and make decisions. A review of Resident 4 ' s MDS dated [DATE], indicated the resident had moderate cognitive impairment (could not navigate to new places, and they have significant difficulty completing complex tasks such as managing finances). The MDS indicated the resident was independent with eating and was dependent on facility staff with transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 4 ' s Physician ' s Order dated 5/11/2024, indicated contact isolation secondary to candida auris and CRE. A review of Resident 5 ' s Admission Record indicated the facility admitted the resident on 12/6/2011 and readmitted the resident on 7/31/2024, with diagnoses including carrier of CRE, encephalopathy (a change in how your brain functions), and anoxic brain damage (occurs when the brain was completely deprived of oxygen). A review of Resident 5 ' s H&P dated 8/2/2024, indicated the resident did not have capacity to understand and make decisions. A review of Resident 5 ' s MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on facility staff with oral/toileting/personal hygiene and transfers. A review of Resident 5 ' s Physician ' s Order dated 8/5/2024, indicated contact precautions secondary to CRE urine/CRAB (carbapenem-resistant Acinetobacter baumannii - a type of bacteria that could be isolated from environmental samples) sputum. A review of Resident 6 ' s Admission Record indicated the facility admitted the resident on 3/8/2024 and readmitted the resident on 6/21/2024, with diagnoses including carrier of CRE, personal history of other infectious and parasitic diseases, and resistance to multiple antibiotics. A review of Resident 6 ' s H&P dated 6/28/2024, indicated the resident did not have capacity to understand and make decisions. A review of Resident 6 ' s MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on facility staff with oral/toileting/personal hygiene and transfers. A review of Resident 6 ' s Physician ' s Order dated 7/19/2024, indicated contact precaution secondary to carbapenem resistant klebsiella pneumoniae (CRKP - a type of bacteria that could cause healthcare-associated infections) (urine). A review of Resident 7 ' s Admission Record indicated the facility admitted the resident on 2/20/2024 and readmitted the resident on 4/25/2024, with diagnoses including encephalopathy, quadriplegia (a pattern of paralysis - when you could not deliberately control or move your muscles that could affect a person from the neck down), and tracheostomy status (a surgical procedure that creates an opening in the neck so a tube could be inserted into the windpipe [trachea] to help a person breathe). A review of Resident 7 ' s H&P dated 4/26/2024, indicated the resident had capacity to understand and make decisions. A review of Resident 7 ' s MDS dated [DATE], 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 was dependent on facility staff with toileting hygiene, showering, and transfers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7 ' s Physician ' s Order dated 4/26/2024, indicated contact isolation diagnosis CRPA (carbapenem resistant pseudomonas aeruginosa - a type of bacteria that could cause serious infections in humans) sputum every shift. A review of Resident 8 ' s Admission Record indicated the facility admitted the resident on 10/31/2017 and readmitted the resident on 11/27/2023, with diagnoses including carrier of CRAB, encephalopathy, and tracheostomy status. A review of Resident 8 ' s H&P dated 11/29/2023, indicated the resident did not have capacity to understand and make decisions. A review of Resident 8 ' s MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on facility staff with oral/toileting/personal hygiene and transfers. A review of Resident 8 ' s MDS dated [DATE], indicated contact isolation for CRAB. During an interview on 8/16/2024 at 1:58 PM, Certified Nursing Assistant (CNA) 1 stated dirty linens were placed in the laundry bin but isolation linens were placed into a different single bag and CNA 1 would inform the Laundry Personnel (LP), the bag was from an isolation room. CNA 1 stated isolation linens were placed in single black bags, and they were not double bagged. CNA 1 stated the dirty linen bags were not labeled and were only placed into a separate bag. CNA 1 stated if the dirty linen bags were not labeled and the Laundry did not know what isolation was in each bag, there could be cross contamination and could cause a spread of infection. During an interview on 8/16/2024 at 2:17 PM, the Laundry Personnel (LP) stated isolation linens were double bagged and labeled with the resident ' s room and bed number from the facility staff and placed in the isolation cart designated in the garage. The LP stated the dirty linen and isolation linen were both placed in black bags and the only difference was the isolation linen was double bagged. The LP stated if the isolation linen was not double bagged, the LP would not know the isolation linen was actually isolation linen. The LP stated the reason the facility separates the dirty linen from the isolation linen was to prevent the spread of infection and the residents does not get sick. During an interview on 8/16/2024 at 2:53 PM, the Director of Nursing (DON) stated dirty linens were placed in the hamper regardless of isolation status. The DON stated everything was considered dirty and the process in washing the linens should have eliminated all microorganisms with the temperature of the water. During a review of the facility ' s policy and procedure (P&P) titled Standard Precautions revised April 2023, indicated Linen soiled with blood, body fluids, secretions, excretions were handled and processed in a manner that prevents skin and mucous membrane exposures, contamination of clothing and avoids transfer of microorganisms to other residents and environments. During a review of the facility ' s P&P titled Laundry and Bedding, Soiled revised April 2023, indicated Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled Infection Control revised January 2016, indicated The Infection Control and Prevention Program would be interdisciplinary and would ensure that recommended practices for the prevention of healthcare-associated infections were implemented and followed by healthcare personnel, making the healthcare setting safe from infection for residents. The P&P indicated Prevention: implementation of measures to prevent transmission of infectious agents and to reduce risks for devise and procedure-related infections.