

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Presbyterian Intercomm Hosp Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 Washington Blvd. Whittier, CA 90602	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote dignity and respect when a care view camera (a specialized camera designed for patient monitoring in healthcare setting that allows healthcare professionals to remotely observe residents and intervene if necessary, typically for safety purposes like fall prevention) was placed in the resident's room for four (4) of eight (8) sampled residents (Residents 33, 49, 60 and 64). This failure resulted in Resident 33, 49, 60 and 64 experiencing feelings of discomfort and not having any personal privacy.1. During a review of Resident 49's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of septic discitis (infection discitis; a serious condition where the intervertebral [a flat, round & cushioned; located between each vertebra {small, bony segments that make up the spine or backbone} in the spine, acting as a shock absorber and allowing for movement] disc spaces in the spine become inflamed due to infection) and lumbar stenosis (a condition where the spinal canal in the lower back narrows, compressing the spinal cord and nerves).During a review of Resident 49's Minimum Data Set (MDS & a resident assessment tool), dated 7/1/2025, the MDS indicated the resident had an intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 49 needed substantial/maximal assistance (helper does more than half the effort) with going from a sitting to a standing position and going from lying down to sitting on the side of the bed and needed partial/moderate assistance (helper does less than half the effort with putting on/taking off footwear. Resident 49 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for personal hygiene and eating. During a review of Resident 49's Patient Transfer Orders dated 7/17/2025, Resident 49's Patient Transfer Orders indicated an order from 6/24/2025 for remote monitor camera.During a concurrent observation in Resident 49's room and interview on 7/17/2025 at 8:20 AM with Certified Nursing Assistant 2 (CNA 2), Resident 49 was observed lying down in bed watching television. A care view camera was observed on the wall, directly across from Resident 49. There was no posted signage observed outside or inside the room directly in front of or around Resident 49 indicating there was a video surveillance. CNA 2 stated there was no posted signage in the room and that there is usually a sign indicating there is video surveillance but not in this room. During a concurrent observation and interview on 7/17/2025 at 8:40 AM with Resident 49 in his room, a sign indicating video monitoring was in progress was observed on the wall directly across from the resident under the care view camera. Resident 49 stated the camera has been up for about three (3) to 4 weeks and it was the first time he had ever seen the sign indicating video monitoring was in progress. Resident 49 stated the staff have never spoken to him about the camera prior to it being utilized and that he feels as if it is an invasion of his privacy and stated he would equate it to putting a camera in a bathroom.During an interview on 7/18/2025 at 9:32 AM with Resident 49, Resident 49 stated he is not a fan of cameras and has no real privacy other than when staff are assisting him with being changed and they call to let the technician know to turn the camera off. Resident 49 stated he did not sign or agree to sign a consent and feels as if the facility just gave him the run around and does not know who is watching him. Resident 49 stated that whoever is watching him can use what they see against him. During an interview on 7/18/2025 at 11:57 AM with Resident 49, Resident 49 stated before yesterday, there was no sign to let himself, his family or visitors know that there was video surveillance in his room and stated he understand the use of cameras in hallways and the hospital entrance but not in the room.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. During a review of Resident 60's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of acute kidney injury (AKI; a rapid decline in kidney function, typically indicated by an increased in serum creatinine [a waste product produced by the body from the normal breakdown of muscle tissue and the digestion of protein] or a decrease in urine output) and acute (sudden/short duration) metabolic encephalopathy (a condition where brain dysfunction arises from metabolic or chemical imbalances in the body).During a review of Resident 60's MDS, dated [DATE], the MDS indicated the resident had an intact cognitive skills for daily decision making. Resident 60 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toilet transfers (the ability to get on and off a toilet or commode) and showers/bathing self (the ability to bathe self, including washing, rinsing, and drying self [excludes washing or back and hair], and needed substantial/maximal assistance with putting on/taking off footwear and lower body dressing. Resident 60 needed partial/moderate assistance with chair/bed-to-chair transfers, going from sitting to a standing position, personal hygiene and eating.During a review of Resident 60's Patient Transfer Orders dated 7/17/2025, the Patient Transfer Orders indicated an order on 7/17/2025 for remote monitor camera.During a concurrent observation in Resident 60's room and interview on 7/17/2025 at 8:20 AM with CNA 2, Resident 60 was observed lying down in bed and CNA 2 was setting up to provide the resident with morning care. A care view camera was observed on the wall, directly across from Resident 60. There was no posted signage observed outside or inside the room directly in front of or around Resident 60 indicating there was a video surveillance. CNA 2 stated there was no posted signage in the room and that there is usually a sign indicating there is video surveillance but not in this room.During an interview on 7/18/2025 at 10:38 AM with Resident 60's Family Representative (FR 1), Resident 60's Family Representative stated on 7/3/2025 when Resident 60 was transferred to the unit, the care view camera was already up. FR 1 further stated both she & the resident were not educated about the camera prior to it being utilized.</p> <p>3. During a review of Resident 64's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of left foot fracture (a break in one of more bones in the foot) and gastroesophageal reflux disease (GERD; a condition where the stomach contents flow back up into the esophagus [a muscular tube that acts as a passageway for food and liquids, transporting them from the throat to the stomach], causing irritation and discomfort).During a review of Resident 64's MDS, dated [DATE], the MDS indicated the resident had an intact cognitive skills for daily decision making. Resident 64 was dependent with putting on/taking off footwear and lower body dressing. Resident 64 needed substantial/maximal assistance with chair/bed-to-chair transfers and going from a sitting position to a standing position and needed setup or clean-up assistance (helper sets up or cleans up; resident completes the activity) with personal hygiene and eating. During a review of Resident 64's Patient Orders dated 7/18/2025, the Patient Orders indicated an order from 7/2/2025 for remote monitor camera.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation in Resident 64's room and interview on 7/18/2025 at 9:38 AM, Resident 64 was observed lying down in bed. A Care View Camera was observed on the wall across from the resident. Resident 64 stated she did not know anything about the camera and did not think it was on. Resident 64 stated she hoped it was not on because she would not want someone watching her at all and if she found out someone was watching her it would not be a happy day for her. Resident 64 also stated that it is important that whoever lies in the bed she is in knows about the camera and whether it is on or not. Resident 64 stated she did not remember if anyone had spoken to her about the camera and did not sign any consent for it. During an interview on 7/17/2025 at 9:25 AM with the Director of Nursing (DON), the DON stated there is no official consent obtained for the use of the care view camera other than patient or family representative education that is to be initiated prior to the camera being utilized. The DON also stated that prior to the care view camera being initiated, a sign is supposed to go up in the room to make patients and visitors aware that the room is under the care view safety video surveillance remote monitoring.</p> <p>During an interview on 7/18/2025 at 11:02 AM with DON, the DON stated the care view cameras were implemented around July 2023, which were utilized for residents who were usually confused and/or forgetful. The DON stated the staff check with the residents throughout the day to see how they are in general. The DON added if there are any conversations that come up regarding the residents being uncomfortable with the care view camera, they would gather more information and provide the residents with a refusal form. The DON further stated a follow-up assessment should be done especially when a resident's mentation improves and that it would be an opportunity to check in on the resident regarding this area.</p> <p>4. During a review of Resident 33's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included pancytopenia (a condition in which there is lower than normal number of red and white blood cells and platelets in the blood) and chronic lymphocytic leukemia (a type of cancer where the bone marrow [soft spongy tissue inside the bone] makes too much abnormal white blood cells called lymphocytes).</p> <p>During a review of Resident 33's Physician's Order, dated 6/29/2025, timed at 1:59 AM, the Physicians Order indicated to place a remote monitor camera in the resident's room.</p> <p>During a review of Resident 33's Minimum Data Set (MDS, a resident assessment tool), dated 7/9/2025, the MDS indicated Resident 33 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 33 required supervision (helper provides cues) with toileting and personal hygiene, shower, upper and lower body dressing and putting on/taking off footwear. The MDS further indicated Resident 33 was independent (resident completes the activity by themselves with no assistance from helper) with eating and oral hygiene.</p> <p>During an observation in Resident 33's room on 7/15/2025 at 4:28 PM, Resident 33 was lying in bed with a video camera inside the room located on top of the ceiling facing the resident.</p> <p>During an observation and interview on 7/17/2025 at 8:37 AM, Resident 33 was lying in bed with no sign posted inside or outside the resident's room indicating the room is under surveillance while video camera was in use. Resident 33 stated, "It was an off feeling knowing I was being watched 24/7 (24 hours and 7 days)." Resident 33 stated he had not seen a sign posted indicating that there was video surveillance in his room since the camera went up.</p> <p>(continued on next page)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>(continued on next page)</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy titled, Resident Assessment Instrument (RAI - a standardized process used in nursing homes to collect information about residents' needs and strengths, enabling the creation of individualized care plans) Process, for two (2) of six (6) sampled residents (Residents 46 and 57) by not ensuring the comprehensive resident assessment was completed within 14 calendar days of resident's admission. This failure had the potential to result in Residents 46 and 57 not having an individualized care plan, which could negatively affect the residents' over all wellbeing.1. During a review of Resident 46's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of metastatic (the spread of cancerous [a disease in which cells grow and divide abnormally, without control] cells from the original [primary] tumor to other parts of the body, forming new tumors [metastases] in those locations) renal cell carcinoma (kidney cancer) and encephalopathy (a disturbance in brain function). During a review of Resident 46's History and Physical Examination (H&P) dated, 6/13/2025, the H&P indicated Resident 46 was alert and oriented times 3 (a person is awake, alert and aware of their identity, location and the current time) with appropriate affect (when a person's emotional expression) {facial expression, body language, or tone of voice matches the situation and their thoughts or what they are saying}. During a concurrent interview and record review on 7/17/2025 at 9:50 AM with Minimum Data Set (a resident assessment tool) Nurse 2 (MDS Nurse 2), Resident 46's Electronic Medical Record (EMR; a digital collection of a patient's health information that is stored and accessed electronically) was reviewed. MDS Nurse 2 stated Resident 46's EMR indicated that the resident's comprehensive assessment, which was due 14 days after admission, was not done. MDS Nurse 2 stated Resident 46's last admission was on 6/12/2025 and the comprehensive assessment would have been due on 6/26/2025. MDS Nurse 2 stated the purpose of the comprehensive assessment is to evaluate the resident and see how the resident was progressing with things such as physical therapy (PT; a medical treatment used to restore functional movements such as standing, walking and moving different body parts) and occupational therapy (OT; helps people participate in their everyday activities by addressing physical, cognitive, emotional, or developmental challenges). During the same interview on 7/17/2025 at 9:50 AM with MDS Nurse 2, MDS Nurse 2 stated the comprehensive MDS assessment reflects the resident's skin, pain, medication, and cognition. MDS Nurse 2 stated it is a snapshot of how the resident is which could be a reference for the resident's care plan. 2. During a review of Resident 57's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of pyelonephritis (a type of urinary tract infection [UTI; an infection in the bladder/urinary tract] that specifically affects one or both kidneys) and chronic respiratory failure (a long-term condition where the respiratory system cannot adequately exchange oxygen and carbon dioxide leading to low blood oxygen levels and/or high carbon dioxide levels) with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues).During a concurrent interview and record review on 7/17/2025 at 9:54 AM with MDS Nurse 2, Resident 57's EMR was reviewed. MDS Nurse 2 stated Resident 57's EMR indicated that the comprehensive assessment that was due 14 days after the resident's admission was not and should have been done. MDS Nurse 2 stated Resident 57 was admitted on [DATE] and the resident's comprehensive assessment would have been due on 6/20/2025. and was not done.During a review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument (RAI) Process, revised 7/3/2025, the P&P indicated, The RAI is a process that assists in the Transitional Care Unit (TCU) staff to consistently and accurately gather information regarding the resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified through the use of Minimum Data Set (MDS). The information gathered will be used to formulate an individualized interdisciplinary plan of care for the resident during their stay in TCU. The P&P also indicated, The RAI is a comprehensive assessment that consist of three major sections: MDS, Care Area Assessments (CAAs) and Utilization Guidelines. The P&P further indicated:a. The MDS i. The MDS must be completed timely and accurately with appropriate signatures form the interdisciplinary team.b. The RAI assessments consist of two types: i. Omnibus Budget Reconciliation Act (OBRA) Assessments are Federally mandated, and must be completed timely and accurately on all residents regardless of payor source by the assigned due date:1. admission: (required by 14th calendar day of resident's admission) (admission date + 13 calendar days) c. Care Area</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete and transmit a discharge tracking assessment (a type of assessment conducted when a resident leaves a nursing home, which includes clinical items for quality monitoring as well as discharge tracking and is transmitted to the Centers for Medicare and Medicaid Services [CMS; a United States government agency that administers healthcare programs]) for one (1) of five (5) sampled residents (Resident 57). This failure had the potential to result in the facility's inaccurate quality monitoring data at transition points, such as when residents enter or leave the facility. During a review of Resident 57's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of pyelonephritis (a type of urinary tract infection [UTI; an infection in the bladder/urinary tract] that specifically affects one or both kidneys) and chronic respiratory failure (a long-term condition where the respiratory system cannot adequately exchange oxygen and carbon dioxide leading to low blood oxygen levels and/or high carbon dioxide levels) with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues).During a concurrent interview and record review on 7/17/2025 at 4:36 PM with Minimum Data Set (a resident assessment tool) Nurse 2 (MDS Nurse 2), Resident 57's Electronic Medical Record (EMR; a digital collection of a patient's health information that is stored and accessed electronically) was reviewed. MDS Nurse 2 stated Resident 57's Electronic Medical Record indicated there was no MDS discharge tracking assessment completed and therefore was not transmitted 14 days after Resident 57 was discharged from the facility on 6/20/2025. MDS Nurse 2 stated Resident 57 was discharged on 6/20/2025 and the discharge MDS would have been due on 7/4/2025. MDS Nurse 2 stated the discharge MDS assessment was not and should have been done. MDS Nurse 2 stated it is important that a discharge MDS is completed and transmitted to CMS because its purpose is to show the resident's progress of the time the resident was admitted to the facility and how they were when they were discharged . During a review of the facility's policy and procedure (P&P) titled Resident Assessment Instrument (RAI) Process revised 7/3/2025, the P&P indicated, The RAI is a process that assists in the Transitional Care Unit (TCU) staff to consistently and accurately gather information regarding the resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified through the use of Minimum Data Set (MDS). The information gathered will be used to formulate an individualized interdisciplinary plan of care for the resident during their stay in TCU. The P&P also indicated, The RAI is a comprehensive assessment that consist of three major sections: MDS, Care Area Assessments (CAAs) and Utilization Guidelines. The P&P further indicated:a. The MDS i. The MDS must be completed timely and accurately with appropriate signatures form the interdisciplinary team.b. The RAI assessments consist of two types: i. Omnibus Budget Reconciliation Act (OBRA) Assessments are Federally mandated, and must be completed timely and accurately on all residents regardless of payor source by the assigned due date:1. discharge: discharge date + 14 calendar days. ii. Medicare Prospective Payment Systems (PPS) Assessments1. Part A PPS Discharge Assessment.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of 1 sampled Resident (Resident 65) who was receiving nutrition by nasogastric tube feeding (NGT - a method of providing nutrition and medication directly into the stomach through a tube inserted through the nose) was provided care to prevent aspiration by failing to ensure the resident's head of the bed was elevated during feeding in accordance with the facility's policy. This deficient practice placed Resident 65 at risk of aspiration (feeding could enter the windpipe and lungs) that could lead to lung problems such as pneumonia (an infection/inflammation of the lungs). Findings:During a review of Resident 65's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dementia (a progressive state of decline in mental abilities). During a review of Resident 65's Care Plan, initiated on 7/3/2025, the Care Plan indicated staff intervention included was to keep resident's head of bed (HOB) over 30 degrees while on NGT feeding. During a review of Resident 65's Physicians order, the Physicians order indicated tube feeding, continuous drip, Glucerna (tube feeding formulas for residents with diabetes) 1.2 1 liter 40 milliliters (ml, unit of measure per liquid)/hour. During a review of Resident 65's Minimum Data Set (MDS- a federally mandated assessment tool), dated 7/9/2025, the MDS indicated Resident 65 had severe cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision and functional abilities were not attempted. The MDS also indicated Resident 65 had an NGT. During a concurrent observation and interview with Certified Nursing Assistant 3 (CNA 3) on 7/16/2025 at 8:52 AM, Resident 65 was in bed receiving Glucerna 40 ml/hour via NGT. Resident 65 was observed sliding down in bed. CNA 3 stated Resident 65's head was not and should be at 30 degrees. During an interview on 7/16/2025 at 1:46 PM, Registered Nurse 1 (RN 1) stated, Resident 65 HOB should be at least 30 degrees or higher to prevent aspiration of the tube feeding. During an interview on 7/17/2025 at 3:51 PM, the Director of Nursing (DON) stated the HOB of Resident 65 should be at 30 degrees and above during tube feeding to prevent aspiration. During a review of the facility's Policy and Procedure (P&P) titled, Enteral Feedings (a way to provide nutrition directly into the stomach when the person is unable to eat or drink enough on their own) in Adult Patient, the P&P revised 7/3/2023, indicated that the patient should be prepared prior to the initiation of enteral feeding and positioned properly by elevating the backrest to a minimum angle of 30 degree and preferably 45 degrees.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555654	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2025
NAME OF PROVIDER OR SUPPLIER Presbyterian Intercomm Hosp Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 12401 Washington Blvd. Whittier, CA 90602	
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer a medication for one (1) of seven (7) sampled residents (Resident 5) as indicated on the physician's order. This failure had the potential to place Resident 5 at risk for developing a Urinary Tract Infection (UTI; an infection in the bladder/urinary tract) due to not receiving her Estradiol (hormone medication used for regulating various bodily processes). During a review of Resident 5's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD; a chronic lung disease causing difficulty in breathing) and coronary artery disease (CAD; a condition where the blood vessels that supply the heart become narrowed or blocked). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated (date), the MDS indicated the resident had intact cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 5 needed supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with walking 10 feet, car transfers (the ability to transfer in and out of a car or van on the passenger side), chair/bed-to-chair transfers and lower body dressing (the ability to dress and undress below the waist). Resident 5 was independent with going from lying down to sitting on the side of the bed, upper body dressing (the ability to dress and undress above the waist), personal hygiene and eating. During a review of Resident 5's Patient Transfer Orders, dated 7/16/2025, the Patient Transfer Orders indicated an order on 7/2/2025 for Estradiol vaginal cream, 1 application daily at bedtime for genitourinary syndrome of menopause (GSM; a condition in postmenopausal [12 months after the final menstrual period] women where the genital and urinary tracts are affected due to hormonal changes and encompasses a range of symptoms such as urinary discomfort and increased risk for urinary tract infections). During a review of Resident 5's Medication Administration Report, dated from 7/1/2025 to 7/16/2025, the Medication Administration Report indicated on 7/10/2025 at 6:13 AM Resident 5's Estradiol was not given due to not being available. During an interview on 7/15/2025 at 10:49 AM with Resident 5, Resident 5 stated the facility lost her Estradiol medication and did not receive it for two nights in a row. Resident 5 stated she needs to use this medication to prevent her from getting a UTI. During a concurrent interview and record review on 7/16/2025 at 3:23 PM with Clinical Nurse Manager (CNM), Resident 5's Electronic Medical Record (EMR; a digital version of a patient's health information that is stored and accessed electronically) was reviewed. Resident 5's EMR indicated the resident had an order for Estradiol every night at bedtime and that it was not given on the night of 7/9/2025 due to it not being available. CNM stated if a medication is not available, they would send a dose request to pharmacy. During the same concurrent interview and record review on 7/16/2025 at 3:23 PM with CNM, CNM stated if a dose is missed, the resident's physician (MD) should be notified. The CNM stated there was no documentation of the MD being notified of Resident 5 missing her Estradiol dose on 7/9/2025. CNM stated it is important to notify the MD since it is a prescribed medication that was ordered to be given and was not received by the resident. During a concurrent interview and record review on 7/17/2025 at 4:41 PM with MDS Nurse 2 (MDS Nurse 2), Resident 5's EMR was reviewed. MDS Nurse 2 stated Resident 5's EMR indicated Resident 5 did not receive her Estradiol cream as ordered on 7/9/2025 at bedtime due to it not being available. MDS Nurse 2 stated normally if a medication is not available, they would send a message to pharmacy for either an anticipated dose or if they need another dose, which would in turn be delivered into the resident's bin. MDS Nurse 2 stated the MD should be notified if a dose is missed. MDS Nurse 2 further stated the documentation found in Resident 5's EMR only indicated it was not given on 7/9/2025 due to it not being available and no documentation could be found of the medication being requested from pharmacy or that the MD was notified. During an interview on 7/17/2025 at 4:49 PM with the Director of Nursing (DON), the DON stated their process for a medication that is not available is to use the pharmacy messenger request to have it delivered and if the medication is marked off as not given regardless of what the reason may be, the MD needs to be notified. The DON stated it is important to notify the MD so the MD could decide if an alternative could be given and for the staff to know what the next step in the process would be. During a concurrent interview and record review on 7/18/2025 at 9:08 AM with CNM, the facility's policy and procedure (P&P) titled, Medication Administration in Adults and Pediatrics, revised 9/27/2023 was reviewed. The P&P indicated, If missing or delayed administration of medication has altered treatment plan or posed realized or unrealized harm to patient the prescribing</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have accurate and complete medical records for one (1) of seven (7) sampled residents (Residents 60) by failing to document the Nurse Practitioner (NP, a registered nurse with advanced education and training, holding a master's or doctoral degree in nursing) notification of Resident 60's refusal to take Atenolol (drug used to treat high blood pressure) in accordance with the facility's policy. This deficient practice resulted in the inaccurate representation of care provided which could delay the provision of necessary care and services needed for Resident 60's wellbeing. Findings: During a review of Resident 60's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included urinary retention (a condition in which the resident is unable to empty all the urine from his bladder) and acute kidney injury (sudden and rapid decline in kidney function). During a review of Resident 60's Minimum Data Set (MDS, a resident assessment tool), dated 7/15/2025, the MDS indicated Resident 60 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 60 was dependent (helper does all the effort) with toileting and shower and required substantial/maximal assistance (helper does more than half the effort) with lower body dressing and putting on and taking off footwear. The MDS further indicated Resident 60 required partial/moderate assistance (helper does less than half the effort) with eating, oral hygiene, and upper body dressing. During a review of Resident 60's Physician's order summary, the Physicians order summary indicated an order for Atenolol 50 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount daily and to hold for Systolic Blood Pressure (SBP, the pressure in the arteries when the heart beats) below 100 -millimeter mercury (mmHg, units used to measure blood pressure). During a medication pass observation with Registered Nurse 1 (RN 1) on 7/17/2025 at 9:30 AM, Resident 60's SBP indicated a reading of 108 mmHg. Resident 60 refused the Atenolol 50 mg daily dose offered by RN 1 and stated his SBP was ok. During a review of Resident 60's Medication Administration Record (MAR) on 7/18/2025, the MAR indicated to hold Atenolol for SBP below 100 mmHg. The MAR did not indicate the reason Resident 60's Atenolol was not administered and the NP notification of the refusal. During a concurrent record review and interview on 7/18/2025 at 9:03 AM, RN 1 stated Resident 60's medical records did not reflect that she notified the NP of the resident's refusal for Atenolol. RN 1 stated she did not but should have documented the NP notification of the resident's refusal for Atenolol in the resident's medical records. RN 1 stated it was important to document the NP notification since it would be considered not done if it was not documented. During an interview on 7/18/2025 at 9:09 AM, the Clinical Nurse Manger (CNM) stated that because it was an ordered medication for certain treatments, there could be risks from missing the medication and so it needs to be documented that the physician was made aware. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration in Adults and Pediatrics, revised 9/27/2023, the P&P indicated that medications not administered should have the reason for not administering documented in the MAR. The P&P also indicated that if the patient refuses the medication, ordering physician will be notified and documented in the MAR.</p>		