STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555787	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Nursing and Wellness Center, Inc	7926 S Painter Ave 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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the facility ' s policy and procedure [P&P] titled Admission Assessment and Follow Up: Role of the Nurse, for one of two sampled residents (Resident 1) when it failed to ensure all appropriate discharge orders from General Acute Care Hospital (GACH) 3 were verified with the attending physician (Physician 1) upon Resident 1 ' s readmission to the facility on [DATE]. This deficient practice could result in Resident 1 not receiving emergency medications such as Narcan (is a medicine that treat someone from fentanyl or prescription opioid medicine overdose) needed to treat opioid overdose. Findings: During a review of Resident 1 ' s GACH 3 records titled History and Physical dated [DATE], indicated [Resident 1] was found slumped [sitting with the body leaning forward, for example, because a person was asleep or unconscious] over in the wheelchair, then became unresponsive. No seizure [a sudden, uncontrolled movement] activity noted. Resident 1 was started on CPR (cardiopulmonary resuscitation, [an emergency treatment that's done when someone's breathing or heartbeat has stopped]) when paramedics arrived. Resident 1 was noted with agonal breathing (when someone who is not getting enough oxygen is gasping for air) and pinpoint pupils [a condition where the pupils of the eyes appear unusually small] with Glasgow coma scale (used to objectively describe the extent of impaired consciousness) of 3 (is the lowest possible score and is associated with an extremely high mortality rate). Resident 1 was given Narcan (is a medicine that treat someone from fentanyl or prescription opioid medicine overdose) with improvement. During a review of Resident 1 ' s GACH 3 Urine Drug Screen [UDS] dated [DATE] timed at 12:15 PM, the urine drug screen indicated Resident 1 ' s urine indicated Presumptive Positive for Fentanyl Urine and Opiates, Urine. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555787	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

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F 0635

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of Resident 1 ' s GACH 3 Physician Progress Notes dated [DATE], the Progress Notes indicated Resident 1 ' s Chest X-ray [a way for providers to get pictures of the inside of your body] and CT [Computed Tomography - an imaging test that helps healthcare providers detect diseases and injuries] of the head did not indicate any acute abnormal process. The GACH 3 Physician Progress Notes indicated under Problem List, indicated Resident 1 syncope, unresponsiveness, opiate overdose, possible respiratory arrest due to accidental fentanyl overdose, and fentanyl/opioid positive on UDS. The Progress Notes further indicated, to continue to monitor Resident 1 ' s vital signs and administer Narcan as needed.

A review of GACH 3 ' s Patient ' s Home Medications added during Discharge Reconciliation dated [DATE], indicated a list of Resident 1 ' s medications ordered from GACH 3.

Narcan 4 milligrams/ 0.1 milliliters nasal spray, 1 spray intranasally every 8 hours as needed for opioid overdose.

During a review of Resident 1 ' s facility records titled Admission Record indicated a facility readmission on [DATE], with diagnoses that included flaccid hemiplegia (a neurological condition characterized by weakness or paralysis and reduced muscle tone) affecting left non dominant side, chronic obstructive pulmonary disease (COPD -a group of lung diseases that block airflow and make it difficult to breathe).

During a review of Resident 1 ' s facility records titled Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool) dated [DATE], the MDS indicated the Resident 1 had moderately impaired cognition (thought process).

During a review of Resident 1 ' s facility records titled History and Physical (H&P) dated [DATE], indicated the resident had fluctuating capacity to understand and make decisions.

During a review of Resident 1 ' s facility records titled Nursing Admission Screening/History dated [DATE] indicated Resident 1 was readmitted back to the facility from GACH 3 with the following reasons . Possible respiratory arrest . Unresponsive and Syncope.

During a review of Resident 1 ' s facility records titled Telephone Order (TO) dated [DATE], the TO indicated Physician 1 ' s telephone orders to continue previous medications and treatments as ordered.

During an interview on [DATE] at 4:29 PM with the Director of Nursing (DON), and concurrent record review of Resident ' s 1 current Order Summary Report, the DON stated there was no documented evidence that Resident 1 ' s Narcan medication was ordered upon Resident ' s 1 readmission back to the facility on [DATE] by Resident 1 ' s primary physician, as indicated in the GACH 3 discharge orders.

(continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:30 PM, the DON stated it is a standard of practice and expected that the admitting licensed nurse should review all GACH records and care plans when completing a resident admission or readmission to ensure all admission orders are addressed with the resident ' s Physician. The DON stated she was Resident 1 ' s admission nurse and did not see the Narcan order. The DON stated, if I would have seen I would have notified Resident 1 ' s physician and completed a drug regimen review for Resident 1. The DON stated she spoke to Resident 1 ' s physician and informed him there were no changes to Resident 1 ' s previous medications, she did not read each discharge medication orders one by one to Resident 1 ' s Physician over the phone. A review of facility policy and procedure titled Admission Assessment and Follow Up: Role of the Nurse with a revision date of [DATE] indicated, 11. Reconcile the list of medications from the medication history, admitting orders, the previous medication administration review (if available), and the discharge summary from the previous institution, according to established procedures. 12. Contact attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders that are based on these findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48661 Based on observation, interview, and record review the facility failed to manage a resident ' s pain timely and effectively for one of two sampled residents (Resident 1), in accordance with the facility ' s policy and procedure titled Pain Assessment and Management, by failing to: 1. Follow the General Acute Care Hospital (GACH) 1 recommendations on pain management and the physician ' s order for Norco as needed for severe pain dated [DATE]. 2. Follow up with the pharmacy to ensure the ordered pain medication [Norco] was received and delivered timely. 3. Notify the physician when Resident 1 ' s pain management regimen was ineffective, and the resident received pain medication for mild pain [Ibuprofen], almost daily. 4. Update Resident 1 ' s Pain Care Plan to reflect specific resident-centered interventions needed to relieve the resident ' s pain. 5. Implement the facility ' s policy & procedure (P&P) titled Pain Assessment and Management that included monitoring for the effectiveness of interventions and modifying approaches as necessary. Assessing pain consists of identifying characteristics of pain and the pattern of pain. Report the following information to the physician or practitioner: prolonged, unrelieved pain despite care plan interventions. These deficient practices resulted in Resident 1 taking an unknown medication to relieve moderate to severe pain and was sent to GACH for an overdose of Fentanyl (a potent synthetic opioid drug used as pain relief and anesthetic) with the potential of having a negative effect on the resident ' s physical comfort and psychosocial well-being. Findings: A review of Resident 1 ' s GACH 1 record dated [DATE], indicated the resident was evaluated for left arm pain and prescribed Norco ,d+[DATE] (Hydrocodone bitartrate 5 mg [unit of measurement] and Acetaminophen 325 mg) mg per tablet, take one tablet by mouth every six hours as needed for severe pain (, d+[DATE]) for up to five days. During a review of Resident 1 ' s GACH 2 records titled History and Physical [H&P] Report dated [DATE], indicated the resident came to the emergency room for worsening left shoulder pain. The H&P indicated under Assessment and Plan to rule out stroke [a medical emergency that occurs when blood flow to the brain is disrupted, damaging or killing brain tissue], adjust psychiatric [relating to mental illness] medications and for pain management. The GACH 2 record indicated Resident 1 was discharged with Acetaminophen [over the counter pain medication] 325 mg oral tablet: two tablets orally every 4 hours, as needed, for mild pain (, d+[DATE]) pain scale. The GACH 2 record indicated the resident was discharged to the facility on [DATE]. The H&P under Social History indicated, Resident 1 has a remote history of smoking. Resident 1 has a history of drug abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s facility records titled Admission Record indicated a facility readmission on [DATE], with diagnoses that included flaccid hemiplegia (a neurological condition characterized by weakness or paralysis and reduced muscle tone) affecting left non dominant side, chronic obstructive pulmonary disease (COPD -a group of lung diseases that block airflow and make it difficult to breathe). A review of the facility records indicated Resident 1 ' s Change in Condition (COC) dated [DATE] timed at 8:40 AM, indicated the resident had intractable pain to the left shoulder with a pain level of 8 on the pain scale (a way to measure how much pain someone was experiencing - a score of 0 meant no pain, and 10 meant the worse pain you have ever known) with increased left shoulder weakness, and left shoulder limitation. The COC indicated the current pain reliever - Ibuprofen was ineffective. The COC indicated the physician was notified and the facility received orders to transfer the resident to GACH 1 for further evaluation. A review of the facility records indicated Resident 1 ' s PRN Pain Assessment Flowsheet dated from [DATE] to [DATE], the PRN Pain Assessment indicated the resident had generalized body pain with a pain level of 8 out of 10 on the pain scale. The PRN Pain Assessment Flowsheet indicated non-pharmacological interventions included repositioning, dim light/quiet environment, snack/drinks, 1:1 attention, re-direction, music, massage, or toileting. The PRN Pain Assessment Flowsheet indicated the non-pharmacological interventions were not effective and the resident ' s pain level was the same before the interventions were implemented, resulting in the resident receiving pain medication every time Resident 1 complained of pain. A review of the facility records indicated Resident 1 ' s Medication Administration Record (MAR) dated from [DATE] to [DATE], indicated the resident received Ibuprofen every day for the month of [DATE], except for four days. The MAR indicated for two of the four days Resident 1 did not receive Ibuprofen, the resident received Norco. A review of the facility records indicated Resident 1 ' s Minimum Data Set (MDS, a standardized resident assessment and care-planning tool) dated [DATE], indicated the resident had moderate cognitive impairment (could not navigate to new places, and they have significant difficulty completing complex tasks such as managing finances). The MDS indicated the resident had impairment on both upper and lower extremity sides and utilized a walker and a wheelchair for mobility devices. The MDS indicated the resident received scheduled and as needed (PRN) pain medication. The MDS indicated the resident had the presence of pain occasionally, the pain did not affect the resident ' s sleep, and Resident 1 ' s pain rarely interfered with the resident ' s day-to-day activities. The MDS indicated the residents pain scale was a three from a zero to 10 pain scale. A review of the facility records indicated Resident 1 ' s History and Physical (H&P) dated [DATE], indicated the resident had fluctuating capacity to understand and make decisions. A review of the facility records indicated Resident 1 ' s Drug Regimen Review on [DATE] timed at 7:59 PM, indicated the resident ' s primary admission diagnosis was chronic pain syndrome. The Drug Regimen Review indicated new medications ordered on admission included Tylenol oral tablet 325 mg (Acetaminophen) two tablets on 4-,d+[DATE] pain scale every six hours, Tylenol oral tablet 325 mg (Acetaminophen) one tablet on 1-,d+[DATE] pain scale every six hours, and Ibuprofen 600 mg PRN every 12 hours for pain scale 7-,d+[DATE]. The Drug Regimen Review indicated there were no potential medication issues noted, and the medications were reviewed by the pharmacist and the physician. (continued on next page)

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A review of the facility records indicated Resident 1 ' s Pain Care Plan dated [DATE], indicated the resident had neuropathic pain related to diagnoses. The Care Plan goal indicated the resident would verbalize and/or show decrease physical signs in pain with pain relieving strategies. The Care Plan interventions included assessing level of pain using the pain rating scale, implement non-pharmacological interventions of repositioning and dim lighting, and provide relaxation techniques. The Care Plan interventions continued with aromatherapy, reassuring words/gestures, administer pain medication as ordered, monitor response using pain scale related to medications, treatments, and procedures, and evaluate the need to provide medications prior to treatment or therapy.

During a review of Resident 1 ' s facility records titled Order summary Report indicated the following active medication orders for Resident 1 dated [DATE]:

Amlodipine Besylate (medication for blood pressure) 10 milligram [mg - unit of measurement] one time a day.

Aspirin 81 mg (medication for CVA) 81 milligram one time a day.

Ativan (medication for anxiety) 0.5 mg two times a day.

Folic Acid (medication for anemia) 1 mg one time a day.

Gabapentin (medication for numbness and pain from nerve damage) 300 mg three times a day.

Ibuprofen (medication for pain) 600 mg as needed every 12 hours.

Lactulose (medication to prevent complication of liver disease) 10 grams in 15 mg, one time a day.

Lidocaine patch (medication for pain) 5% apply for 12 hours.

Lisinopril (medication for blood pressure) 5 mg one time a day

Milk of Magnesia (medication for constipation) 30 ml as needed one time a day

Olanzapine (medication for mental illness) 5 mg 1 time a day

Tylenol (medication for mild pain) 325 mg give 1 as needed every 6 hours

Tylenol (medication for pain level ,d+[DATE]) 325 mg give 2 as needed every 6 hours

Vitamin B1(supplement) 100 mg one time a day

Vitamin C (supplement) 500 mg one time a day

Zolpidem Tartrate (medication for inability to sleep) 5 mg give one tablet

A review of the facility records indicated Resident 1 ' s Progress Note dated [DATE] timed at 12:52 PM, indicated the resident was complaining of pain to the left arm/shoulder with a ,d+[DATE] on the pain scale. The Progress Note indicated the resident received PRN pain medication as ordered.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility records indicated Resident 1 ' s Physician ' s Order dated [DATE] timed at 2:39 PM, indicated Ibuprofen oral tablet 600 mg, give one tablet by mouth every 12 hours as needed for pain scale 4-, d+[DATE] and give with food/snack. A review of the facility records indicated Resident 1 ' s Physician ' s Order dated [DATE] timed at 2:50 PM, indicated Norco oral tablet ,d+[DATE] mg give 1 tablet my mouth every 8 hours as needed for pain 7-, d+[DATE], hold if respiration rate (the number of breaths a person takes in a minute) was less than 12 breaths/min and notify MD (Doctor of Medicine). Do not exceed 3G (grams, unit of measurement) APAP (acetaminophen, a common pain reliever and fever reducer)/24 hours. A review of the facility records indicated Resident 1 ' s PRN Pain Assessment Flowsheet dated from [DATE] to [DATE], indicated the resident had left shoulder pain with a pain level ranging from six to eight on the pain scale. The PRN Pain Assessment Flowsheet indicated the non-pharmacological interventions were not effective and the residents pain level was the same before the interventions were implemented, resulting in the resident receiving pain medication every time Resident 1 complained of pain. A review of the facility records indicated Resident 1 ' s MAR dated from [DATE] to [DATE], indicated the resident received Ibuprofen on [DATE], [DATE] to [DATE], and [DATE] to [DATE]. The MAR indicated the resident received Norco on [DATE] to [DATE]. During a review of Resident 1 ' s facility records titled Situation, Background Assessment, Recommendations [SBAR] dated [DATE] timed at 9:45 AM, indicated at 9:30 AM, Resident 1 was up in the wheelchair and conversing [talking] with the staff. The SBAR indicated Resident 1 started drooling (when saliva flows out of your mouth unintentionally) on the right side of his mouth. Resident 1 was non-verbal, non-responsive to pain and skin color was purple/clammy skin (skin that is wet from sweating). The SBAR further indicated Resident 1 ' s blood pressure was ,d+[DATE], pulse rate was 94, respirations were 12. Resident 1 ' s oxygen saturation (the amount of oxygen carried by red blood cells) was absent and a non-breather mask (a special medical device that helps provide you with oxygen in emergencies) oxygen inhalation at 10 Liters (metric unit of capacity) was placed on Resident 1. The SBAR indicated Resident 1 still remained unresponsive . The resident ' s pupil of eye constricted (to reduce the light entering the eye) and fixed (a pupil that does not respond to light). The resident ' s physician (Physician 1) was notified and made aware. The SBAR indicated 911 emergency services was notified and the resident was transferred to GACH 3. During a review of Resident 1 ' s GACH 3 records titled History and Physical dated [DATE], indicated [Resident 1] was found slumped [sitting with the body leaning forward, for example, because a person was asleep or unconscious] over in the wheelchair, then became unresponsive. No seizure [a sudden, uncontrolled movement] activity noted. Resident 1 was started on CPR (cardiopulmonary resuscitation, [an emergency treatment that's done when someone's breathing or heartbeat has stopped]) when paramedics arrived. Resident 1 was noted with agonal breathing (when someone who is not getting enough oxygen is gasping for air) and pinpoint pupils [a condition where the pupils of the eyes appear unusually small] with Glasgow coma scale (used to objectively describe the extent of impaired consciousness) of 3 (is the lowest possible score and is associated with an extremely high mortality rate). Resident 1 was given Narcan (is a medicine that treat someone from fentanyl or prescription opioid medicine overdose) with improvement. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s GACH 3 Urine Drug Screen [UDS- used to detect illegal and some prescription drugs in the urine] dated [DATE] timed at 12:15 PM, the UDS indicated Resident 1 ' s urine indicated Presumptive Positive [shows a response, which is usually because a drug is present] for Fentanyl Urine and Opiates [a drug that contains opioids (a class of controlled drug used for moderate to severe pain)], Urine. During an interview and observation on [DATE] at 1:43 PM, with Resident 1, Resident 1 was observed sitting in the wheelchair at the facility ' s Dining Room. Resident 1 stated, The day ([DATE]) I went to the hospital [GACH 3] I took a pill my friend gave me; it was supposed to make me feel better. I don ' t remember what happened that day, I woke up in the hospital (GACH 3). Resident 1 stated his friend dropped off the pill in front of the facility through the gate. Resident 1 stated the facility ' s security guard was present outside, when his friend gave him the pill. Resident 1 stated the security guard was not paying attention when he was handed the pill through the facility gate. Resident 1 stated he did not want to say who the friend was who gave him the pill. Resident 1 further stated, I learned my lesson and I would not do that again. During an interview on [DATE] at 3:34 PM, Licensed Vocational Nurse (LVN) 1 stated Resident 1 ' s pain was not being managed well in the facility, because the resident received pain medication daily. LVN 1 stated Resident 1 was in pain every day and needed pain medication every day. LVN 1 stated she was unsure when to refer a resident for a pain evaluation and had not spoken with the physician regarding Resident 1 ' s pain. LVN 1 stated if the interventions were not working, the resident could be angry, and the pain could affect Resident 1 ' s mood and sleep. LVN 1 stated the facility should have been re-assessing and implementing new pain interventions when the previous pain interventions were not effective. During another interview on [DATE] at 4:18 PM, Resident 1 stated the pain on his left arm/shoulder started three to four weeks ago and the resident was unable to lift up a fork or spoon. Resident 1 stated getting the order for Norco took two days after coming back to the facility from GACH 2 and when the resident asked the licensed nurses why getting the Norco was taking so long, the nurses did not know. Resident 1 stated because he was in so much pain, Resident 1 stated he took something because of the pain. Resident 1 stated he was unsure what medication he took, but thought the medication were pain killers. Resident 1 stated he did not want to go into details about the incident but probably would not have taken something if he had received appropriate pain medication from the facility because the Ibuprofen was not working. During an interview on [DATE] at 6:03 PM, the Medical Director (MD) stated when a resident was in pain, the physician would assess the pain, check vital signs (measurements of the body ' s basic functions, such as breathing rate, temperature, blood pressure, and pulse rate), check the resident ' s medication list, and try to find out the cause of the pain. The MD stated if the pain was chronic, then a medication would be prescribed but if a new pain was present then the resident would be sent to the GACH emergency room (ER) to further evaluate the pain. The MD stated pain consults were sometimes ordered but the availability of pain doctors was very few and there would be a delay, so ordering a pain consult would be an alternative if the resident refused to go to the GACH ER. The MD stated if a resident was in continued pain, the physician should have re-assessed the resident, but trying to be appropriate with the pain medication was not easy because of dependency on residents. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:48 AM, the Registered Nurse Supervisor (RNS) stated once an order was obtained from the physician, the RNS would fax the order to the pharmacy and confirm the pharmacy had received the medication order. The RNS stated on [DATE] an order for Norco was obtained for Resident 1. RNS stated she faxed the Norco order to the Pharmacy, and the RNS received a confirmation that the fax went through but did not get a verbal confirmation from the pharmacy. The RNS stated she endorsed the medication to the oncoming LVN for the next shift, but did not remember who the RNS endorsed the information to and also did not document the endorsement. The RNS stated there should have been documentation regarding the order and endorsement so there would not be any confusion if the medication was received or not because the resident should have been getting the Norco for pain. The RNS stated she also endorsed the Norco order to the DON, but there was no documentation regarding that endorsement. During an interview on [DATE] at 12:13 PM, the Pharmacy Technician (PT) stated the pharmacy received the Norco order via fax on [DATE]. The PT stated on [DATE] the pharmacy followed up with the ordering physician because the Norco order required an authorization to dispense the medication to the facility and the pharmacy had not received the authorization yet. The PT stated on [DATE] the pharmacy was informed Resident 1 had been admitted to the acute hospital, therefore the Norco order was placed on hold. The PT stated when a resident was admitted to the acute hospital, the facility must inform the pharmacy of the admitted and the return to facility date to ensure the resident receives the ordered medication. The PT stated the pharmacy was unaware Resident 1 was readmitted back to the facility on [DATE]. The PT stated the physician did not release the hold on the Norco order to the pharmacy which was what the physician was supposed to do. The PT stated on [DATE] the physician re-sent the Norco order that was on hold from [DATE], to be dispensed. The PT stated on [DATE] [2 days from readmission] the facility received the Norco medication. During an interview on [DATE] at 2:45 PM, the OT stated the resident receives occupational therapy five times a week. The OT stated the resident was never in pain during therapy, so the OT never addressed Resident 1 ' s pain and only focused on feeding and grooming. The OT stated he was aware of the resident ' s left shoulder pain and knew the resident went to the hospital recently due to the pain. The OT stated he had not provided any exercises to alleviate the resident ' s pain. The OT stated if the resident was in a good position, then that could help with the pain and would screen Resident 1 for any movements that would make him hurt. During a concurrent observation and interview in the Activities Room on [DATE] at 3:20 PM, Resident 1 was observed bringing his face down to his hand to wipe his mouth. Resident 1 stated the worst pain level experienced was an eight or nine on the pain scale and the pain had affected him a lot. Resident 1 stated he tried to be more positive but was very frustrated because he was unable to use his arm to eat and raise his arm up. Resident 1 stated he was also frustrated because he was stuck in a wheelchair and could not walk to alleviate some of the pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review of the facility ' s policy and procedure (P&P) revised , d+[DATE], titled Pain Assessment and Management on [DATE] at 5:03 PM, the P&P stated Pain management was a multidisciplinary care process that included the following: monitoring for the effectiveness of interventions and modifying approaches as necessary. Assessing pain consists of identifying characteristics of pain and the pattern of pain. Report the following information to the physician or practitioner: prolonged, unrelieved pain despite care plan interventions. During the interview, the DON stated if the interventions were not working, the interventions should have been updated. The DON stated the resident should have been referred to a pain specialist so the resident could be treated properly because he was consistently in pain. The DON stated the facility did not document the characteristics of pain or the pattern of pain when assessing the resident for pain. The DON stated documenting the characteristics and pattern of pain were important to validate the effectiveness of the medication to provide different interventions as needed.

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NAME OF PROVIDER OR SUPPLIER Whittier Nursing and Wellness Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 7926 S Painter Ave Whittier, CA 90602	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42878 Based on interview and record review, the facility failed to provide necessary services (drug counseling and surveillance [monitoring of behavior; activities]) and develop person centered care plans for the behavioral healthcare needs for substance abuse for one of three sampled residents (Resident 1), who had a history of drug abuse (the excessive or addictive use of drugs for nonmedical purposes) and prevent Resident 1 from experiencing a drug overdose (an excessive and dangerous dose of a drug) of opiate (a controlled drug used to treat pain or cause sleep) and fentanyl (a powerful, controlled drug that is used to treat severe pain) while residing in the facility by failing to: 1. Develop and implement behavior health care plans for drug abuse to meet the behavioral needs of Resident 1 ' s when Resident 1 was readmitted to the facility from the General Acute Care Hospital 2 (GACH) on [DATE] in accordance with the facility policies and procedures [P&P] titled Behavioral assessment, intervention and monitoring and Care plans, comprehensive person-centered. 2. Develop individualized interventions, which included drug abuse counseling and surveillance of a drug abuser, upon Resident 1 ' s readmission to the facility on [DATE], when Resident 1 was diagnosed with opiate and fentanyl overdose in GACH 3 on [DATE], in accordance with the facility P&P titled Behavioral assessment, intervention and monitoring and Care plans, comprehensive person-centered. 3. Assess and identify Resident 1 ' s behavioral needs for drug counseling and surveillance, upon readmission back to the facility from GACH 3 on [DATE], by identifying risk factors, causes and how Resident 1 was exposed to illicit (illegal) drug use, due to a recent opiate/fentanyl overdose incident in the facility, as indicated in the facility ' s policy and procedure [P&P] titled Management of Illicit Drug Use and Referrals, Social Services. 4. Attempt to perform voluntary inspections of Resident 1 ' s belongings, when facility staff had reasonable suspicion of possession of illicit drugs to prevent recurrence of illicit drug use and overdose. The facility did not conduct voluntary inspection of Resident 1 ' s belongings to ensure illicit drugs were no longer present in the resident ' s possession, upon readmission back to the facility, on [DATE], after being transferred to GACH 3 for opiate/fentanyl overdose, in accordance with the facility ' s P&P titled Behavioral assessment, intervention and monitoring and Management of Illicit Drug Use. On [DATE] at 6:56 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance [not following rules] with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the failure to obtain necessary services, develop person centered care plans for the behavioral healthcare needs of a resident who had history of substance abuse and opiate/fentanyl overdose. The survey team notified the Director of Nursing (DON) and the Administrator (ADM) of the IJ situation on [DATE] at 6:56 PM, due to the facility ' s failure to obtain necessary services, develop person centered care plans for the behavioral healthcare needs of Resident 1. On [DATE] at 1:30 PM, the ADM provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Nursing and Wellness Center, Inc	7926 S Painter Ave Whittier, CA 90602

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 2:27 PM, while onsite and after the surveyor verified/confirmed the facility ' s full implementation of the IJ Removal Plan, through observation, interview, and record reviews, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. The IJ Removal Plan dated [DATE], included the following: -On [DATE], the facility reviewed and developed a behavior care plan for drug abuse for Resident 1 ' s past history of drug abuse. The facility conducted an Interdisciplinary Team [IDT - a group of professionals from different disciplines who work together to provide personalized care)] meeting on [DATE], with Resident 1 regarding any drug use, which Resident 1 denied at the time. -The ADM conducted an investigation on [DATE], to determine the possibilities on how the incident on [DATE], could have happened. Based on ADM investigation (concluded on [DATE]) closer supervision could be needed by the gate. -On [DATE], the facility Security guards was immediately given in-service to be in close proximity (near) to the gate. The Security Guard was placed at the facility gate at 8 PM on [DATE]. Security Guards ' shifts are 7 AM to 3 PM and 3 PM to 11 PM, seven days a week. Security Guards will screen everyone they encounter, with an emphasis on looking for suspicious behavior and drug contraband [illicit goods] from all persons, including staff, residents and visitors. Security Guards will document all person interactions with time, date, and name. Security Guards will report abnormal findings to nursing supervisor. Staff will also have the responsibility for facility wide supervision and was in-serviced specifically for Fentanyl, regarding how to spot signs of active, potential usage and its physical form by the Director of Staff Development (DSD) on [DATE]. 48 staff out of 54 staff informed with an expected completion date [DATE]. ADM called the police to report the incident on [DATE], the call was placed at 1:55 PM, on [DATE]. In the ADM or DON ' s absence, the nursing supervisor can inform the police of any illicit activity. -On [DATE], the IDT reviewed all residents' charts to determine if there are other residents that have history of drug abuse, two residents found. The facility updated their behavior care plans to ensure their needs are met and completed. History of drug abuse created and placed at the Nursing Station with contents identifying all current residents that have a history of drug abuse, for staff reference. Staff informed regarding newly identified residents on [DATE]. -Developed an individualized intervention for Resident 1, which included scheduling of counseling from the facility Psychologist [a person who specializes in the study of mind and behavior] on [DATE], with a focus on opiate and fentanyl overdose and drug abuse. The Psychologist will visit Resident 1, two times a month. -Upon readmission, Resident 1 will be interviewed by Social Services, questions will include an emphasis on history of illicit drug abuse. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-All nursing staff will review residents' records to establish if there is a history of drug abuse/use, care plans will be implemented for residents that are found to have a history of drug abuse. -Resident belongings will also be thoroughly checked (with the resident ' s permission) to ensure no contraband is present and brought into the facility. -Residents suspected of illicit drug usage (Fentanyl) will be drug tested in according to the facility ' s Illicit drug policy. Residents have the right to refuse drug testing as it is voluntary. -For ongoing suspicion of illicit drug use of residents, the IDT team will conduct and IDT meeting informing the resident of the facility policy, including that all drug testing is voluntary. -On [DATE], the facility staff conducted a search in Resident 1 ' s room with the resident ' s consent. This search was repeated on [DATE], no contraband found. The facility also conducted a whole facility search and no contraband was found on [DATE]. The facility will conduct weekly contraband searches every 4 weeks and them monthly for the next 6 months. -Resident 1 was prescribed Norco (a drug used to treat moderate to severe pain) every eight hours as needed for pain management. This is to prevent Resident 1 from seeking pain relief through illicit means. Findings: During a review of Resident 1 ' s GACH 2 records titled History and Physical [H&P] Report dated [DATE], indicated the resident came to the emergency room for worsening left shoulder pain. The H&P indicated under Assessment and Plan to rule out stroke [a medical emergency that occurs when blood flow to the brain is disrupted, damaging or killing brain tissue], adjust psychiatric [relating to mental illness] medications and for pain management. The GACH 2 record indicated Resident 1 was discharged with Acetaminophen [over the counter pain medication] 325 mg oral tablet: two tablets orally every 4 hours, as needed, for mild pain (, d+[DATE]) pain scale. The GACH 2 record indicated the resident was discharged to the facility on [DATE]. The H&P under Social History indicated, Resident 1 has a remote history of smoking. Resident 1 has a history of drug abuse. During a review of Resident 1 ' s facility records titled Admission Record indicated a facility readmission on [DATE], with diagnoses that included flaccid hemiplegia (a neurological condition characterized by weakness or paralysis and reduced muscle tone) affecting left non dominant side, chronic obstructive pulmonary disease (COPD -a group of lung diseases that block airflow and make it difficult to breathe). During a review of Resident 1 ' s facility records titled Order summary Report indicated the following active medication orders for Resident 1 dated [DATE]: Amlodipine Besylate (medication for blood pressure) 10 milligram [mg - unit of measurement] one time a day. Aspirin 81 mg (medication for CVA) 81 milligram one time a day. Ativan (medication for anxiety) 0.5 mg two times a day. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Folic Acid (medication for anemia) 1 mg one time a day. Gabapentin (medication for numbness and pain from nerve damage) 300 mg three times a day. Ibuprofen (medication for pain) 600 mg as needed every 12 hours. Lactulose (medication to prevent complication of liver disease) 10 grams in 15 mg, one time a day. Lidocaine patch (medication for pain) 5% apply for 12 hours. Lisinopril (medication for blood pressure) 5 mg one time a day Milk of Magnesia (medication for constipation) 30 ml as needed one time a day Olanzapine (medication for mental illness) 5 mg 1 time a day Tylenol (medication for mild pain) 325 mg give 1 as needed every 6 hours Tylenol (medication for pain level ,d+[DATE]) 325 mg give 2 as needed every 6 hours Vitamin B1(supplement) 100 mg one time a day Vitamin C (supplement) 500 mg one time a day Zolpidem Tartrate (medication for inability to sleep) 5 mg give one tablet During a review of Resident 1 ' s facility records titled History and Physical (H&P) dated [DATE], indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 1 ' s facility records titled Social Service History & Initial assessment dated [DATE], authored by the Social Services Director [SSD] indicated under Social Factors and History of drug/alcohol abuse, was left unmarked. During a review of Resident 1 ' s facility records titled Situation, Background Assessment, Recommendations [SBAR] dated [DATE] timed at 9:45 AM, indicated at 9:30 AM, Resident 1 was up in the wheelchair and conversing [talking] with the staff. The SBAR indicated Resident 1 started drooling (when saliva flows out of your mouth unintentionally) on the right side of his mouth. Resident 1 was non-verbal, non-responsive to pain and skin color was purple/clammy skin (skin that is wet from sweating). The SBAR further indicated Resident 1 ' s blood pressure was ,d+[DATE], pulse rate was 94, respirations was 12. Resident 1 ' s oxygen saturation (the amount of oxygen carried by red blood cells) was absent and a non-breather mask (a special medical device that helps provide you with oxygen in emergencies) oxygen inhalation at 10 Liters (metric unit of capacity) was placed on Resident 1. The SBAR indicated Resident 1 still remained unresponsive . The resident ' s pupil of eye constricted (to reduce the light entering the eye) and fixed (a pupil that does not respond to light). The resident ' s physician (Physician 1) was notified and made aware. The SBAR indicated 911 emergency services was notified and the resident was transferred to GACH 3. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of Resident 1 ' s GACH 3 records titled History and Physical dated [DATE], indicated [Resident 1] was found slumped [sitting with the body leaning forward, for example, because a person was asleep or unconscious] over in the wheelchair, then became unresponsive. No seizure [a sudden, uncontrolled movement] activity noted. Resident 1 was started on CPR (cardiopulmonary resuscitation, [an emergency treatment that's done when someone's breathing or heartbeat has stopped]) when paramedics arrived. Resident 1 was noted with agonal breathing (when someone who is not getting enough oxygen is gasping for air) and pinpoint pupils [a condition where the pupils of the eyes appear unusually small] with Glasgow coma scale (used to objectively describe the extent of impaired consciousness) of 3 (is the lowest possible score and is associated with an extremely high mortality rate). Resident 1 was given Narcan (is a medicine that treat someone from fentanyl or prescription opioid medicine overdose) with improvement. During a review of Resident 1 ' s GACH 3 Urine Drug Screen [UDS- used to detect illegal and some prescription drugs in the urine] dated [DATE] timed at 12:15 PM, the UDS indicated Resident 1 ' s urine indicated Presumptive Positive [shows a response, which is usually because a drug is present] for Fentanyl Urine and Opiates [a drug that contains opioids (a class of controlled drug used for moderate to severe pain)], Urine. During a review of Resident 1 ' s GACH 3 Physician Progress Notes dated [DATE], the Progress Notes indicated Resident 1 ' s Chest X-ray [a way for providers to get pictures of the inside of your body] and CT [Computed Tomography - an imaging test that helps healthcare providers detect diseases and injuries] of the head did not indicate any acute abnormal process. The GACH 3 Physician Progress Notes indicated under Problem List, indicated Resident 1 had syncope (a loss of consciousness for a short period of time), unresponsiveness, opiate overdose, possible respiratory arrest [a condition that exists at any point a patient stops breathing] due to accidental fentanyl overdose, and fentanyl/opioid positive on UDS. The Progress Notes further indicated to continue monitoring Resident 1 ' s vital signs [clinical measurements, specifically pulse rate, temperature, respiration [breathing] rate, and blood pressure] and administer Narcan as needed. During a review of Resident 1 ' s facility records titled Admission Record indicated another readmission back to the facility on [DATE], with diagnoses that included syncope and collapse [fall down], personal history of other specified condition, flaccid hemiplegia affecting left non dominant side and COPD. During a review of Resident 1 ' s facility records titled Nursing Admission Screening/History dated [DATE] indicated Resident 1 was readmitted back to the facility from GACH 3 with the following reasons . Possible respiratory arrest . Unresponsive and Syncope. (continued on next page)

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F 0740

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

During a review of Resident 1 ' s facility records titled IDT /Comprehensive Care Plan Summary dated [DATE], indicated the IDT met with Resident 1 and reviewed Resident 1 ' s plan of care. The IDT record indicated Resident 1 was readmitted from GACH 3 on [DATE] , under the care of Physician 1 with left flaccid paralysis/hemiplegia [loss of strength in the arm, leg, and sometimes face on one side of the body], cerebrovascular accident [CVA -caused by blood clots and broke vessels in the brain), hepatic encephalopathy (brain disfunction caused by liver disfunction), anxiety (condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), hypertension (a condition in which the force of the blood against the artery walls is too high) .and bipolar disorder (a disorder associated with episodes of mood swings). The IDT record further indicated that the IDT had met with Resident 1 today [[DATE]] regarding GACH 3 reports of Fentanyl overdose. The IDT record indicated Resident 1 denied taking any medications other than what was prescribed for him. The IDT record indicated, Resident 1 denied taking opioids and/ or any other illegal substance. The IDT record indicated . Will continue to monitor Resident 1 ' s condition. Will provide frequent visual check for safety. Will continue current plan of care.

During a review of Resident 1 ' s facility records titled Telephone Order (TO) dated [DATE], the TO indicated Physician 1 ' s telephone orders to continue previous medications and treatments as ordered.

During an interview and observation on [DATE] at 1:43 PM, with Resident 1, Resident 1 was observed sitting in the wheelchair at the facility ' s Dining Room. Resident 1 stated, The day ([DATE]) I went to the hospital [GACH 3] I took a pill my friend gave me; it was supposed to make me feel better. I don ' t remember what happened that day, I woke up in the hospital (GACH 3). Resident 1 stated his friend dropped off the pill in front of the facility through the gate. Resident 1 stated the facility ' s security guard was present outside, when his friend gave him the pill. Resident 1 stated the security guard was not paying attention when he was handed the pill through the facility gate. Resident 1 stated he did not want to say who the friend was who gave him the pill. Resident 1 further stated, I learned my lesson and I would not do that again.

During an interview on [DATE] at 3:45 PM with the ADM and concurrent record review of the facility ' s investigation regarding the incident that happened with Resident 1 on [DATE], the ADM provided typewritten staff interview statements that indicated the following information:

-Facility record titled Facility Interview dated [DATE] and signed by the facility ADM, indicated a typewritten statement from Registered Nurse [RN] 1. The interview statement indicated, Registered Nurse (RN 1) stated that on she saw Resident 1 ' s change of condition. Immediately went to help and call 911. Did not notice anything unusual during the shift.

-Facility record titled Facility Interview dated [DATE] and signed by the facility ADM, indicated a typewritten statement from Certified Nursing Assistant (CNA) 1. The interview statement indicated CNA 1 had [Resident 1] for an assignment. CNA 1 responded to the change of condition. Did not notice anything unusual during the shift. No visitors for Resident 1. No out on pass, aware of.

-Facility record titled Facility Interview dated [DATE], and signed by the facility ADM, indicated [CNA 2] responded to the change of condition. Did not notice anything unusual during the shift.

(continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	-Facility record titled Facility Interview dated [DATE], and signed by the facility ADM, indicated [CNA 3] night shift, did not notice anything unusual. No issues. -Facility record titled Facility Interview dated [DATE], and signed by the facility ADM, indicated [Resident 1] does not recall taking anything unusual. Felt fine until the incident, feels safe, no issues with facility. During an interview on [DATE] at 2:10 PM, CNA 1 stated she came in to work at 6:30 AM in the morning of [DATE] and remembered seeing Resident 1. CNA 1 stated before 8 AM, she helped Resident 1 get out of bed and up to the shower chair. CNA 1 stated that after the shower, CNA 1 took Resident 1 to the bathroom dressed him and helped him brush his teeth and get dressed. CNA 1 stated she recalled seeing Resident 1 wheeling himself out in his wheelchair into the hallway between 8:30 AM to 9:00 AM. CNA 1 stated a few minutes after that she heard RN 1 calling for help for Resident 1. CNA 1 stated she rushed over and saw Resident 1 looked pale and blue. CNA 1 stated, the paramedics arrived and took Resident 1 between 9:20 AM to 9:30 AM on [DATE]. During an interview on [DATE] at 2:15 PM, RN 1 stated she remembered in the morning of [DATE], Resident 1 came up to RN 1 to get his medications after breakfast around 8:50 AM to 9:00AM. RN 1 stated she gave Resident 1 an Ibuprofen (over the counter pain medication), for pain. RN 1 stated seeing Resident 1 wheeled himself away and was hanging out with the other residents in the hallway. RN 1 stated around 9:30 AM, she saw Resident 1 in the facility hallway in his wheelchair, drooling, with the head tilted to the side. RN 1 stated she called a Code Blue (a code that indicated that someone is experiencing a life-threatening medical emergency) and asked a CNA [unknown CNA] to assist her to put Resident 1 down to the floor. RN 1 stated Resident 1 ' s oxygen saturation level on [DATE] was around 91% to 92% [normal oxygen saturation levels are 95 % to 100%]. RN 1 stated she increased Resident 1 ' s oxygen level to 10 Liters (a unit of measurement) and instructed someone to call 911 emergency services. RN 1 stated Resident 1 would slightly open his eyes after he got oxygen but could not talk. During an interview with on [DATE] at 2:24 PM, with the DON, the DON stated Resident 1 was transferred to GACH 3 on [DATE], after being found unresponsive and drooling. The DON stated on [DATE], before Resident 1 arrived back at the facility, the DON spoke to a GACH 3 licensed nurse, who notified the facility that Resident 1 ' s urine drug test, tested positive for Fentanyl and other opiates. The DON stated the GACH 3 licensed nurse stated Resident 1 was admitted to GACH 3 for medication overdose. The DON stated there was no way he [Resident 1] can overdose . that did not happen. I think it was a stroke because of Resident 1 ' s history of CVA [cerebrovascular accident]. During the same interview on [DATE] at 2:24 PM and concurrent review of Resident 1 ' s Medication Administration Records (MAR) for [DATE] to [DATE], the DON stated that Resident 1 was not on Fentanyl or any types of opioid medications prior to the change in condition [syncope and unresponsiveness] on [DATE]. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During another interview and concurrent record review on [DATE] at 2:45 PM, Resident 1 ' s active care plans was reviewed with the DON. During the interview, the DON stated there was no documented evidence that a care plan was developed for Resident 1 ' s history of drug abuse in the past as indicated in GACH 2 record dated [DATE] and GACH 3 records dated [DATE], or the recent fentanyl/opiate overdose on [DATE]. The DON stated, We [facility] did not do care plan because it [overdose] did not happen . that he [Resident 1] had an overdose (fentanyl or opioids). The DON further stated that the facility did not have any residents receiving fentanyl. During the same interview and concurrent record review on [DATE] at 2:45 PM, Resident 1 ' s IDT/Comprehensive care pan summary dated [DATE] was reviewed with the DON. When asked what the licensed nurses were monitoring for Resident 1, as indicated in the IDT care plan summary, the DON stated Resident 1 was being monitored for vitals sign abnormalities once a shift. During an interview on [DATE] at 3:24 PM, with the facility ' s security guard (SG 1), SG 1 stated that when someone comes to the facility gate, he would open the gate and inform the nurses. SG 1 stated he was never instructed to intervene or question if an unknown individual was seen outside the gate talking to a resident in the facility. During the same interview, on [DATE] at 3:24 PM, the SSD stated when a new resident is admitted or readmitted to the facility, the facility SSD and the licensed nurses would go over all of the resident ' s GACH records. The SSD stated that the SSD would complete a full social services assessment upon admission/readmission. The SSD stated the facility did not order or arrange any behavioral referrals for Resident 1 to see a psychologist or psychiatrist [a doctor specializing in the diagnosis and treatment of mental illness] for substance abuse counseling upon his readmission on [DATE], from GACH 3. During a concurrent interview and record review of Resident 1 ' s care plans developed from [DATE] to [DATE], with the facility ' s SSD on [DATE] at 2:22 PM, the SSD stated there was no care plan developed for Resident 1 ' s history of substance abuse from [DATE] and [DATE] facility readmissions. The SSD stated she did not know Resident 1 had a history of drug abuse as indicated in the GACH 2 Social History record, dated [DATE]. The SSD further stated Resident 1 did not have care plans developed for fentanyl overdose or drug abuse or any type of surveillance monitoring for substance abuse, because the facility did not believe Resident 1 ' s fentanyl and opiate overdose was real. The SSD stated the facility did not have any residents taking fentanyl medications. The SSD stated she did not search Resident 1 ' s entire room and belongings to search for illicit drugs, with Resident 1 ' s consent on [DATE] upon Resident 1 ' s readmission back to the facility from GACH 3 on [DATE]. During an interview on [DATE] at 4:29 PM with the DON, the DON stated there was no care plan developed to perform voluntary inspections of Resident 1 ' s room and belongings for possession of illicit drugs, upon Resident 1 ' s readmission from GACH 3 on [DATE]. The DON stated she searched Resident 1 ' s room on [DATE] with another facility staff but could not recall who the staff was and did not document the inspection. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility ' s P&P titled, Management of Illicit Drug Use [not dated], the P&P indicated the purpose of the policy was To establish a consistent, complaint, and legal response to the identification, prevention, and management of illicit drug use among residents to ensure safety . The aim is to ensure the safety of all residents, staff, and the facility. The P&P further indicated 1. Prevention and Education- All new resident ' s history and physical will be reviewed upon admission for substance abuse history. This information will guide care planning and the prevention of potential issues. During a review of the facility ' s P&P titled, Referrals, Social Services revised on [DATE], the P&P indicated Social Services personnel shall coordinate most resident referrals with outside agencies . The P&P further indicated 3. Referrals for residents with psychological, history of alcohol or substance abuse related needs must be based on physician evaluation of resident need, after which Social Services will collaborate with the nursing department to arrange for recommended services. 4. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. 5. Social services will document the referral in the resident ' s medical record. 6. Social services and administration will maintain a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs . During a review of the facility ' s P&P titled, Behavioral assessment, intervention and monitoring revised [DATE], the P&P indicated 1. The interdisciplinary team will thoroughly evaluate new or changing behavioral symptoms in order to identify underlying causes and address any modifiable factors that may have contributed to the resident ' s change in condition The care plan will incorporate findings from the comprehensive assessment and be consistent with current standards of practice. During a review of the facility ' s P&P titled Care plans, comprehensive person-centered, revised on [DATE], the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical and functional needs is developed and implemented for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555787	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whittier Nursing and Wellness Center, Inc	7926 S Painter Ave 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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 48661 Based on observation, interview, and record review the facility failed to follow the facility ' s policy and procedure (P&P) titled Smoking Schedule to ensure staff supervision during smoke breaks was implemented to provide safety for each resident during smoking, for one of three sampled residents (Resident 2) by failing to: Provide Staff supervision for Resident 2 during the facility ' s smoke break on 9/18/2024. Provide in-service to facility staff about the facility ' s Smoking P&P and smoking care plan for each resident who smokes. Ensure the facility maintained an updated list of resident smokers for reference. This deficient practice had the potential for Resident 2 and other resident smokers to be at risk for injury or burns without proper supervision and for the facility staff supervising not having the knowledge of what type of supervision are needed for each resident smoker. Findings: During a review of Resident 2 ' s Admission Record indicated the facility admitted the resident on 9/9/2024, with diagnoses including chronic obstructive pulmonary disease (COPD - a common lung disease that makes breathing difficult), asthma (a chronic lung disease that makes breathing hard because the airways in the lungs become inflamed and narrow), and hypertension (a serious medical condition that occurs when blood pressure in the blood vessels was too high). During a review of Resident 2 ' s Smoking Safety Evaluation dated 9/9/2024 timed at 3:45 PM, indicated the resident utilized tobacco (a plant with leaves that have high levels of addictive chemical nicotine) and required supervision during designated smoking times. The Smoking Safety Evaluation indicated the resident would follow the facility ' s policy on location and time of smoking. During a review of Resident 2 ' s Smoking Care Plan dated 9/9/2024, indicated the resident was at high risk for injury related to smoking. The Care Plan goal included the resident to be safe, would not smoke in room/bed, and would only smoke in designated areas with supervision as needed. The Care Plan interventions included to provide supervision when the resident was smoking and to monitor the resident ' s compliance with the facility ' s smoking policy. During a review of Resident 2 ' s History and Physical (H&P) dated 9/10/2024, indicated the resident had the capacity to understand and make decisions. During a review of Resident 2 ' s Minimum Data Set (MDS, a standardized assessment and care-planning tool) dated 9/15/2024, indicated the resident ' s cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident was currently using tobacco. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whittier Nursing and Wellness Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 7926 S Painter Ave Whittier, CA 90602	

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation at the Smoking Patio on 9/18/2024 at 4:50 PM, Security Guard (SG) 1 was observed handing a cigarette to Resident 2, lighting the cigarette, and leaving the resident alone and unsupervised to smoke while SG 2 returned to sit and monitor the gate at the facility. During an interview on 9/18/2024 at 4:54 PM, SG 2 was sitting in front of the gate at the facility. SG 2 stated he was instructed to sit in front of the gate at all times to monitor who comes in and out of the facility. SG 2 was supposed to report any suspicious activity and was not informed to stay with the resident smokers once SG 2 handed the residents their cigarettes. During a concurrent observation and interview at the Smoking Patio on 9/18/2024 at 4:55 PM, the Director of Nursing (DON) observed Resident 2 smoking in the Smoking Patio unsupervised. The DON stated residents should have been supervised and was not aware the resident was smoking unsupervised. During an interview on 9/19/2024 at 9 AM, SG 3 stated he was in charge of supervising the smoke breaks for the facility every two hours. SG 3 stated during the smoke break a nurse covered the front gate while SG 3 supervised the residents. SG 3 stated the residents were provided a cigarette and the cigarettes were lit by SG 3. SG 3 stated he was never in-serviced on smoke breaks and was told to get the nurse if something happened to the residents during a smoke break. SG 3 stated he did not know what type of supervision was needed for each resident who smokes. SG 3 stated the facility never informed SG 3 to provide a smoking apron to the residents. During an observation of the Smoking Patio on 9/19/2024 at 9:41 AM, the Smoking Patio had four metal smoking ash urns (receptacles for cigarette butts and ashes that could be stand-alone or attached to a trash bin). The Smoking Patio had aprons hanging, a fire extinguisher, and a fire blanket with a sign posted Designated Smoking Area. The Smoking Patio had the hours of smoking times as well as the smoking policy and procedure (P&P) posted. During an interview on 9/19/2024 at 9:44 AM, the Activities Assistant (AA) stated the facility had not provided her a list of residents who smoke. The AA stated she did not have information on the list of smokers or residents requiring an apron during smoke breaks. During an interview on 9/19/2024 at 11:34 AM, the Social Services Director (SSD) stated she updated the AA on which residents who smoke. The SSD stated the AA should have been aware of the residents who smoke for the risk and safety of the residents. During a review of the facility ' s undated List of Residents who Smoke 2024, indicated there were seven smokers in the facility including Resident 2. During a review of the facility ' s Smoking Time, revised 8/21/2023, indicated smoking times were every two hours from 8 AM to 10 AM and from 2 PM to 10 PM. The Smoking Time indicated there was a three-hour break from 10 AM to 1PM and a one-hour break from 1 PM to 2 PM. During a concurrent interview and record review on 9/19/2024 at 12:27 PM of the facility ' s undated P&P titled Smoking Schedule, the Administrator (ADM) stated facility staff who supervised smoke breaks should have been in-serviced to know which residents need certain items to smoke safely. The P&P indicated, Smoking schedule shall be monitored under staff supervision. Smoking should have only been allowed in designated areas and during scheduled hours. The ADM stated following the policy was important for the facility staff to be aware for the safety of all residents. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Whittier Nursing and Wellness Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 7926 S Painter Ave Whittier, CA 90602	

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/19/2024 at 12:40 PM of the facility ' s undated P&P titled Smoking Schedule, the Director of Staff Development (DSD) stated providing supervision during smoke breaks was important to monitor and provide safety for each resident. The P&P indicated, Smoking schedule shall be monitored under staff supervision. Smoking should have only been allowed in designated areas and during scheduled hours. The DSD stated the P&P meant there should have always been a staff member when a resident was smoking. During a review of the facilities undated P&P titled Smoking Schedule, indicated A list of resident smokers shall be developed, maintained and updated on an as needed basis for reference.