

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 01/31/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of eight sampled residents (Resident 16 and 39) was offered to formulate and received information related to Advance Directive (a legal document indicating a resident's preference on end-of-life treatment decisions) information during their initial admission and subsequent re-admission to the facility.</p> <p>This failure had the potential to result in Resident 16 and 39 not having their wishes met regarding end-of-life treatment decisions.</p> <p>Findings:</p> <p>1. During a review of Resident 16 ' s Admission Record, dated 1/31/2025, the Admission Record indicated Resident 16 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE]. The Admission Record also indicated Resident 16 ' s diagnoses include, but not limited to, ventilator dependence (relying on a medical device to help support or replace breathing), epilepsy (brain condition that results in uncontrolled jerking, blank stares, and loss of consciousness), and persistent vegetative state (a condition in which a person is awake but has no awareness of their surroundings or themselves).</p> <p>During a review of Resident 16 ' s Physician Orders for Life-Sustaining Treatment (POLST), dated 2/21/2017, the POLST did not indicate whether the resident had an advance directive (i.e., the designated section in the form was left blank).</p> <p>During an interview on 1/31/2025 at 3:47 PM with Social Services Director (SSD), SSD stated Resident 16 did not have an advance directive since his first admission to the facility on [DATE]. SSD stated an advance directive should have been offered and informed by the facility to Resident 16.</p> <p>2. During a review of Resident 39's Admission Record, dated 1/31/2025, the Admission Record indicated Resident 39 was initially admitted to the facility on [DATE] and most recently readmitted on [DATE].</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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 39's History and Physical (H&P), dated 5/16/2024, the H&P indicated Resident 39 ' s diagnoses include, but not limited to, ventilator dependence (relying on a medical device to help support or replace breathing), muscular dystrophy (a hereditary condition that results in weakness and loss in muscle), and quadriplegia (partial or total loss of function in body region and all four limbs).</p> <p>During a review of Resident 39 ' s Physician Orders for Life-Sustaining Treatment (POLST), dated 1/19/2017, the POLST indicated that Resident 39 did not have an advance directive.</p> <p>During an interview on 1/31/2025 at 9:28 AM with Medical Records Director (MRD), MRD stated there is no signed Advance Healthcare Directive Acknowledgement (AHDA) form in Resident 39's medical record. The MRD stated, a signed AHDA form confirms the facility discussed advance directives with a resident or his/her responsible party. MRD further stated Resident 39's responsible party recently passed away. MRD stated Resident 39's Family Member (FM) 4 is the new decision-maker regarding Resident 39's medical treatment at the facility.</p> <p>During a concurrent interview and record review on 1/31/2025 at 9:38 AM with Social Services (SS), Resident 39 ' s AHDA form was reviewed. SS stated she spoke with Resident 39 on 1/27/2025 regarding an advance directive, and she filled out the AHDA form the same day. SS stated the AHDA form is currently unsigned because Resident 39 wants to wait for FM 4 to sign it on Resident 39's behalf.</p> <p>During an observation and interview on 1/31/2025 at 10:30 AM with Resident 39 in his room, Resident 39 communicates by mouthing words with his lips and nodding his head. When asked if someone had spoken to him regarding an advance directive, Resident 39 nodded in the affirmative. When asked if the advance directive discussion occurred on Monday, 1/27/2025, Resident 39 nodded yes. Resident 39 also nodded in agreement when asked if he wished to wait for FM 2 to come in and sign the facility ' s AHDA form.</p> <p>During an interview on 1/31/2025 at 3:47 PM with Social Services Director (SSD), SSD stated advance directives are important because if a resident cannot make decisions for himself/herself, then the advance directive assigns the decision-making power to someone who will make the right decisions according to the resident ' s wishes. SSD stated an advance directive is important for a facility to know what the family and resident wants.</p> <p>During an interview on 1/31/2025 at 3:47 PM with Social Services Director (SSD), SSD stated there is no advance directive on file for Resident 39, even from the time of his first admission. SSD further stated Resident 39 ' s responsible party did not want an advance directive. SSD also stated even if the responsible party did not want one, information regarding an advance directive should have been given to Resident 39 and his responsible party during his initial admission.</p>		

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<p>F 0642</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a qualified health professional conducts resident assessments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878</p> <p>Based on interview and record review, the facility failed to ensure the Discharge Minimum Data Set (MDS-a resident assessment and care-screening tool) was transmitted timely and within 30 days, to the Centers for Medicare and Medicaid Services (CMS) system for one of 19 sampled residents (Resident 87) MDS Assessments.</p> <p>This deficient practice had the potential to affect the quality-of-care monitoring system to ensure safe, efficient, resident centered care in a timely manner.</p> <p>Findings:</p> <p>During a review of Resident 87's Admission Record (AR), the AR indicated the facility originally admitted Resident 87 on 1/30/2024 and readmitted him on 7/14/2024 with diagnoses that included metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), heart failure (a condition where the heart muscle is weakened and cannot pump blood efficiently), diabetes mellitus (a group of diseases that result in too much sugar in the blood) and hyperlipidemia (a condition where there are high levels of fat in the blood).</p> <p>During a review of Resident 87's MDS dated [DATE], the MDS indicated Type of Assessment Quarterly for Resident 87.</p> <p>During a review of Resident 87's Discharge Summary dated 9/6/2024, the Summary indicated Resident 87 was in the facility from 7/14/2024 to 8/30/2024.</p> <p>During a review of Resident 87's Discharge Licensed Nurses Note dated 8/30/2024, the Note indicated Resident 87 was discharged to an Assisted Living Facility (housing for elderly or disabled people that provides nursing care, housekeeping, and prepared meals as needed).</p> <p>During an interview and record review on 1/30/2025 2:17 PM of Resident 87 ' s Medical Record, with Minimum Data Set Nurse (MDSN), MDSN stated she could not find a discharge MDS for Resident 87. MDSN stated Resident 87 ' s discharge MDS was not completed because she forgot to complete when Resident 87 was discharged from the facility.</p> <p>During an interview on 1/30/2025 at 1:50 PM, with the Director of Nursing (DON), the DON stated it was important for the facility to complete and submit all MDS ' s for the residents in the facility to ensure they are reporting the correct and actual information to the Centers for Medicare & Medicaid Services on time.</p> <p>A review of facility provided CMS'S RAI Version 3.0 Manual dated October 2024, indicated Discharge assessment return not anticipated-MDS must be completed when the resident is not expected to return to the facility within 30 days</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on observation, interview, and record review, the facility failed to follow professional standards of practice in nursing care for one of two sampled residents (Resident 86) by failing to:</p> <ol style="list-style-type: none"> 1. Check for gastric residual volume (refers to the volume of fluid remaining in the stomach) using a syringe to suction out the stomach fluids via Gastrostomy Tube (G Tube-a tube surgically inserted into your stomach through your abdomen) before medication administration. 2. Flush (rinse) the G-tube with water in-between each medication administration. <p>This failure had the potential to cause complications, including aspiration (inhalation of foreign materials) and pneumonia (a lung infection), and clogged GTube needing a surgical replacement thta could negatively impact the resident's care and health outcomes.</p> <p>Findings:</p> <p>During a review of Resident 86's Admission Record (Face Sheet), indicated the facility admitted Resident 86 on 11/8/2023, and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a broad term for any brain disease that alters brain function), and sepsis (infection of the blood).</p> <p>During a review of Resident 86's History and Physical (H&P), dated 10/10/2024 indicated, Resident 86 had the mental capacity to make medical decisions.</p> <p>During a review of Resident 86's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 11/13/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, dependent on staff for the activities of daily living.</p> <p>During a review of the Order Summary Report dated 1/31/2025 indicated orders for the following:</p> <ol style="list-style-type: none"> 1. Aspirin (medication that prevent blood clot to form) tablet Chewable 81 MG (milligrams (MG) Give 1 tablet via G-Tube one time a day for CVA (cerebrovascular accident or stroke [occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts/ruptures]) ppx (prophylaxis [prevention])). 2. Cranberry Oral Tablet 450 MG (Cranberry (Vaccinium macrocarpon)) Give 2 tablet via G-Tube one time a day for UTI (urinary tract infection) prophylaxis (prevention). two 450mg tabs = 900mg. 3. Artificial Tears Ophthalmic (eye drops) Solution 0.2-0.2-1 % (Glycerin Hypromellose-Polyethylene Glycol 400) Instill 1 drop in both eyes every 4 hours for dry eyes 4. Pantoprazole Sodium Oral Packet 40 MG (Pantoprazole Sodium) Give 1 packet via G-Tube one time a day for GERD (gastroesophageal reflux disease -a digestive disease in which stomach acid or bile irritates the food pipe lining) MIX 1 PACKET IN apple sauce exp. APPLE SAUCE OR JUICE VIA G-TUBE. <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. Robinul Oral Tablet 1 MG (Glycopyrrolate) Give 1 tablet via G-Tube one time a day for excess secretion/sputum.</p> <p>6. LiquaCel Oral Liquid (Amino Acids) Give 30 ml via G-Tube one time a day for Skin management If unavailable may use pro-stat.</p> <p>7. Methocarbamol Oral Tablet 500 MG (Methocarbamol) Give 2 tablet by mouth two times a day for muscle spasm.</p> <p>8. Multivitamins/Minerals Adult Oral Liquid (Multiple Vitamins w/Minerals) Give 15 ml via G-Tube in the morning for supplement</p> <p>9. Vitamin C Oral Tablet 500 MG (Ascorbic Acid) Give 1 tablet via G-Tube one time a day for skin integrity for 3 Months.</p> <p>During a medication pass observation on 1/30/2025 at 9:30 AM, Licensed Vocational Nurse (LVN) 1 was observed preparing to crush tablets and pour liquid medications into each medication cup of the medications mentioned above. LVN 1 poured 15 ml water into each crushed medication on medicine cup.</p> <p>During an observation on 1/30/2025 at 9:33 AM, LVN 1 was observed administering medications to Resident 86 via G-Tube with a syringe without checking for residuals before administering medications. LVN 1 administered the medications one at a time and did not flush the G-tube with water in between medications.</p> <p>During an interview on 1/30/2025 at 9:40 AM with LVN 1, stated she should have flushed before with 5-10 ml of water in between medications. LVN 1 also stated there is a possibility of drug reaction that may deactivate the medications.</p> <p>During an interview on 1/31/2025 at 6:30 PM, the Assistant Director of Nursing (ADON) stated that medications should be given by gravity, when possible, but a syringe may be used slowly if there are standing orders. The ADON emphasized and stated that nurses should flush the G-tube with water before administering medications, use 15 mL of water between each medication, and flush with 15 mL at the end to clear the tube. The ADON further explained that checking for residuals is important to ensure proper digestion and reduce the risk of complications, including aspiration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, indicated to verify placement of feeding tube.</p> <p>a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician.</p> <p>8. Attach syringe (without plunger) to the end of the tubing.</p> <p>9. Unclamp and flush with least 15 ml water (or prescribed amount) prior to administering medication.</p> <p>10. Administer each medication separately by gravity flow:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion.</p> <p>b. Open the clamp and deliver medication slowly. May gently push if necessary</p> <p>11. If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications.</p> <p>12. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of water (or prescribed amount).</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878</p> <p>Based on interview and record review, the facility failed to initiate routine Bowel and Bladder training programs to prevent a fall (refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force) for one of one sampled resident (Resident 198) who was assessed at being high risk for fall. Resident 198 was observed walking out of his room and falling on top of plastic Wet Floor sign placed in front of his room door when attempting to use the restroom unassisted by facility staff.</p> <p>This deficient practice had the potential to result in unmet resident ' s needs, which can result in Resident 198 to sustain serious injuries from a fall.</p> <p>Finding:</p> <p>During a review of Resident 198's Admission Record indicated the facility admitted Resident 198 on 1/16/2025 with diagnoses that included spinal stenosis (the spaces inside the bones of the spine get small), lack of coordination (a condition that makes it difficult to control your bodies movements).</p> <p>During a review of Resident 198's History and Physical [H&P] dated 1/17/2025, the H&P indicated the resident is able to make decisions for activities of daily living.</p> <p>During a review of Resident 198's Minimum Data Set (MDS, a resident assessment tool), dated 1/20/2025, indicated Resident 198 used a walker and wheelchair. The MDS indicated Resident 198 required partial/moderate assistance (helper does less than half the effort) for toileting, shower, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 198 required supervision or touching assistance (helper provides verbal cues and or touching/steadying and/or contact guard assistance as resident completes activities)</p> <p>During a review of Resident 198's MDS section Bladder and Bowel indicated a trial toileting program for Resident 198 had not been initiated. The MDS also indicated a bowel toileting program had not been initiated for Resident 198.</p> <p>During a review of Resident 198's Admission Fall Risk assessment dated [DATE] timed at 1:21 PM, indicated the resident was considered at high risk for potential falls due to intermittent confusion or poor safety awareness/non compliance, history of falls in the last 12 months, incontinent/needing assistance for toileting, unable to stand without assistance/unsteady gait (a persons manner of walking)/poor sitting or standing balance and use of medications</p> <p>During a review of Resident 198's Admission Fall Risk assessment dated [DATE] timed at 1:21 PM, indicated the resident was considered at high risk for potential falls due to intermittent confusion or poor safety awareness/noncompliance, history of falls in the last 6 months.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 198's IDT(inter disciplinary team) Fall risk dated 1/28/2025 indicated IDT meet and discussed Resident 198 ' s general condition, emphasis on status post and history of falls (2 times) since admission to the facility .Resident 198 still attempts to get out of bed without calling for help despite frequent reminders to call for help/assistance. IDT offered bedside commode for easy toileting but Resident 198 refused.</p> <p>During a review of Resident 198's Actual Fall care plan initiated on 1/26/2025, The care plan indicated Resident 198 had an actual fall related to: balance deficit, cognitive impairment, decrease strength and noncompliance with request for assistance poor safety awareness/judgement and unsteady gait. The care plan interventions included: Bowel and Bladder retraining as indicated, toileting program as indicated.</p> <p>During a review of Resident 198's Fall risk care plan initiated on 1/30/2025, indicated Resident 198 was at risk for falls and injuries the interventions listed included: provide safety measures to reduce risk of falls/prevent injuries, observe resident behavior, frequent supervision/monitoring.</p> <p>During an observation on 1/31/2025 at 7:30 AM of station 1 hallway, Resident 198 was observed walking out of his room and falling over plastic yellow Wet Floor sign placed in front of Resident 198 ' s room doorway.</p> <p>During a concurrent interview on 1/31/2025 at 7:35 AM with Licensed Vocational Nurse (LVN3), LVN 3 stated Resident 198 was high fall risk and was on frequent monitoring due to his past history of falls. LVN 3 stated she would try to walk by Resident 198's room when she could but was on the other side of the station getting ready to pass medication when she heard Resident 198 had fallen. LVN 3 stated Resident 198 had unsteady gait and balance and is not currently on a Bowel and Bladder toileting program.</p> <p>During an interview on 1/31/2025 at 7:50 AM with Resident 198, Resident 198 stated he wanted to go to the bathroom and was going out of his room to look for a restroom when he fell . Resident 198 stated he did know or see the yellow plastic Wet floor sign in front of the door, and it took him by surprise when he stumbled on top of it because he was focused on looking for a bathroom.</p> <p>During an interview on 1/31/2025 at 8:09 AM with Housekeeper (HSKP 1), HSKP 1 stated she had gone into Resident 198 ' s room around 7:20 AM to clean she mopped in front and around Resident 198's bed and in front of the door, once she finished moping she placed the wet floor sign in front of the door to alert anyone that was going to enter the room the floor was wet.</p> <p>During an interview and concurrent record review on 1/31/2025 at 3:28 PM of Resident 198's medical record with Minimum Data Set Nurse (MDSN), MDSN stated Resident 198 was not on a Bowel and Bladder training program prior to today. MDSN stated Resident 198 has episodes of continence and incontinence but is able to make his needs know and should have been started on a Bowel and Bladder training program after his second fall (1/26/2025) in the facility to try and help anticipate the residents needs and prevent him from getting up unassisted and falling due to wanting to go to restroom.</p> <p>During an interview with on 1/31/2025 at 3:42 AM with Director of Nursing (DON), DON stated Resident 198 was high fall risk and staff should always maintain his environment free of clutter and hazards to avoid Resident 198 falling. DON stated the facility should have initiated a Bowel and Bladder program for Resident 198 after his second fall on 1/26/2025.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779</p> <p>Based on observation, interview, and record review, the facility failed to receive restorative nursing care, treatments and services to minimize decline in joint range of motion (ROM, full movement potential of a joint) for four of seven sampled residents (Residents 14, 30, 70, and 72) who were ordered by the physician to receive Restorative Nursing Assistant (RNA- a nursing aide program to help residents maintain their function and joint mobility) assisted exercises and services by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Resident 30 received RNA assisted exercises and services and treatments for passive range of motion (PROM, movement applied to a joint solely by another person) exercises to both upper extremities (BUE, shoulder, elbow, wrist, fingers) and RNA to do PROM for both lower extremities (BLE, [NAME], ankle and lower leg), and apply both ankle-foot orthosis (AFO, a brace that supports the [NAME], ankle and lower leg) and both knee splints (a knee brace supports the knee and holds it in place) four to six hours a day five times a week or as tolerated on. Resident 30 did not receive RNA services and exercises on 12/16/2024, 12/19/2024, 12/25/2024, 12/30/2024, and 12/31/2024 ,1/3/2025 and 1/24/2025. 2. Ensure the physician's order for Resident 70 was accurately transcribed as ordered by the physician to receive RNA exercises, services and placement of AFO five times a week, instead the order was transcribed to for Resident 70 to received RNA services three times a week only. Resident 70 did not receive RNA services on 12/6/2024,12/16/2024,12/19/2024,12/25/2024 and 1/3/2025 and 1/24/2025. 3. Ensure Resident 14's received RNA services and exercise as ordered by the physician to receive PROM exercises to BLE's f/u by application of Bilateral AFO ' s up to QD 3-4 hrs/day for 7 times/week or as tolerated and RNA to perform PROM to both UE ' QD 7x week or as tolerated instead of only two to three times a week. 4. Ensure Resident 72 received RNA services and exercises as ordered by the physician. Resident 72 received AROM of the RUE, PROM of the LUE and application of the left-hand grip splint for eight times instead of 23 times for 12/2024 and 19 times out of 21 times for 1/2025. <p>As a result of these deficient practices, the residents are at risk for further decline in range of motion, mobility and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff that prevents normal movement of a joint or other body part. Contractures may be caused by not using the muscles).</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 30 ' s Admission Record indicated the facility initially admitted Resident 30 on 1/17/2024 and readmitted her on 12/11/2024 with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and contracture of muscle (a condition of shortening and hardening of muscles) of multiple sites. <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 30's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/25/2024, indicated Resident 30 had severely impaired cognitive (ability to think and reasonably) skills for daily decision making. The MDS indicated Resident 30 was dependent with 2 or more-person assistance with oral hygiene, toileting hygiene, shower/bathe self, and personal hygiene.</p> <p>During a review of Resident 30 ' s Care Plan (CP), dated 6/24/2024, indicated the resident had a joint mobility limitation with risk for further contracture formation. The interventions included RNA to assist with PROM BLEs then apply both AFOs and knee splints four to six hours a day five times a week or as tolerated.</p> <p>During a review of Resident 30 ' s CP, dated 12/12/2024, indicated Resident 30 at risk for contractures and decreased ROM to the BUEs, and the interventions, included RNA to perform PROM to BUE five times a week or as tolerated.</p> <p>During a review of Resident 30 ' s Joint Mobility Screening (PT [physical therapy, a combination of exercises, stretches and movements that'll increase your strength, flexibility and mobility to help you move safely and more confidently]), dated 12/12/2024, indicated Resident 30 had severe (>50% loss) passive ROM of the right hip, left hip, right knee, and left knee, and minimal (<25% loss) passive ROM at right ankle and left ankle. The Joint Mobility Screening (PT) indicated Resident 30 had minimal to severe loss of lower extremities passive ROM and she had a diagnosis/condition that puts her at risk for contracture development. The Joint Mobility Screening (PT) indicated the PT recommended Resident 30 to receive RNA/functional maintenance program.</p> <p>During a review of Resident 30 ' s Order Summary Report, dated 1/30/2025, indicated the physician ordered RNA to perform PROM to BUEs five times a week or as tolerated starting on 12/12/2024 and RNA to do PROM for BLEs, then apply bilateral AFO and knee splints four to six hours a day five times a week or as tolerated, starting on 12/13/2024.</p> <p>During a review of Resident 30 ' s Documentation Survey Report, dated 12/2024, indicated Resident 30 did not receive RNA services on 12/16/2024, 12/19/2024, 12/25/2024, 12/30/2024, and 12/31/2024 (total five days) were blank.</p> <p>During a review of Resident 30 ' s Documentation Survey Report, dated 1/2025, indicated the documentation of Resident 30 receiving RNA program on 1/3/2025 and 1/24/2025 were blank.</p> <p>During an observation on 1/28/2025 at 10:19 AM, Resident 30 was lying on her bed with her legs curled up without the AFO and knee splints. The AFO and knee splints were on the top of the cabinet in the room.</p> <p>During an observation on 1/28/2025 at 12:32 PM, Resident 30 was lying on the bed without the AFO and the knee splints on.</p> <p>During a concurrent observation and interview on 1/28/2025 at 3:03 PM with Resident 30 ' s responsible party (RP) 1, Resident 30 was lying on the bed with her legs curled up. RP 1 stated he was concerned if the resident received the RNA program as ordered because the resident had muscle atrophy and did not want the resident ' s condition to deteriorate.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 1/29/2025 at 9:13 AM, Resident 30 was lying on the bed without the AFO and the knee splints on. The AFOs were on the top of the cabinet in the room.</p> <p>During an observation on 1/29/2025 at 2:00 PM, Resident 30 was lying on the bed without the AFO and the knee splints on. The AFOs were on the top of the cabinet in the room.</p> <p>During an observation on 1/30/2025 at 9:20 AM, Resident 30 curled up on the bed without the AFO and the knee splints on.</p> <p>During a concurrent interview and record review on 1/30/2025 at 10:55 AM with RNA 1, Resident 30 ' s Documentation Survey Report, dated 1/2025, was reviewed. RNA 1 stated there was no space to document the number of hours she applied the AFOs and the knee splints for Resident 30. RNA 1 stated Resident 30 was scheduled to receive the RNA program daily from Monday to Friday. RNA 1 stated on 1/3/2025 and 1/24/2025 had no documented evidence Resident 30 received RNA assisted exercises on the two days. RNA 1 stated when the facility was short of staff RNAs would be pulled to perform the CNA ' s assignment instead of RNA assignment. RNA 1 stated if one of the assigned RNAs get pulled to perform CNA ' s assignment or called off then no replacement was available to cover that RNA ' s assignment, then, the residents on that RNA ' s assignment list would not receive their RNA program on that day.</p> <p>2. During a review of Resident 70 ' s Admission Record indicated the facility initially admitted Resident 30 on 5/20/2022 and readmitted her on 12/26/2023 with diagnoses that included hemiplegia (the loss of voluntary muscle movement of one side of the body) and diabetes mellitus (a condition when the blood sugar was too high).</p> <p>During a review of Resident 70's MDS, dated [DATE], indicated Resident 70 had intact memory and cognition (ability to think and reasonably). The MDS indicated Resident 70 required setup or clean-up assistance with eating and oral hygiene, partial/moderate assistance with personal hygiene, substantial/maximal assistance with shower/bathe self, and was dependent with toileting hygiene and chair/bed-chair transfer.</p> <p>During a review of Resident 70 ' s CP, dated 12/18/2024, indicated Resident 70 at risk for contractures due to reduce mobility and paralysis with the intervention that included RNA to do PROM to BLEs then apply bilateral AFOs every day for four to six hours five times a week or as tolerated.</p> <p>During a review of Resident 70 ' s Order Summary Report, dated 1/1/2025, indicated the physician ordered RNA to do PROM to BLEs daily three times a week or as tolerated, starting on 1/2/2024.</p> <p>During a review of Resident 70 ' s Order Summary Report, dated 1/30/2025, indicated the physician ordered RNA to do active assisted range of motion (AAROM, a type of exercise that involves a patient moving a week joint with some help from a therapist or equipment) to both upper extremities daily three times a week or as tolerated, starting on 10/9/2024.</p> <p>During a review of Resident 70 ' s Order Summary Report, dated 1/30/2025, indicated the physician ordered RNA services to perform PROM to BLEs then apply both AFOs daily for four to six hours five times a week or as tolerated, starting on 12/30/2024.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 70 ' s Documentation Survey Report indicated Resident 70 RNA had no documented evidence that the resident received RNA services and exercises on 12/6/2024,12/16/2024, 12/19/2024, and 12/25/2024, the report for the indicated dates were left blank.</p> <p>During a review of Resident 70 ' s Documentation Survey Report, dated 1/2025, indicated the documentation of Resident 70 receiving RNA program on 1/3/2025 and 1/24/2025 were blank. The Report also indicated Resident 70 was only scheduled to receive RNA to do PROM to BLEs then apply both AFOs daily for four to six hours three times a week instead of five times a week as the physician ' s order.</p> <p>During a concurrent observation and interview on 1/29/2025 at 9:15 AM with Resident 70, Resident 70 was lying on the bed and unable to move his lower extremities on his own and he did not have the AFOs placed on BLE, Resident 70 ' s AFOs were on the top of his nightstand. Resident 70 stated staff performed exercises to his upper and lower extremities and place the AFOs on his BLE two or three times a week and not five times a week. Resident 70 stated even though he could not move his legs, he still hoped he would maintain his current condition and not getting contractures.</p> <p>During a concurrent interview and record review on 1/30/2025 at 10:58 AM with RNA 1, Resident 70 ' s Documentation Survey Report, dated 1/2025, was reviewed. RNA 1 stated the dates marked with an x in the report indicated Resident 70 was not scheduled to receive RNA program on those days. RNA 1 stated Resident 70 should be scheduled to receive RNA to do PROM to BLE then apply bilateral AFOs daily four to six hours five times a week or as tolerated, but Resident 70 was only scheduled three times a week and not five times a week as ordered by the physician. RNA 1 stated the Rehabilitation Therapist did not transcribe the order to the RNA program schedule on the computerized system correctly to indicate that the Resident 70 should receive RNA services five times a week. RNA 1 stated if Resident 70 was not scheduled to receive RNA program on a specific day, she would not provide RNA program to Resident 70 even though the physician order indicated five times a week. RNA 1 stated the documentation of the RNA program for Resident 70 on 1/3/2025 and 1/24/2025 was blank, it indicated the resident did not receive the RNA program on these two days.</p> <p>During a concurrent interview on 1/31/2025 at 11:43 AM with RNA 2, RNA 2 stated the skilled nursing unit should schedule two RNAs each day because there were many residents on the RNA program. RNA 2 stated RNAs were pulled to perform CNAs assignments sometimes. RNA 2 stated the nursing unit divided into Station 1 and Station 2. RNA 2 stated if one RNA was pulled to do CNA assignment, the remaining RNA would provide RNA program to the residents in Station 1 within her shift, but if no other RNA available or the RNAs did not work overtime, then, the residents in Station 2 would not receive RNA program on that day.</p> <p>During an interview on 1/31/2025 at 11:45 AM with RNA 2, RNA 2 stated RNAs could not document the number of hours that the resident had the splints on for Residents 30 and 70 because the computerized documentation system did not provide a separate space to document it.</p> <p>During an interview on 1/31/2025 at 2:53 PM with the Director of Rehab (DR), the DR stated the physician order should be transcribed correctly to reflect the specific RNA tasks and correct frequency of RNA program treatment. The DR stated the rehab department did not oversee the RNA program because RNAs were overseen by the Nursing Management.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/31/2025 at 4:46 PM with the Director of Staff Development (DSD), Residents 30 and 70 ' s Documentation Survey Report, dated 12/2024 and 1/2025, and Nursing Staffing Assignment and Sign-in Sheet, dated 12/6/2024, 12/16/2024, 12/19/2024,12/30/2024, 12/31/2024,1/3/2025 and 1/24/2025 were reviewed. The DSD stated no documentation meant it was not done. The DSD stated two RNAs should be scheduled and only assigned to perform RNA program treatments to ensure the residents who needed the RNA program treatment received their RNA program treatment each day. The DSD stated only one RNA was scheduled to provide RNA program to all the residents who needed RNA program in the skilled nursing unit on 12/6/2024, 12/16/2024, 12/19/2024, 12/25/2025, 12/30/2024,12/31/2024, and 1/24/2025 and the RNA did not stay overtime to ensure all the residents who needed RNA program received their RNA program on those days, as the result, Resident 30 and Resident 70 missed their RNA program as the physician order. The DSD stated on 1/3/2025, two RNAs were scheduled but one RNA was pulled to do CNA ' s assignment and resulted in Resident 30 and Resident 70 missed the RNA program on that day. The DSD stated sometimes, the RNAs were pulled to perform the CNAs assignment because they were short of staff sometimes. The DSD stated if the RNAs could not stay overtime or she could not find coverage, the residents would not receive their RNA program on that day. The DSD stated she was responsible to ensure to schedule two RNAs for the skilled nursing unit, but she just could not find RNA coverage on some days. The DSD stated it was important to ensure enough RNAs available to provide the RNA program to the residents as the physician ' s order to prevent the development of contracture and promote ROM. The DSD stated she was responsible for the staffing, but she was not responsible for overseeing the RNA program.</p> <p>During an interview on 1/31/2025 at 6:08 PM with the Assistant Director of Nursing (ADON), the ADON stated the RNA program treatment ordered by the physician should be transcribe properly to reflect each RNA tasks clearly to ensure the proper documentation was completed. The ADON stated it was important to have enough RNAs to ensure residents receive their RNA program to prevent contracture and improve their mobility.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Restorative Nursing Services, dated 7/2017, indicated Residents will receive restorative nursing care as needed to help promote optimal safety and independence.</p> <p>50012</p> <p>3. During a review of Resident 72 ' s Admission Record (Face Sheet), indicated the facility admitted Resident 72 on readmitted on [DATE] with diagnoses that included diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin), epilepsy (a brain disorder that can cause people to suddenly become unconscious and have violent, uncontrolled movements of the body) and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated).</p> <p>During a review of Resident 72 ' s History and Physical (H&P), dated 9/12/2024 indicated, Resident 72 does not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 72's MDS dated [DATE], indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During A review of Resident 72's Order Summary Report, indicated an order dated 11/19/2024 for Resident 72 to receive RNA services for the following: RNA: to ambulate resident using R HR (Right side handrail)in hallway QD (everyday) 5x/week (five times a week) or as tolerated AFO on L LE (during ambulation one time a day.</p> <p>During A review of Resident 72's Order Summary Report, indicated an order dated 11/20/2024 for Resident 72 RNA to performed AROM to RUE (right upper extremity) and PROM to the LUE follow by application of Left resting hand splint for 6 hours QD 7x/week (seven times a week) or as tolerated.</p> <p>During a review of the Joint Mobility Screening, dated 11/22/2024, indicated the resident's left ankle mobility limitation was moderate (25% to 50% loss). The left and right hips, knees, and right ankle were full range (WFL or 75% to 100% of function). JMA further indicated that the current program effectiveness declined.</p> <p>During a review of the Documentation Survey Report (DSR) for 11/2024 there was no DSR for 11/2024 for Resident 72's RNA to ambulate, AROM of the RUE, PROM of the LUE, for the application of the resting hand splint.</p> <p>During a review of the Documentation Survey Report for 12/2024 and 1/2025 indicated Resident 72 received RNA only eight times instead of 23 times for 12/2024 and 19 times out of 21 times for 1/2025. There was no documentation of AROM of the RUE, PROM of the LUE and application of the left-hand grip splint for 12/2024 and 1/2025.</p> <p>During the initial tour of the facility on 1/28/2025 at 4:30 PM, Resident 72 was observed sitting in a wheelchair in Resident 72 ' s room, with a noticeable lack of proper positioning of the left foot; left foot was observed pointing away from the body. The left hand appeared flaccid (soft), with no sling in place. An AFO was noted on the left foot. Resident 72 expressed concerns about declining physical function. Resident 72 stated that he was previously able to maintain his left foot in a straight position, but now he was unable to do so.</p> <p>During an observation on 1/29/2025 at 11:36 AM, Resident 72 was lying on the bed without the AFO and the left-hand splint on.</p> <p>During a concurrent observation and interview on 1/28/2025 at 12:15 PM with Resident 72, Resident 72 was sitting on his wheelchair no left-hand splint observed. AFO was observed on his left foot.</p> <p>During an observation on 1/29/2025 at 10:25 AM, Resident 72 was lying on the bed without the AFO and the left-hand splint. The AFO and the splint were inside the first bedside table drawer.</p> <p>During an observation on 1/29/2025 at 1:45 PM, Resident 72 was sitting on his wheelchair no left-hand splint observed. AFO was observed on his left foot.</p> <p>During an observation on 1/30/2025 at 11:20 AM, Resident 72 was lying on the bed without the AFO and the left-hand splint.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/30/2025 at 11:10 AM, with Restorative Nurse 1 (RNA 1), RNA 1 stated there were currently three RNAs for the residents in the facility and they were pulled to cover for CNA task instead of performing the RNA duties when there was a shortage of CNAs. RNA 1 stated if the RNAs were doing CNA duties, they could not provide residents RNA exercises and services to the residents in RNA program.</p> <p>4. During a review of Resident 14 ' s Admission Record (Face Sheet), the facility admitted Resident 14 on 4/20/2010 and readmitted on [DATE] with diagnoses including hemiplegia (the loss of voluntary muscle movement of one side of the body) and diabetes mellitus (a condition when the blood sugar was too high).</p> <p>During a review of Resident 14 ' s History and Physical (H&P), dated 9/12/2024 indicated, Resident 14 has the mental capacity to make medical decisions.</p> <p>During a review of Resident 14's MDS dated [DATE], indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>During A review of Resident 14's Order Summary Report, indicated an order with a start date of 9/25/2023 for Resident 14 to receive RNA program for the following: RNA: to do PROM exercises to BLE ' s f/u by application of Bilateral AFO ' s up to QD 3-4 hrs/day for 7 times/week or as tolerated and RNA to perform PROME to both UE ' QD 7x week or as tolerated.</p> <p>During a review of the Documentation Survey Report for 8/2024 and 9/2024 indicated Resident 14 received RNA services 23 times instead of 31 times for 8/2024 and 23 times instead of 30 times for 9/2024.</p> <p>During a review of the Documentation Survey Report for 10/2024 and 11/2024 indicated Resident 14 received RNA 23 times instead of 31 times for 10/2024 and 27 times instead of 30 times for 11/2024.</p> <p>During a review of the Documentation Survey Report for 12/2024 and 1/2025 indicated Resident 14 received RNA 21 times instead of 31 times for 12/2024 and 19 times instead of 21 times for 1/2025.</p> <p>During a review of the Joint Mobility Screening dated 1/17/2025, indicated the resident's left ankle mobility limitation was severe (> 50% loss). The left and right hips, knees, and right ankle were full range (WFL or 75% to 100% of function).</p> <p>During the initial tour of the facility on 1/28/2025 2:30 PM, Resident 14 was observed sitting in his bed in Resident 14 ' s room, with a right hand appeared flaccid. Resident 14 stated that he is receiving therapy, and that staff put the AFOs on him two or three times a week when he receives therapy.</p> <p>During a concurrent observation and interview on 1/29/2025 at 2:15 PM with Resident 14, Resident 14 was sitting on his wheelchair no AFOs were observed on his LE. Resident 14 stated the RNAs did not apply them today.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 1/30/2025 at 10:55 AM with RNA 1, RNA 1 stated that if the documentation for 8/2024,9/2024,10/2024, 11/2024 12/2024 ,1/2025 was blank, it meant the resident did not receive the RNA services on those days. RNA 1 stated that when the facility was short-staffed, RNAs were reassigned to CNA duties, leading to missed RNA sessions if no replacement was found.</p> <p>During an interview on 1/31/2025 at 2:53 PM with the Director of Rehab (DR), the DR stated the importance of accurate transcription of orders and clarified that the rehab department did not oversee the RNA program, as RNAs were part of nursing staff.</p> <p>During a concurrent interview and record review on 1/31/2025 at 4:46 PM with the DSD, Residents 72 and Documentation Survey Report, dated 12/2024 and 1/2025, and Nursing Staffing Assignment and Sign-in Sheet, dated and were reviewed. The DSD stated no documentation meant it was not done. The DSD stated that two RNAs should be scheduled daily, but only one was scheduled on 12/16/2024, 12/19/2024, 12/30/2024, 12/31/2024, 1/3/2024 and 1/24/2025. The DSD acknowledged that RNAs were sometimes pulled for CNA duties when short-staffed, and without overtime or coverage, residents missed their programs. The DSD stated she was responsible for scheduling RNAs.</p> <p>During an interview on 1/31/2025 at 6:53 PM with the Director of Nursing (DON), DON stated that scheduling adequate RNAs is crucial to ensure residents receive necessary RNA services as prescribed services help maintain or improve residents' range of motion, prevent contractures, and support overall mobility and function. The DON stated that consistent RNA care contributes to better health outcomes and quality of life for residents. Without proper staffing, residents may miss essential therapy, which can negatively impact their physical condition over time.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled, Restorative Nursing Services, dated 7/2017, indicated Residents will receive restorative nursing care as needed to help promote optimal safety and independence.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision and safety measures to prevent a fall (refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force) for one of one sampled residents (Resident 198) with high risk for fall. Resident 198 was observed walking out of his room and falling on top of plastic Wet Floor sign placed in front of his room door.</p> <p>This deficient practice had the potential for Resident 198 to sustain serious injuries from the fall.</p> <p>Cross reference F677</p> <p>Findings:</p> <p>During a review of Resident 198 ' s Admission Record indicated the facility admitted Resident 198 on 1/16/2025 with diagnoses that included spinal stenosis (the spaces inside the bones of the spine get small), lack of coordination (a condition that makes it difficult to control your bodies movements).</p> <p>During a review of Resident 198's History and Physical [H&P] dated 1/17/2025, the H&P indicated the resident is able to make decisions for activities of daily living.</p> <p>During a review of Resident 198's Minimum Data Set (MDS, a resident assessment tool), dated 1/20/2025, indicated Resident 198 used a walker and wheelchair. The MDS indicated Resident 198 required partial/moderate assistance (helper does less than half the effort) for toileting, shower, lower body dressing, putting on/taking off footwear and personal hygiene. The MDS indicated Resident 198 required supervision or touching assistance (helper provides verbal cues and or touching/steadying and/or contact guard assistance as resident completes activities).</p> <p>During a review of Resident 198's Admission Fall Risk assessment dated [DATE] timed at 1:21 PM, indicated the resident was considered at high risk for potential falls due to intermittent confusion or poor safety awareness/non compliance, history of falls in the last 12 months, incontinent/needing assistance for toileting, unable to stand without assistance/unsteady gait (a persons manner of walking)/poor sitting or standing balance and use of medications</p> <p>During a review of Resident 198's Admission Fall Risk assessment dated [DATE] timed at 1:21 PM, indicated the resident was considered at high risk for potential falls due to intermittent confusion or poor safety awareness/noncompliance, history of falls in the last 6 months.</p> <p>During a review of Resident 198's Actual Fall care plan initiated on 1/26/2025, The care plan indicated Resident 198 had an actual fall related to balance deficit, cognitive impairment, decrease strength and noncompliance with request for assistance poor safety awareness/judgement and unsteady gait. The care plan interventions included Bowel and Bladder retraining as indicated, toileting program as indicated.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 198's Fall risk care plan initiated on 1/30/2025, indicated Resident 198 was at risk for falls and injuries the interventions listed included providing safety measures to reduce risk of falls/prevent injuries, observe resident behavior, frequent supervision/monitoring.</p> <p>During an observation on 1/31/2025 at 7:30 AM of station 1 hallway, Resident 198 was observed walking out of his room and falling over plastic yellow Wet Floor sign placed in front of Resident 198's room doorway.</p> <p>During a concurrent interview on 1/31/2025 at 7:35 AM with Licensed Vocational Nurse (LVN3), LVN 3 stated Resident 198 was high fall risk and was on frequent monitoring due to his past history of falls. LVN 3 stated she would try to walk by Resident 198 ' s room when she could but was on the other side of the station getting ready to pass medication when she heard Resident 198 had fallen. LVN 3 stated Resident 198 had unsteady gait and balance and is not currently on a Bowel and Bladder toileting program.</p> <p>During an interview on 1/31/2025 at 8:09 AM with Housekeeper (HSKP 1), HSKP 1 stated she had gone into Resident 198' s room around 7:20 AM to clean she mopped in front and around resident 198's bed and in front of the door, once she finished moping she placed the wet floor sign in front of the door to alert anyone that was going to enter the room the floor was wet.</p> <p>During an interview with on 1/31/2025 at 3:42 AM with Director of Nursing (DON), DON stated Resident 198 was high fall risk and staff should always maintain his environment free of clutter and hazards to avoid Resident 198 falling. The DON stated wet floor sign should not have been left in front of Resident 198 ' s room doorway as it was considered a hazard for Resident 198 who is high fall risk and has unsteady gait and balance.</p> <p>During a review of the facility's policy and procedure (P&P) titled Safety and Supervision of Residents dated with a revised date of July 2017, indicated Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility failed to provide appropriate assessments, treatments, and services for one of one sampled residents (Resident 82) who was incontinent (involuntary loss of urine) of bladder and had an indwelling foley catheter (a thin, flexible tube inserted into the bladder to drain urine and left in place for a set amount of time) for wound care management.</p> <p>Resident 82's foley catheter was not strapped properly to her leg to prevent dislodgement (removal) and had sediment (particles free floating in urine) in the urine.</p> <p>This had the potential to result in Resident 82 sustaining a UTI (an infection in the bladder/urinary tract) unable to maintain patency of the foley catheter drainage system (a closed system containing the foley catheter to a drainage bag that collects urine) that may result in urosepsis (life threatening blood infection because of a UTI spreading to the kidneys), trauma in the catheter site and hospitalization .</p> <p>Findings:</p> <p>During a review of Resident 82's Admission Record, the facility admitted Resident 82 on 6/1/2023 and readmitted Resident 82 on 11/20/2024 with diagnoses that include respiratory failure (a condition where the lungs cannot get enough oxygen into the blood tissues), stage 4 pressure ulcer (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and sepsis (a life threatening blood infection).</p> <p>During a review of Resident 82's Catheter Assessment & Care Plan, dated 9/27/2024, indicated Resident 82 had a foley catheter for wound care management. The interventions included monitoring for signs and symptoms of UTI such as pain during urination, abdominal distention, elevated temperature changes in level of consciousness (LOC, how aware and alert a resident is of their surroundings), increased heart rate, decreased blood pressure, increased mucous, increased sediment, change in color of urine, change in urine odor, daily foley catheter care, and maintain proper alignment of the foley catheter to promote proper damage.</p> <p>During a review of Resident 82's care plan, revised on 10/14/2024, the care plan indicated Resident 82 was at risk for skin breakdown secondary to incontinence related to the use of a foley catheter and drainage system for wound management. The interventions included monitor for hematuria (blood in urine), abdominal distention, and signs and symptoms of infection.</p> <p>During a review of Resident 82's care plan, revised on 11/02/2024, the care plan indicated Resident 82 had alterations in urinary elimination patterns related to hematuria (presence of blood in the urine). The document indicated the interventions included flushing the indwelling catheter for patency and to monitor for signs and symptoms of UTI.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 82's Order Summary Report, dated 11/20/2024, the order indicated to monitor Resident 82's foley catheter urinary drainage bag and document color, consistency, odor, hematuria, bladder distention (fullness or complained of a burning sensation).</p> <p>During a review of Resident 82's TAR, with an order date on 11/20/2024, the order indicated to monitor Resident 82's foley catheter drainage bag and document the following: color, consistency, odor, hematuria, bladder distention, and burning sensation. The TAR indicated that Resident 82 did not have any documentation of the color and consistency of the urine from January 1, 2025 to January 30, 2025.</p> <p>During a review of Resident 82's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 11/23/2024, Resident 82 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 82's Minimum Data Set (MDS, a resident's assessment), dated 12/4/2025, the MDS did not indicate Resident 82's cognitive (a person's mental process of thinking, learning, remembering, and using judgement) skills. The MDS indicated Resident 82's cognitive skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 82 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and functional mobility (a person's ability to move safely and independently within their environment). The MDS indicated Resident 82 had an indwelling foley catheter.</p> <p>During a review of Resident 82's Order Summary Report, with an order date of 1/9/2025, the order indicated to flush foley catheter with 60 milliliters (mL, unit of measure) of normal saline as needed when clogged.</p> <p>During a review of Resident 82's TAR, with an order date of 1/9/2025, the order indicated to flush Resident 82's foley catheter with 60 mL of Normal saline as needed when the catheter was clogged. The TAR indicated there was no documented evidence Resident 82's catheter had been flushed.</p> <p>During an observation on 1/28/2025 at 10:30AM in Resident 82's room, Resident 82's foley catheter had some sediment and cloudiness noted in the drainage tubing and drainage bag.</p> <p>During an observation on 1/29/2025 at 1:45PM in Resident 82's room, Resident 82's foley catheter was not strapped to her left upper leg. Resident 82's foley catheter had sediments in her drainage tubing.</p> <p>During an interview on 1/29/2025 at 2:17PM with TXN 1, TXN 1 stated it was the licensed nurses' responsible to assess the urine characteristics within the foley catheter and ensure the foley catheter was strapped to the resident's upper leg. TXN 1 stated, this morning, Resident 82's foley catheter was strapped to her upper leg, and her urine's color was amber and had no sediment in the drainage tubing or bag.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 1/29/2025 at 2:30PM with TXN 1 in Resident 82's room, TXN 1 assessed Resident 82's foley catheter. TXN 1 stated, Resident 82's foley catheter was not strapped to her leg, and it should not look like that. TXN 1 stated, there was some sediment noted in Resident 82's foley catheter drainage tube. TXN 1 stated, she was unable to flush Resident 82's foley catheter with normal saline because there could be sediment clogging the foley catheter.</p> <p>During an interview on 1/29/2025 at 2:45PM with TXN 1, TXN 1 stated, if the foley catheter was not strapped to Resident 82's leg, the foley catheter could be dislodged and cause trauma to Resident 82's catheter site.</p> <p>During an interview on 1/29/2025 at 2:45PM with TXN 1, TXN 1 stated, the sediment in Resident 82's foley catheter could be a sign of a UTI and Resident 82 could be retaining urine in her bladder if she was not voiding properly. TXN 1 stated, the UTI could lead to sepsis and hospitalization .</p> <p>During a concurrent interview and record review on 1/29/2025 at 2:45PM with TXN 1, Resident 82's Change of Condition (CoC) evaluation was reviewed. TXN 1 stated, there was no recent CoC documented for the sediment in Resident 82's foley catheter. TXN 1 stated, if there was no CoC documented, the physician was not aware of the sediment in Resident 82's change of condition.</p> <p>During an interview on 1/31/2025 at 6:24PM with the Assistant Director of Nursing (ADON), the ADON stated, the licensed nurses should assess the resident's foley catheter and drainage bag every shift for signs and symptoms of infection such as sediment in the tubing, color of the urine, strong odor, blood in the urine, temperature, or if the resident experience any pain or discomfort.</p> <p>During an interview on 1/31/2025 at 6:24PM with the ADON, the ADON stated, Resident 82's foley catheter should not have any sediment because sediment is not normal. The ADON stated, the licensed nurses should have assessed Resident 82 and notified the physician right away.</p> <p>During a review of the facility's policy and procedures (P&P) titled Catheter Care, Urinary, revised 8/2022, the P&P indicated to observe the resident for complications and to report unusual findings to the physician or supervisor immediately such as: if the resident had the urge to void, if urine has an unusual appearance (i.e color, blood, etc.), if there was bleeding or catheter dislodgement, if the resident complains of burning or tenderness, and if signs of UTI or urinary retention occur.</p> <p>During a review of the facility's P&P titled Change in a Resident's Condition or Status, revised 3/2023, the P&P indicated the nurse will notify the resident's physician or physician on call if there was a significant change in the resident's physical/emotional/mental condition. The P&P indicated a significant change as a resident's condition that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility failed to use appropriate alternative interventions before installation of bilateral upper half side rails (metal or plastic bars attached to the side of the bed) for one of one sampled resident (Resident 298).</p> <p>This failure had the potential for Resident 298 to be at risk for entrapment (when a resident can get caught by the head, neck, chest, or other body parts in the tight spaces around the side rails) and physical injuries</p> <p>Findings:</p> <p>During a review of Resident 298's Admission Record, the facility admitted Resident 298 on 1/8/2025 and the facility readmitted Resident 298 on 1/28/2025 with the diagnoses of acute respiratory failure (the inability for the body to maintain adequate oxygen to the tissues), hemiplegia (one-sided paralysis) and hemiparesis (one-sided weakness) following other cerebrovascular disease (decrease blood flow to the brain) affecting right dominant side, and surgical aftercare following surgery on the nervous system.</p> <p>During a review of Resident 298's Informed Consent (when the physician educated the resident on the risk and benefits of a procedure or treatment), dated 1/8/2025, the document indicated bilateral upper half side rails while Resident 298 was in bed due to sliding down in bed and an elevated head of bed (HOB, the end of the bed where a resident's head rest) related to enteral feedings (tube feeding, a method of providing nutrition directly to the stomach or small intestine). The document indicated Resident 298 gave verbal consent only; unwilling or unable to sign form. There was no documented evidence of a physician's signature, who obtained the Informed Consent. The document indicated the nurse (unable to identify) had verified consent for the proposed treatment.</p> <p>During a review of Resident 298's History and Physical (H&P, a comprehensive physician's note regarding the assessment of the resident's health status), dated 1/9/2025, Resident 298 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 298's Side rail/Entrapment Assessment/ Care Plan document, dated 1/9/2025, the document indicated Resident 298 needed bilateral upper half side rails due to generalized muscle weakness. The document's recommendation indicated the need for bilateral upper half side rails related to Resident 298 sliding down in bed because of the elevated HOB related to tube feeding management.</p> <p>During a review of Resident 298's Resident-Physical (Initial Evaluation) document, dated 1/9/2025, the document indicated Resident 298's behavior of sliding down the bed placed her at risk for fall and injury. There was no documented evidence of the use of alternative interventions attempted prior to the use of side rails.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 298's Order Summary Report (instructions that communicated the medical care that the residents received while in the facility), with an order date of 1/9/2025, indicated Resident 298 had bilateral upper half side rails up when in bed because Resident 298 slides down in bed due to an elevated HOB and tube feeding.</p> <p>During a review of Resident 298's Minimum Data Set (MDS, a resident assessment tool), dated 1/14/2025, the MDS indicated Resident 298's cognitive (a person's mental process of thinking, learning, remembering, and using judgement) skills were intact. The MDS indicated Resident 298 required maximal assistance (helper does more than half the effort) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and for functional mobility (a person's ability to move safely and independently within their environment). The MDS indicated Resident 298's side rails were not used in bed.</p> <p>During an observation on 1/28/2025 at 10:40AM in Resident 298's room, Resident 298 was observed lying in bed, HOB slighted elevated, and bilateral upper side rails positioned up.</p> <p>During an observation on 1/31/2025 at 2:55PM in Resident 298's room, Resident 298 was observed lying in low bed, HOB slightly elevated, and bilateral upper side rails positioned up.</p> <p>During an interview on 1/31/2025 at 3:00PM with Certified Nurse Assistant (CNA) 4, CNA 4 stated, she checked a resident's side rail when performing a resident's ADLs, repositioning the resident in bed, or using the Hoyer lift (a mechanical device used to lift and/or transfer a resident). CNA 4 stated, she checked the side rails by unlocking the side rails to lowered position and locking them in the raised position. CNA 4 stated, it was important to put the side rails up in locked positioned because many of the residents were immobile and could fall out of bed.</p> <p>During an interview on 1/31/2025 at 3:10PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, most residents on her unit were considered a fall risk and were automatically placed on side rails upon admission. LVN 1 stated, side rails were considered restraints and needed a physician's order. LVN 1 stated, licensed nurses and CNAs check the resident's side rails while performing ADLs to ensure the side rails can be unlocked in the lowered position and locked in the upper position. LVN 1 stated, there was no documentation for side rail monitoring, but the licensed nurses and CNAs report to the Registered Nurse (RN) supervisor or the maintenance supervisor (MS) if the side rail was not working.</p> <p>During an interview on 1/31/2025 at 3:25PM with RN 1, RN 1 stated, most residents get placed on side rails upon admission to her unit.</p> <p>During an interview with the ADON stated, the ADON stated, the facility should try to start with the least restrictive measure such as positioning devices, frequent visual monitoring, and bolster mattresses (mattress with foam cushions along the edges of the mattress) before side rails.</p> <p>During a concurrent interview and record review on 1/31/2025 at 6:35PM with the ADON, Resident 298's Restraint-Physical (Initial Evaluation) document, dated 1/9/2025, was reviewed. The Restraint-Physical (Initial Evaluation) document indicated there was no documented evidence that side rails alternatives were attempted prior to the application of the bilateral upper side rails. The ADON stated, the document showed the licensed nursing staff did not attempt to try any alternatives before placing Resident 298 on side rails. The ADON stated, the side rails were a risk for entrapment.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility ' s policies and procedures (P&P) titled, Bed Safety and Bed Rails, revised 8/2022, the P&P indicated the use of bed side rails were prohibited unless the criteria for bed side rails had been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P indicated, prior to using side rails, side rail alternatives must be attempted. The P&P indicated alternatives to side rails included roll guards, foam bumpers, lowering the bed, or use of concave mattresses to reduce rolling off the bed.</p>		

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<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>46779</p> <p>Based on observation, interview and record review the facility failed to ensure sufficient staffing were provided to perform RNA (Restorative Nursing Assistant) assisted services and exercises as ordered by the physician to the residents in the facility that had limited range of motion (ROM). Two of Two RNA's (RNA 1 and 2) assigned to perform RNA services and exercises reported they were reassigned to perform Certified Nursing Assistant (CNA) duties when the facility had no sufficient CNA to attend to residents in the facility.</p> <p>This deficient practice had the potential to result in a decline in the resident's quality of care and further decline in mobility and ROM.</p> <p>Findings:</p> <p>During a review of the facility ' s Daily Staffing Assignment, dated 8/3/2024, 8/4/2024, 8/5/2024, 10/23/2024, 10/25/2024, 11/21/2024, 12/6/2024, 12/16/2024, 12/30/2024, 12/31/2024, 1/24/2024, indicated only one RNA was assigned to provide exercises to the residents with limited ROM and the RNA did not work overtime to attend to RNA duties.</p> <p>During a review of the facility ' s Daily Staffing Assignment, dated 8/1/2024, 8/6/2024, 8/22/2024, 10/3/2024, 10/5/2024, 10/18/2024, 10/24/2024, 11/1/2024, 11/6/2024, 11/7/2024, and 11/13/2024 indicated no RNA was assigned to provide exercises to the residents with limited ROM</p> <p>During a review of the facility ' s Daily Staffing Assignment, dated 8/17/2024 and 9/9/2024, indicated three RNAs worked but two were assigned to perform CNAs ' duties, and did not work overtime as RNA. There was one RNA that provided exercises to the residents with limited ROM.</p> <p>During a review of the facility ' s Dailly Staffing Assignment, dated 8/18/2024, 9/15/2024, 9/21/2024, 11/18/2024, 11/28/2024, 12/10/2024, and 1/3/2024, indicated two RNAs were assigned and two RNAs did not work overtime as RNA.</p> <p>During a review of the facility ' s Daily Staffing Assignment, dated 10/4/2024, 10/17/2024, 11/2/2024, 12/7/2024, 12/15/2024, and 12/19/2024, indicated no RNA performed the RNA duties to provide exercises to the residents with limited ROM.</p> <p>During a concurrent interview and record review on 1/30/2025 at 10:55 AM with RNA 1, RNA 1 stated when the facility was short of staff and no replacement available to cover the certified nursing assistants (CNA) ' s assignments, RNAs would be pulled to perform the CNA ' s assignments instead of RNA assignment. RNA 1 further stated if one of the assigned RNAs got pulled to perform the CNA ' s assignment or called off and no replacement was available to cover that RNA ' s assignment, then, the residents on that RNA ' s assignment list would not receive their RNA program on that day.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview on 1/31/2025 at 11:43 AM with RNA 2, RNA 2 stated the skilled nursing unit should schedule two RNAs each day because there were many residents on the RNA program. RNA 2 stated RNAs were pulled to perform CNAs assignments sometimes. RNA 2 stated the nursing unit divided into Station 1 and Station 2. RNA 2 stated if one RNA was pulled to do CNA assignment, the remaining RNA would provide RNA program to the residents in Station 1 within her shift, but if no other RNA available or the RNAs did not work overtime, then, the residents in Station 2 would not receive RNA program on that day.</p> <p>During a concurrent interview and record review on 1/31/2025 at 4:46 PM with the Director of Staff Development (DSD), DSD stated two RNAs should be scheduled and only assigned to perform RNA program treatments each day to ensure the residents who needed the RNA program treatment received their RNA program treatment. The DSD stated only one RNA was scheduled to provide RNA program to all the residents who needed RNA program in the skilled nursing unit on 8/3/2024, 8/4/2024, 8/5/2024, 12/6/2024, 12/16/2024, 12/19/2024, 12/25/2025, 12/30/2024, 12/31/2024, and 1/24/2025 and the RNA did not stay overtime to ensure all the residents who needed RNA program received their RNA assisted exercises and services on those days, as the result the residents missed their RNA assisted exercises and services as ordered by the physician. The DSD stated on 10/4/2024, one RNA was assigned, but the RNA was pulled to perform the CNA ' s assignment, and the RNA did not stay overtime to provide RNA program to the residents on that day. The DSD stated on 1/3/2025, two RNAs were scheduled but one RNA was reassigned to do CNA ' s assignment and resulted in residents missed their RNA program on that day. The DSD stated sometimes, the RNAs were pulled to perform the CNAs assignment because they were short of staff sometimes. The DSD stated on 8/1/2024 and 8/6/2024, there were no RNA assigned that day. The DSD stated if the RNAs could not stay overtime or she could not find coverage, the residents would not receive their RNA program on that day. The DSD stated she was responsible to ensure to schedule two RNAs for the skilled nursing unit, but she just could not find RNA coverage on some days. The DSD stated it was important to ensure enough RNAs available to provide the RNA program to the residents as the physician ' s order to prevent the development of contracture and promote ROM.</p> <p>During an interview on 1/31/2025 at 6:08 PM with the Assistant Director of Nursing (ADON), the ADON stated it was important to have enough RNAs to ensure residents receive their RNA program to prevent contracture and improve their mobility.</p> <p>During a concurrent interview and record review on 1/30/2025 at 10:55 AM with RNA 1, RNA 1 stated that if the documentation for 8/2024,9/2024,10/2024, 11/2024 12/2024 ,1/2025 was blank, it meant the resident did not receive the program on those days. RNA 1 stated that when the facility was short-staffed, RNAs were reassigned to CNA duties, leading to missed RNA sessions if no replacement was found.</p> <p>During an interview on 1/31/2025 at 2:53 PM with the Director of Rehab (DR), the DR stated the importance of accurate transcription of orders and clarified that the rehab department did not oversee the RNA program, as RNAs were part of nursing staff.</p> <p>During a review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, indicated Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>42878</p> <p>Based on interview and record review, the facility failed to ensure one out of three sampled Licensed Vocational Nurses (LVN 2) and one out of three sampled Certified Nursing Assistants (CNA 3) in the facility completed their annual competency assessment and evaluation (a process that assess and evaluates an employees skills, knowledge and performance) for the appropriate job category when providing quality care.</p> <p>As a result of this deficient practice placed the residents at risk for not receiving competent/quality of care services, treatments, and risk for infection from daily care.</p> <p>Findings:</p> <p>During a review of LVN 2's employee file records indicated the facility hired LVN 2 on 4/03/2020. LVN 2 ' s employee records included a Licensed Nurse Competency Check List dated 11/17/2023.</p> <p>During a review of CNA 3's employee file records indicated the facility hired CNA 3 on 1/28/2005. CNA 3's employee records included a Certified Nursing assistant Competency Check List dated 12/3/2023.</p> <p>During an interview and concurrent record review on 1/29/2025 at 11:15 AM with the Director of Nursing (DON), the DON stated all Licensed Nurses should complete competency skills upon hire and then annually. The DON stated she did not know why LVN 2's annual competency was not completed last year but it should have been completed.</p> <p>During an interview and concurrent record review on 1/29/2025 at 1:25 PM with Director of Staff Development (DSD), DSD stated Competency evaluation are conducted via written test and return demonstration upon hiring and annually for all staff. The DSD stated she did not know why CNA 3 ' s competency was not completed annually in 2024.</p> <p>During a review of facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing dated with revision date of August 2022, indicated Our facility provides sufficient numbers with the appropriate skills and competency necessary to provide nursing related care and services for all residents in accordance with the residents plan of care and the facility assessment</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility ' s error rate was less than five percent (5%). During a medication pass observation License Vocational Nurse (LVN)1 did not flush in between each medication administration via gastrostomy tube [GT- a tube inserted into the stomach through a surgical incision use for feeding and administration of medication for a resident unable to swallow] to one of three sampled residents (Resident 86) resulting in 33.3% medication error rate for nine medications out of 27 opportunities.</p> <p>These deficient practices had the potential to result in inconsistent medication administration, risks of physical and chemical incompatibilities between the medications, that could alter drug therapeutic effectiveness, and stomach irritation.</p> <p>Findings:</p> <p>During a review of Resident 86 ' s Admission Record (Face Sheet), the facility admitted Resident 86 on 11/8/2023 and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a broad term for any brain disease that alters brain function) and sepsis (infection of the blood).</p> <p>During a review of Resident 86 ' s History and Physical (H&P), dated 10/10/2024 indicated, Resident 86 had the mental capacity to make medical decisions.</p> <p>During a review of Resident 86's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 11/13/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, dependent on staff for the activities of daily living.</p> <p>During a review of the Order Summary Report dated 1/31/2025 indicated orders for the following:</p> <ol style="list-style-type: none"> 1. Aspirin (medication that prevent blood clot to form) tablet Chewable 81 MG (milligrams (MG) Give 1 tablet via G-Tube one time a day for CVA (cerebrovascular accident or stroke [occurs when a blood vessel that carries oxygen and nutrients to the brain is either blocked by a clot or bursts/ruptures]) ppx (prophylaxis [prevention]). 2. Cranberry Oral Tablet 450 MG (Cranberry (Vaccinium macrocarpon)) Give 2 tablet via G-Tube one time a day for UTI prophylaxis two 450mg tabs = 900mg. 3. Artificial Tears Ophthalmic (eye drops) Solution 0.2-0.2-1 % (Glycerin Hypromellose-Polyethylene Glycol 400) Instill 1 drop in both eyes every 4 hours for dry eyes 4. Pantoprazole Sodium Oral Packet 40 MG (Pantoprazole Sodium) Give 1 packet via G-Tube one time a day for GERD (gastroesophageal reflux disease -a digestive disease in which stomach acid or bile irritates the food pipe lining) MIX 1 PACKET IN apple sauce exp. APPLE SAUCE OR JUICE VIA G-TUBE. 5. Robinul Oral Tablet 1 MG (Glycopyrrolate) Give 1 tablet via G-Tube one time a day for excess secretion/sputum. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. LiquaCel Oral Liquid (Amino Acids) Give 30 ml via G-Tube one time a day for Skin management If unavailable may use pro-stat.</p> <p>7. Methocarbamol Oral Tablet 500 MG (Methocarbamol) Give 2 tablet by mouth two times a day for muscle spasm.</p> <p>8. Multivitamins/Minerals Adult Oral Liquid (Multiple Vitamins w/Minerals) Give 15 ml via G-Tube in the morning for supplement</p> <p>9. Vitamin C Oral Tablet 500 MG (Ascorbic Acid) Give 1 tablet via G-Tube one time a day for skin integrity for 3 Months.</p> <p>During a medication pass observation on 1/30/2025 at 9:30 AM, Licensed Vocational Nurse (LVN) 1 was observed preparing to crush tablets and pour liquid medications into each medication cup of the medications mentioned above. LVN 1 poured 15 ml water into each crushed medication on medicine cup.</p> <p>During an observation on 1/30/2025 at 9:33 AM, LVN 1 was observed administering medications to Resident 86 via G-Tube with a syringe without checking for residuals before administering medications. LVN 1 administered the medications one at a time and did not flush the G-tube with water in between medications.</p> <p>During an interview on 1/30/2025 at 9:40 AM with LVN 1, stated she should have flushed before with 5-10 ml of water in between medications. LVN 1 also stated there was a possibility of drug reaction that may deactivate (make inactive or ineffective) the medications.</p> <p>During an interview on 1/31/2025 at 6:30PM with Assistant Director of Nursing (ADON) stated medications are given by gravity, when possible, but if that doesn ' t work, a syringe is used slowly if there are standing orders. ADON stated nurse should flush with water before giving medications, 15 mL between each medication, and 15 mL at the end to clear the tube. This process helps ensure safe medication administration.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, indicated:</p> <p>Verify placement of feeding tube.</p> <p>a. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician.</p> <p>8. Attach syringe (without plunger) to the end of the tubing</p> <p>9. Unclamp and flush with least 15 ml water (or prescribed amount) prior to administering medication.</p> <p>10. Administer each medication separately by gravity flow:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion.</p> <p>b. Open the clamp and deliver medication slowly. May gently push if necessary</p> <p>11. If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications.</p> <p>12. When the last of the medication begins to drain from the tubing, flush the tubing with 15 mL of water (or prescribed amount).</p>

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<p>F 0814</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Dispose of garbage and refuse properly.</p> <p>46779</p> <p>Based on observation, interview, and record review, the facility failed to ensure two of four outdoor refuse containers (a waste container that a person controls that includes dumpsters, trash cans, garbage pails, and plastic trash bags) was closed with a tight-fitting lid and kept covered.</p> <p>This failure had the potential to attract insects and harbor pests in the refuse area that can cause a wide spread of diseases and affect the residents, staff, and visitors.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 1/28/2025 at 9:17 AM with the Dietary Supervisor (DS) at the facility ' s courtyard, two outdoor refuse containers were observed with no secured lid covered and no other staff was around throwing trash into the refuse containers. The two open refuse containers were full and overflowing with the closed plastic bags of garbage hanging outside the contains. One open refuse container had a red stick propped the lid open. The DS stated the lid of the refuse containers should be closed at all times.</p> <p>During a concurrent observation and interview on 1/28/2025 at 9:20 AM with the MS, the MS removed the red stick from the open refuse container and closed the refuse container. The MS stated the opening of the refuse containers were too high for some staff to reach and throw a trash in, so the staff used the red stick to open the refuse containers but he or she forgot to remove the red stick and close the lid. The MS stated the lid of the refuse containers should be closed at all times to prevent infestation of insects and pests, and to prevent illness to the residents, staff and visitors.</p> <p>During a review of the facility ' s policy and procedure titled, Food-Related Garbage and Refuse Disposal, dated 10/2017, indicated, All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use.</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50012</p> <p>Based on observation, interview, and record review, the facility failed to provide required specialized rehabilitation services (services that included but is not limited to physical therapy [provide exercises to help injured or ill people improve movement and manage pain] and occupational therapy [helps people to have physical, sensory, or cognitive problems] and promoting independence for individuals with complex rehabilitation needs in accordance with facility policy and professional standards of care for one of four sampled residents (Residents 14).</p> <p>For Resident 14 was not assessed and addressed for potential joint mobility concerns annually and quarterly since 2024.</p> <p>This deficient practice had the potential to negatively impact the resident's physical and mobility function including contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints), pain and discomfort.</p> <p>Findings:</p> <p>During a review of Resident 14 ' s Admission Record (Face Sheet), the facility admitted Resident 14 on 4/20/2010 and readmitted on [DATE] with diagnoses including hemiplegia (the loss of voluntary muscle movement of one side of the body) and diabetes mellitus (a condition when the blood sugar was too high).</p> <p>During a review of Resident 14 ' s History and Physical (H&P), dated 9/12/2024 indicated, Resident 14 has the mental capacity to make medical decisions.</p> <p>During a review of Resident 14's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 10/1/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was intact, and needed supervision to extensive assistance from the staff for the activities of daily living.</p> <p>During a review of the Review of Resident 14 clinical records revealed that the last documented OT joint mobility screening for Resident 14 was completed in 2022. No subsequent screenings were found in the resident's medical record.</p> <p>During a review of Resident 14 clinical records revealed that there was no PT and OT joint mobility screening for Resident 14 for the year of 2024.</p> <p>During a concurrent interview and record review on 1/31/2025 at 2:53 PM with the Director of Rehab (DR), the DR acknowledged that the annual PT joint mobility for Resident 14 was missed for the 2024 assessment period. DR acknowledge that the last OT joint mobility assessment for Resident 14 was completed on 10/18/2022. DR stated that per policy the residents need to have a Joint mobility assessment at least annually. DR further stated that Joint mobility assessments are done upon admission, readmission and annually. DR stated that these screenings are essential for monitoring joint function and maintaining residents' physical capabilities.</p> <p>(continued on next page)</p>		

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<p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/31/2025 at 6:05 PM with the Director of Nursing (DON), the DON stated joint mobility assessments are important to prevent contractures, identifying early signs of musculoskeletal decline, and maintaining residents' functional independence. Missing these evaluations puts residents at risk for complications that could have been prevented or managed with timely interventions.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Screening, indicated Joint Mobility Screening form is to be completed by PT and/or OT. Quarterly and Annual screens (both Rehabilitation and/or Joint Mobility Screening forms) may be done as per facility policy and in conjunction with the MDS assessment schedule.</p>

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50203</p> <p>Based on interview and record review, the facility failed to explain the arbitration agreement (a provide agreement that allows individual parties to resolve disputes rather than in a lawsuit) to one of three sampled residents (Resident 198) in a form and manner that his responsible party understands. Resident 198 ' s responsible party reported not understanding the arbitration agreement and the rights to make informed decisions and choices about important aspects of Resident 198 ' s health, safety, and welfare.</p> <p>This failure resulted in the resident's responsible party not to make an informed decision about the resident's care to ensure the resident received care according to his rights.</p> <p>Findings:</p> <p>During a review of Resident 198's Admission Record, the facility admitted Resident 198 on 1/16/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities), and cognitive communication deficit (trouble communicating due to problems with thinking skills such as attention, memory, organization, or reasoning).</p> <p>During a review of Resident 198's Admission Record, Family Member (FM) 1 was listed as Resident 198 ' s primary decision maker.</p> <p>During a review of Resident 198's History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident's health status), dated 1/11/2025, indicated Resident 198 had the ability to make decisions for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily).</p> <p>During a review of Resident 198's Minimum Data Set (MDS, a resident assessment tool), dated 1/20/2025, the MDS indicated Resident 198 cognitive (a person ' s mental process of thinking, learning, remembering, and using judgement) skills were severely impaired, and there was no documented evidence Resident 198 had the cognitive skills to make decisions regarding tasks of daily life.</p> <p>During a review of Resident 198's Information Regarding the Resident-Facility Arbitration Agreement (Arbitration Information), dated 1/16/2025, the Arbitration Agreement Information document indicated that residents and their responsible party acknowledged reading and understanding the document and had been provided the opportunity by the facility to ask questions regarding arbitration. The document was signed by FM 1 and dated on 1/16/2025.</p> <p>During a review of Resident 198's Resident - Facility Arbitration Agreement (Arbitration Agreement), dated 1/16/2025, the Arbitration Agreement document indicated that the residents and their responsible party have read the Arbitration Agreement and accepted the terms of the agreement on behalf of the resident. The document was signed on behalf of Resident 198 and dated 1/16/2025.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/31/2025 at 5:40PM with FM 1, FM 1 stated she did not know what an arbitration agreement was. FM 1 stated, she did come to the facility on [DATE] to sign documents as Resident 198 's responsible party. FM 1 stated, she cannot tell me what an arbitration agreement meant because the person at the front desk handed her documents to sign but did not go over what the forms meant. FM 1 stated, she just handed me papers to sign, so I signed them.</p> <p>During an interview on 1/31/2025 at 5:45PM with the Admissions Coordinator (AC), the AC stated, the Arbitration Information document was self-explanatory and the resident or their responsible party can read the form for themselves. The AC stated the Arbitration Information document was given to the resident and their responsible party to clarify the terms of the Arbitration Agreement document. The AC stated, if the resident or responsible party had additional questions, she was not allowed to answer the questions.</p> <p>During a concurrent interview and record review on 1/31/2025 at 6:15PM with the Administrator (ADM), the State Operations Manual Appendix PP (SOM), revised on 8/8/2024, the SOM was reviewed. The SOM indicated, the facility must ensure the arbitration agreement was explained to the resident or their responsible party in a form and manner that he understands. The ADM stated, the Arbitration Agreement Information document should have been read aloud to Resident 198 's responsible party. The ADM stated it was important for the Arbitration Agreement Information to be read to the resident or responsible party to inform of their rights.</p> <p>During a review of the facility's document The Information Regarding the Resident-Facility Arbitration Agreement, date unknown, the document indicated the resident, or the responsible part acknowledged, read, and understood the document and had been provided an opportunity by the facility to ask questions regarding arbitration.</p> <p>During a review of the facility's document Resident-Facility Arbitration Agreement, revised 11/19, the document indicated, the resident or the person on behalf of the resident has read and accepted the terms of the document.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>50203</p> <p>Based on observation, interview, and record review, the facility ' s Quality Assessment and Assurance (QAA) committee failed to maintain an effective system to identify, monitor and evaluate implementation of a plan of correction for the deficient practice previously cited on 8/1/2024 related to insufficient Restorative Nursing Assistant (RNA, a certified nurse assistant [CNA] with specialized training in rehabilitation skills who assists the restorative team with supervised and delegated restorative programs) and CNA and residents not RNA services o provide exercises and devices as ordered by the physician to prevent decline in the mobility.</p> <p>As a result of these deficient practices, the residents who required RNA services are at risk for further decline in range of motion, mobility and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff that prevents normal movement of a joint or other body part. Contractures may be caused by not using the muscles).</p> <p>Crossed Reference to F725 and F688</p> <p>Findings:</p> <p>During a review of the Statement of Deficiencies (CMS 2567) from the abbreviated standard survey completed on 8/1/2024, indicated the survey team identified the facility failed to provide sufficient RNA staffing for 19 residents receiving the RNA program. A review of the plan of correction (POC), under Monitoring/Quality Assurance and Performance Improvement (QAPI), indicated the Director of Staff Development (DSD) will report the RNA assignments daily, the Medical Records Director (MRD) will conduct RNA audits daily and report results to the Director of Nursing (DON) and the DSD for review, and the DON or Designee will conduct bi-monthly (twice a month) RNA meetings to address any issues related to RNA and RNA staffing.</p> <p>During an interview on 1/31/2025 at 6:45PM with the Administrator (ADM) and the DON, the ADM and the DON stated the facility was not aware of the continued issues related to RNA services such as the RNA was removed from his/her duties to perform CNA task and that residents were not provided RNA assisted exercises, service and the devices as ordered by the physician. The DON stated, it was only identified this week when the surveyors identified the issue.</p> <p>During an interview on 1/31/2025 at 6:45PM with the DON, the DON stated MRD conducted the RNA audits by looking at the RNA record in the Electronic Medical Records (EMR) system. The DON stated the RNA services program was a collaboration between the DSD and the Director of Rehabilitation (DOR) services. The DON stated, the DSD and DON review the RNA orders with the assigned RNA but they were unaware the physician orders were being transcribed incorrectly into the RNA record in the EMR system. The DON stated she was in charge of the oversight of the RNA services, but she failed to identify concerns regarding the residents not receiving the RNA services as ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0867</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 policies and procedures (P&P) titled, Quality Assurance and Performance Improvement (QAPI) Program, revised 2/2020, the P&P indicated key components of identifying and correcting quality deficiencies include tracking and measuring performance, establishing goals and thresholds for performance measurements, identifying and prioritizing quality deficiencies, systematically analyzing underlying causes of systemic quality deficiencies, developing and implementing corrective action or performance improvement activities, and monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed.</p> <p>During a review of the facility ' s P&P titled, Quality Assurance and Performance Improvement (QAPI) Program - Feedback, Data and Monitoring, revised 3/2020, the P&P indicated a root cause analysis is conducted to identify problematic processes and systems that need to be addressed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878</p> <p>Based on observation, interview, and record review, the facility failed implement the facility's policy and procedure on infection control to prevent spread of infection for five of five sampled residents (Resident 62, 67, 92, 78 and 77) by failing to:</p> <ol style="list-style-type: none"> 1. For Resident 62, the resident's Suprapubic Catheter (a medical device that drains urine from the bladder directly through the abdominal wall) attached to a drainage bag that was found of the floor. 2. For Resident 67 and Resident 92, Certified Nursing Assistant (CNA) 1 did not perform hand hygiene before and after providing care between the residents. 3. For Resident 78's the feeding tubing (a tubing attached to the feeding bag with nutritional formula that connects to the Gastrostomy Tube [GT- a tube inserted into the stomach through a surgical incision use for feeding and administration of medication for a resident unable to swallow]) was on the floor. 4. For Resident 77's family member (FM) 2 and FM 3 were not following the Enhanced Barrier Precautions (EBP, infection control interventions including the use of gown and gloves) while in close contact with Resident 77 and while handling Resident 77 ' s dirty linens, which increased the risk of Multi-Resistant Drug Organism (MRDO, a germ that was resistant to many antibiotics) spread among residents, staff members, and visitors. <p>These deficient practices had the potential to result in widespread infection (a process when a microorganism, such as bacteria, fungi, or a virus, enters a person's body and causes harm) and in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 62 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 62 was readmitted to the facility on [DATE] with diagnoses that included of Hemiplegia and Hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body) following Cerebral infarction affecting right dominant side, Aphasia(a disorder that affects how you communicate). <p>During a review of Resident 62 ' s History and Physical [H&P] dated 11/22/2024, the H&P indicated the resident is able to make decisions for activities of daily living.</p> <p>During a review of Resident 62's Order Summary Report dated 1/10/2025, indicated a physician order for: Suprapubic Catheter for Neurogenic Bladder (a condition where the nerves that control the bladder are damaged).</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 1/28/2025 at 10:59 AM with Infection Control Nurse (IPN) of Resident 62's room, Resident 62's catheter bag was observed laying on the floor from Resident 62's left side of the bed. The IPN stated the catheter bag should never be touching or laying on the floor as the floor is dirty and could contaminate and make Resident 62 sick.</p> <p>During a review of the facility ' s policy and procedure (P&P) titled Catheter Care, Urinary dated revised in August 2022 indicated Infection Control 2. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>46779</p> <p>2. During a review of Resident 67's Admission Record indicated the facility initially admitted Resident 67 on 9/25/2024 with diagnoses that included dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and hypertension (high blood pressure).</p> <p>During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/30/2024, indicated Resident 67 had severely impaired memory and cognition (ability to think and reasonably). The MDS indicated Resident 67 required supervision or touching assistance with eating, partial/moderate assistance with chair/bed-to-chair transfer, and substantial/maximal assistance with oral hygiene, toileting hygiene, shower/bathe self, personal hygiene.</p> <p>During a review of Resident 92's Admission Record indicated the facility initially admitted Resident 92 on 7/25/2024 and readmitted him on 1/21/2025 with diagnoses that included hemiparesis (a medical condition that causes weakness on one side of the body) and hypertension.</p> <p>During a review of Resident 92's MDS, dated [DATE], indicated Resident 92 had moderately impaired memory and cognition. The MDS indicated Resident 92 required setup or clean-up assistance with eating and oral hygiene, and substantial/maximal assistance with toileting hygiene, shower/bathe self, personal hygiene and chair/bed-to-chair transfer.</p> <p>During an observation on 1/28/25 at 12:34 PM, Certified Nursing Assistant (CNA) 1 carried Resident 92's lunch meal tray to his room and put the meal tray on his bedside table. CNA 1 touched Resident 92's knee, then, set up the meal tray for Resident 92. CNA 1 did not perform hand hygiene and exited Resident 92 ' s room. Then, CNA 1 took Resident 67 ' s meal tray from the meal cart to Resident 67 ' s room. CNA 1 put down Resident 67 ' s meal tray on her bedside table, then, CNA 1 fixed Resident 67 ' s blanket, set up the meal tray, and positioned the resident on the bed to eat. CNA 1 and did not perform hand hygiene.</p> <p>During an interview on 1/28/2025 at 12:36 PM with CNA 1, CNA 1 stated she was supposed to perform hand hygiene before and after providing care to each resident, but she was too busy passing the tray today and she forgot. CNA 1 stated it was important to perform hand hygiene to prevent spreading the infection.</p> <p>During an interview on 1/31/2025 at 6:05 PM with the Assistant Director of Nursing (ADON), the ADON stated it was important to perform hand hygiene before and after providing care for each resident because it could prevent the spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</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 policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 4/2023, the P&P indicated Use an alcohol-based hand rub containing at least 70% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .b. Before and after direct contact with residents .o. Before and after eating or handling food .p. Before and after assisting a resident with meals .</p> <p>50012</p> <p>3. During a review of Resident 78's Admission Record (Face Sheet), the facility admitted Resident 78 on 2/15/2023 and readmitted on [DATE] with diagnoses including hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and sepsis (life threatening infection in the blood).</p> <p>During a review of Resident 78's History and Physical (H&P), dated 11/1/2024 indicated, Resident 78 did not have the mental capacity to make medical decisions.</p> <p>During a review of Resident 78's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 11/20/2024, indicated the cognitive (the ability to think and process information) skills for daily decisions making was severely impaired, and is totally dependent on staff for bed mobility, locomotion off and on unit, transfer, dressing, toilet use, personal hygiene, and bathing.</p> <p>During an initial tour observation and interview on 1/28/2024 at 10:45AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the tube feeding that connects to the gastrostomy tube [GT- a tube inserted into the stomach through a surgical incision use for feeding and administration of medication for a resident unable to swallow] was touching the floor in Resident 78's room. LVN 1 stated that the feeding tubing that connects to the G-tube tubing should not be on the floor because of infection control issue.</p> <p>During an interview on 1/31/2025 at 6:35PM with Assistant Director of Nursing (ADON), stated that if a resident's G-tube comes into contact with the floor, the tubing must be replaced due to infection control concerns. ADON stated the tubing should not be touching the floor.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program (IPCP), dated 12/2023, the P&P indicated an IPCP was established and maintained to provide a safe, sanitary and comfortable environment. The P&P indicated it was important to prevent the spread of infection by implementing infection control measures to avoid complications and the widespread of infection throughout the facility.</p> <p>50203</p> <p>4. During a review of Resident 77's Admission Record, the facility admitted Resident 77 on 10/11/2023 and readmitted Resident 77 on 11/19/2024 with diagnoses that included Amyotrophic Lateral Sclerosis (ALS a progressive disease that causes muscle weakness and paralysis), Chronic Respiratory Failure (the inability for the body to maintain adequate oxygen to the tissues), and artificial openings of gastrointestinal tract.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 77's care plan, revised on 10/18/2024, the care plan indicated Resident 77 was placed on EBPs due to being high risk for infection due to the placement of tracheostomy tube (a tube surgically inserted into the neck to the airway to assist with breathing). The interventions included hand hygiene during direct contact and provide EBP personal protective equipment (PPE, clothing and equipment that was worn or used to provide protect against hazardous substances and/or environments such as gloves, gowns, and masks).</p> <p>During a review of Resident 77's History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 11/20/2024, Resident 77 did have the capacity to understand and make decisions.</p> <p>During a review of Resident 77's care plan, revised on 11/20/2024, the care plan indicated Resident 77 was high risk for infection due to a current active infection and indwelling medical device. The interventions included perform hand hygiene, wear gowns and gloves while performing high contact activities: morning and evening cares, changing linens, providing hygiene, incontinence (loss of bladder control) cares, indwelling device (medical devices inserted into the body) care if indicated, and wound care if indicated.</p> <p>During a review of Resident 77's Order Summary Report (instructions that communicated the medical care that a resident received within the facility), an order date of 12/16/2024, indicated Resident 77 was placed on EBPs due to her tracheostomy and gastrostomy (g-tube, tube inserted into the stomach through the abdomen) tube.</p> <p>During a review of Resident 77's Minimum Data Set (MDS, a resident ' s assessment tool), dated 1/16/2025, Resident 77's cognitive (a person's mental process of thinking, learning, remembering, and using judgement) skills were intact. The MDS indicated Resident 77 was dependent (helper does all the effort. Resident does none of the effort to complete the activity) for activities of daily living (ADLs, activities such as bathing, dressing, and toileting a person performs daily) and functional mobility (a person ' s ability to move safely and independently within their environment). The MDS indicated Resident 77 had a feeding tube (a flexible, thin tube inserted into a person ' s stomach or small intestine to provide liquid nutrition), received tracheostomy (a tube surgically inserted in the neck to provide airway to the lungs) care, and was on a mechanical ventilator (a machine that moves air in and out of lungs).</p> <p>During an observation on 1/28/2025 at 10:06AM outside of Resident 77 ' s room, there was a EBP sign posted by the door and an isolation cart containing PPE.</p> <p>During an observation and interview on 1/29/2025 at 11:05AM with FM 2 and FM 3 in Resident 77 ' s room, FM 2 and FM 3 were inside Resident 77 ' s room without wearing PPE. FM 3 was leaning over Resident 77 ' s bed with her clothing touching Resident 77 ' s bed and gave Resident 77 a hug. FM 2 stated, she had not seen the licensed nurses wear gowns since late - October of 2024. FM 2 stated, the licensed nurses do not wear gowns when providing Resident 77 with g-tube care, changing her adult underwear, or changing her linens. FM 2 stated, she has seen the licensed nurses only wear gloves and mask when performing these close contact activities for Resident 77.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/29/2025 at 11:53AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, a resident was placed on enhanced barrier precautions if the resident had an indwelling medical device or an open wound. LVN 1 stated, it was important to wear PPE when in high contact with the resident or the resident ' s environment to prevent cross contamination and spread of infection to other residents, staff, and visitors.</p> <p>During an interview on 1/29/2025 at 12:08PM with Certified Nurse Assistant (CNA) 5, CNA 5 stated, it was important for staff and visitors to wear PPE for residents who EBPs when directly touching the resident or the resident ' s environment to prevent the spread of infection within the facility or at the visitor's home.</p> <p>During an observation on 1/29/2025 at 12:22PM in the hallway, FM 3 came out of Resident 77 ' s room holding a pile of used towels without gloves to put the used towels in the dirty linen cart.</p> <p>During an interview on 1/29/2025 at 2:40PM with the Infection Preventionist (IP), the IP stated residents who had indwelling devices or open wounds were placed on EBPs and required staff and visitors to wear PPE when interacting with the resident and the resident ' s environment. The IP stated, staff and visitors should wear PPE during certain high contact activities such as bathing, wound care, and dressing patients, even if they show no signs of infection. The IP stated, EBPs help prevent the spread MRDO when providing care.</p> <p>During a review of the facility ' s policies and procedures (P&P) titled Enhanced Barrier Precautions, revised 8/2022, the P&P indicated, EBPs were utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. The P&P indicated, high-contact resident care activities for EBP used included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (feeding tube, tracheostomy/ventilator), and wound care.</p>

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46779</p> <p>Based on observation, interview and record review, the facility failed to ensure resident's bedroom measured at least 80 square feet (sq. ft.-a unit of measurement) per resident in multiple resident bedrooms for 11 out of 39 resident's rooms. Rooms 5, 6, 8, 9, 11, 12, 14, 15, 16, 17, and 18 measured less than 80 sq. ft. per resident.</p> <p>This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents.</p> <p>Findings:</p> <p>During a concurrent interview and record review on 1/31/2025 at 3:30 PM, with the Administrator (ADM), the Client Accommodations Analysis (CAA- a form used to identify the room sizes and number of beds in the room), dated 1/28/2025, indicated there were 32 resident's bedrooms in the facility that measured less than 80 sq. ft. per resident care area. The CAA indicated 32 resident's bedrooms did not measure 80 sq. ft. per resident as listed below:</p> <table border="1"> <thead> <tr> <th>Room#</th> <th>Required Square Footage</th> <th>Square Footage</th> <th>Number of Beds</th> <th>Number of Resident</th> </tr> </thead> <tbody> <tr><td>5</td><td>240</td><td>194.4</td><td>3</td><td>2</td></tr> <tr><td>6</td><td>240</td><td>208.8</td><td>3</td><td>3</td></tr> <tr><td>8</td><td>240</td><td>192.1</td><td>3</td><td>2</td></tr> <tr><td>9</td><td>240</td><td>201.8</td><td>3</td><td>3</td></tr> <tr><td>11</td><td>240</td><td>198.6</td><td>3</td><td>3</td></tr> <tr><td>12</td><td>240</td><td>210.9</td><td>3</td><td>3</td></tr> <tr><td>14</td><td>160</td><td>143</td><td>2</td><td>2</td></tr> <tr><td>15</td><td>160</td><td>140.8</td><td>2</td><td>2</td></tr> <tr><td>16</td><td>320</td><td>284.6</td><td>4</td><td>1</td></tr> <tr><td>17</td><td>320</td><td>287</td><td>4</td><td>3</td></tr> <tr><td>18</td><td>160</td><td>142.4</td><td>2</td><td>2</td></tr> </tbody> </table> <p>(continued on next page)</p>	Room#	Required Square Footage	Square Footage	Number of Beds	Number of Resident	5	240	194.4	3	2	6	240	208.8	3	3	8	240	192.1	3	2	9	240	201.8	3	3	11	240	198.6	3	3	12	240	210.9	3	3	14	160	143	2	2	15	160	140.8	2	2	16	320	284.6	4	1	17	320	287	4	3	18	160	142.4	2	2
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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 1/28/2025 at 9:50 AM, in room [ROOM NUMBER], two staff were assisting one resident from the bed to a shower chair. one staff moved the bed toward to the wall and another resident pushed the bedside table toward to the space close to the head of the bed. The staff made enough room to move the shower chair next to the resident's bed, then, they assisted the resident transferred from the bed to the shower chair.</p> <p>During an interview on 1/28/2025 at 10:09 AM, with Resident 67. Resident 67 stated she and three other residents shared a room, and the current room size was enough to ambulate and move around. Resident 67 stated she did not see the care for her and her roommates was affected because of the current room size.</p> <p>During an interview on 1/28/2025 at 10:17 AM with Resident 3 stated she used a wheelchair, and the staff moved the bedside table, and her bed as needed to make the room for her wheelchair, so she could transfer from the bed to the wheelchair and from the wheelchair to the bed. Resident 3 stated she could get in and out from the room without any issue and the current room size did not affect her care.</p> <p>During an interview on 1/31/2025 at 3:50 PM with Restorative Nursing Assistant (RNA), RNA 2 stated there was no space issue for all the rooms and they were able to move different equipment into the room to provide care for residents without restriction. RNA 1 stated they were able to work with current room size and safely transfer residents by moving the bed and the bedside table aside to make rooms.</p> <p>During an interview on 1/31/2025 at 4:35 PM, with Certified Nursing Assistant (CNA) 2, CNA 2 stated there was no problem with the current room size and they could move the bed, nightstand and bedside table aside to make space to allow different equipment to go in and out of the room as needed. CNA 2 stated the current room size did not affect the staff providing care to the residents.</p> <p>During the re-certification survey observations, and interviews with residents and facility staff between 1/28/2025 and 1/31/2025, the above listed rooms had sufficient space for the residents ' freedom of movement. The rooms had adequate space to provide nursing care, privacy during care, and the ability to maneuver resident care equipment with the room. The room size did not present any adverse effect on the residents ' personal space, nursing care, and comfort.</p> <p>During the review of the facility ' s Variance request, dated 1/28/2025 indicated that granting the variance will not adversely affect the residents ' health and safety or impede the ability of any residents to obtain their highest level of partible wellbeing.</p>		

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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 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878</p> <p>Based on observation, interview, and record review, the facility failed to maintain a resident ' s call light in operating condition for three of four residents sampled (Resident 5, 48 and 62).</p> <p>This deficient practice had the potential for unmet resident ' s needs and calls for assistance that, may cause negative outcomes such as accidents/injury and/or anxiety (fear of the unknow) and depression (a severe feeling of hopelessness and sadness).</p> <p>Findings:</p> <p>1. During a review of Resident 5 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included Chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), Alzheimer disease (a progressive disease that destroys memory and other important mental functions).</p> <p>During a review of Resident 5 ' s History and Physical [H&P] dated 10/27/2024, the H&P indicated the resident does not have the capacity to understand and make decisions.</p> <p>During a review of Resident 5 ' s Risk for falls and injury care plan revised on 10/04/2024 with a goal to reduce risk of falls and injury included an intervention to keep call light within easy reach and encourage resident to use it to get assistance.</p> <p>2. During a review of Resident 48 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included Cerebral infarction (occurs when blood flow to the brain is interrupted, causing brain cells to die), Hemiplegia and Hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body) following Cerebral infarction affecting right dominant side.</p> <p>During a review of Resident 48 ' s History and Physical [H&P] dated 7/23/2024, the H&P indicated the resident has the capacity to understand and make decisions.</p> <p>During a review of Resident 48 ' s Risk for Fall care plan revised on 1/17/2025 with a goal to reduce risk of falls and injury included an intervention to keep call light within easy reach and encourage resident to use it to get assistance.</p> <p>3. During a review of Resident 62 ' s Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated a readmission to the facility on [DATE] with diagnoses that included of Hemiplegia and Hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body) following Cerebral infarction affecting right dominant side, Aphasia(a disorder that affects how you communicate).</p> <p>During a review of Resident 62 ' s History and Physical [H&P] dated 11/22/2024, the H&P indicated the resident is able to make decisions for activities of daily living.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 62 ' s Risk for Fall and injury care plan revised on 7/03/2024 with a goal to reduce risk of falls and injury included an intervention to keep call light within easy reach and encourage resident to use it to get assistance.</p> <p>During a concurrent observation and interview with Resident 5, inside Resident 5 ' s ,48 and 62's room, on 1/28/2025 at 10:40 AM, Resident 5's call light was observed in Resident 5's hand. Resident 5's call light was observed plugged into the wall. Resident - stated he had pressed the call light over and over for a while and no one had come to as he wanted a snack because he was hungry.</p> <p>During a concurrent observation and interview on 1/28/2025 at 10:42 AM with Infection Preventionist Nurse (IPN) and Assistant Director of Nursing (ADON). The ADON confirmed the call light was not turning on outside to indicate Resident 5 ' s call lights had been pressed. The ADON stated the call light was also not lighting up at the nurse's station. The IPN was observed pressing the call lights for Residents 48 and 62 in the room and checked outside by ADON who verified the light was not turning on outside the resident room or at the nurse's station to indicate the call lights had been pressed for all three residents' beds. The ADON stated the Maintenance Supervisor would need to be contacted and ask him to fix the call lights.</p> <p>During an interview on 1/31/2025 at 8:30 AM with Maintenance Supervisor (MS), MS stated he checks the call lights daily along with Maintenance Assistant and during the day the call light is checked by the nurse or the certified nursing assistant (CNA). MS stated it had not been reported to the Maintenance department that Resident ' s 5, 48 and 62 ' s call light was not working outside the room and at the nurse's station.</p> <p>During an interview on 1/31/2025 at 4:00 PM- with Director of Nursing (DON), the DON stated it is important for all the residents to have working call lights to let nursing staff know when a resident needs assistance and to prevent falls, injuries and delay care.</p> <p>During a review of the facility's policy and procedure (P&P) titled Maintenance Service dated with a revised date of December 2009, indicated The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .g. maintaining the paging system in good working order.</p>		