

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 08/29/2024
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661</p> <p>Based on interview and record review the facility failed to document resident ' s belongings and prevent personal items from being lost for one of four sampled resident (Resident 1) by failing to document the resident ' s rosary as indicated in the facilities policy and procedure (P&P).</p> <p>This deficient practice resulted in Resident 1 ' s rosary being lost.</p> <p>Findings:</p> <p>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 anoxic brain damage (occurs when the brain was completely deprived of oxygen), restlessness and agitation, gastrostomy status (a surgical procedure that involves placing a feeding tube through the skin and into the stomach wall).</p> <p>A review of Resident 1 ' s history and physical exam (H&P) dated 5/12/2024, indicated the resident did not have capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on facility staff with toileting/personal hygiene, showering, and transfers.</p> <p>During an interview on 8/28/2024 at 4:39 PM, FM stated while Resident 1 was in the Sub-Acute Unit (a level of care that was more intensive than skilled nursing care but less intensive than acute care) Resident 1 received a rosary from the Priest. The FM stated from the time Resident 1 was transferred to the skilled nursing care side the rosary was not with Resident 1.</p> <p>During a concurrent interview and record review of Resident 1 ' s Inventory List on 8/29/2024 at 12:17 PM, Resident 1 ' s Inventory List dated 5/14/2024, indicated on admission the resident had one glasses and one pair of heel protectors, no diabetic socks and rosary were listed. Certified Nursing Assistant (CNA) 1 stated Resident 1 had glasses, socks, and a rosary as part of Resident 1 ' s belongings. CNA 1 found Resident 1 ' s glasses and socks but was unable to find the resident ' s rosary. CNA 1 stated all of the resident ' s belongings should have been on the Inventory List and if the items were not on the Inventory List the resident ' s belongings could get lost and the resident would be upset.</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
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/29/2024 at 12:37 PM, the Licensed Vocational Nurse (LVN) 1 stated when residents bring in new items, those items must be checked off on the Inventory List and the facility staff informs social services. LVN 1 stated the family should have reported all items to the facility staff, but the facility staff were the ones who were responsible for documenting the new items. LVN 1 stated if the resident ' s belongings were lost, the resident and the family member would be upset because the items were the resident ' s property, and the family would be losing money.</p> <p>During an interview on 8/29/2024 at 1:23 PM, the Director of Nursing (DON) stated when new items were brought in by the resident or FM, the nursing staff or social services confirmed where the item came from. The DON stated if the item was from church services, the facility did not put that item in the Inventory List, but glasses would be documented because that belongs to the resident. The DON stated if the Inventory List did not get updated the facility would not be able to determine items brought in by the resident or FM. The DON stated the facility tries to educate the resident or FM in the interdisciplinary team (IDT) meeting about the process regarding belongings so the facility could identify which item belongs to which resident. The DON stated if a resident ' s belongings were missing, the resident could feel a sense of loss or sadness. The DON stated documenting resident ' s belongings was important for the facility to have accountability and justification when items needed to be replaced.</p> <p>During an interview on 8/29/2024 at 3:04 PM, the Social Services Director (SSD) stated the facility was responsible for updating the Inventory List. The SSD stated when a resident ' s belonging were lost, the facility would check the Inventory List to see if the item was documented, if the item was not documented the facility would investigate why the item was not inventoried. The SSD stated the lost item could affect the resident because the lost item was the resident ' s belonging, and they could be upset.</p> <p>A review of Resident 1 ' s Grievance Report dated 8/19/2024, indicated Resident 1 ' s Family Member (FM) informed the facility Resident 1 ' s diabetic socks and rosary were missing. The Grievance Report indicated a thorough search was conducted in the area where the items were last seen but the items were not found and were not listed in the inventory list. The Grievance Report indicated the Assistant Director of Nursing (ADON) attempted to contact the FM on two occasions with no answer and left a voice message. The Grievance Report indicated the facility would replace the missing items but required a description of the items to proceed.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Personal Property dated August 2022, indicated The resident ' s personal belongings and clothing were inventoried and documented upon admission and updated as necessary.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661</p> <p>Based on interview and record review the facility failed to provide medically related social services for one of four sampled resident (Resident 1) by failing to follow up on an x-ray (invisible electromagnetic energy beams to produce images of internal tissues, bones, and organs on film or digital media) recommended by the dentist for Resident 1 ' s bottom left aching tooth to further evaluate and treatment as indicated in the facility ' s policy and procedure (P&P).</p> <p>This deficient practice had the potential for delay in care and services lead to the potential for Resident 1 to suffer pain from the aching tooth and loss of tooth.</p> <p>Findings:</p> <p>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 anoxic brain damage (occurs when the brain was completely deprived of oxygen), restlessness and agitation, gastrostomy status (a surgical procedure that involves placing a feeding tube through the skin and into the stomach wall).</p> <p>A review of Resident 1 ' s history and physical exam (H&P) dated 5/12/2024, indicated the resident did not have capacity to understand and make decisions.</p> <p>A review of Resident 1 ' s MDS dated [DATE], indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on facility staff with toileting/personal hygiene, showering, and transfers.</p> <p>A review of Resident 1 ' s Dental Notes dated 8/6/2024, indicated the evaluation was requested by the Social Services Director (SSD). The Dental notes indicated the Doctor recommended Resident 1 needed x-rays to confirm if the resident had pain.</p> <p>A review of Resident 1 ' s chart on 8/29/24 indicated Resident 1 did not have x-rays done as Dentist recommended on 8/6/2024.</p> <p>During an interview on 8/29/2024 at 12:37 PM, the Licensed Vocational Nurse (LVN) 1 stated recommendations from the Dentist were reviewed by the Registered Nurse Supervisor (RNS) and the RNS was supposed to communicate with social services to follow through on the recommendations. LVN 1 stated the Dentist provided recommendations for a reason and if the recommendations were not done, that could affect the Resident 1 ' s health. LVN 1 stated she was not aware of the recommendation from the Dentist for an x-ray.</p> <p>During an interview on 8/29/2024 at 1:05 PM, the RNS stated recommendations from the Dentist were followed up by the RNS and dental services were booked through social services. The RNS stated if Resident 1 did not receive recommended dental services, the resident would feel unheard and could affect the resident negatively if recommended dental services were not provided. The RNS stated the RNS was not aware of the recommendation from the Dentist for an x-ray.</p> <p>(continued on next page)</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/29/2024 at 3:04 PM, the SSD stated when recommendations were given by the Dentist, the SSD was the person to follow up on those recommendations. The SSD stated when recommendations were made, the Dentist usually reviewed the recommendations with the SSD, but the recommendation for Resident 1 regarding the x-ray was missed. The SSD stated if recommendations were not followed the resident could be in pain or get worse if the required treatment was not provided.</p> <p>A review of the facility ' s policy and procedure (P&P) titled Social Services dated September 2021, indicated Our facility provides medically related social services to assure that each resident could attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The P&P indicated The social/worker/social services staff were responsible for making referrals and obtaining needed services from outside entities. Medically-related social service are provided to maintain or improve each resident ' s ability to control everyday physical needs.</p>