

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/04/2025
NAME OF PROVIDER OR SUPPLIER Whittier Nursing and Wellness Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours seven days a week in the facility including the following weekends: 10/18/2025, 10/19/2025, 10/25/2025 10/26/2025, 11/16/2025/ 11/22/2025, and 11/29/2025 that care for 30 or 30 residents in the facility. This deficient practice had the potential for the residents' care not to be supervised and assessed clinically by the RN which could affect the quality of care and quality of life of the residents. Findings: During a review of the facility's Direct Care Service Hours Per Patient Day (DHPPD, a staffing metric ensuring enough caregiver time per resident, calculated as total direct care hours divided by patient census) from 9/2025 to 11/2025, indicated there was no RN on duty for 8 consecutive hours for the following dates: 10/18/2025, 10/19/2025, 10/26/2025, 11/16/2025/ 11/22/2025, and 11/29/2025 in the facility. During an interview with the Director of Nursing (DON) on 12/3/2025 at 1:42 PM, the DON stated the facility did not require an RN for 8 hours on the weekends because it was a small facility. The DON stated the facility has been exempted because the facility was small. The DON stated when she comes into work for direct care duties, she only signs in on the Nursing Staffing Assignment and Sign in Sheet. During a subsequent interview with the DON on 12/3/2025 at 2:36 PM, the DON stated she was at facility often and sometimes forgets to sign the Nursing Staffing Assignment and Sign in Sheet. The DON stated she goes to the facility on the weekends to fulfill weekend coverage. The DON confirmed she only signs on the assignment sheet and if she does not sign it means she was not at the facility. During a review of the facility's timecards for the facility's RNs and the Director of Nursing (DON) from 9/2025 to 11/2025, indicated there was no RN or DON for 8 consecutive hours for the following dates: 10/18/2025, 10/19/2025, 10/26/2025, 11/16/2025/ 11/22/2025, and 11/29/2025. During a review of the facility's Nursing Staffing Assignment and Sign in Sheet for the following dates: On 10/18/2025, indicated there was no Director of Nursing (DON) or RN signature 2. On 10/19/2025, indicated there was no DON or RN signature 2. On 10/26/2025, indicated there was no DON or RN signature 3. On 11/16/2025, indicated there was a DON signature, but did not indicate actual shift start/end time or actual meal break start/end time. 4. On 11/22/2025, indicated there was a DON signature, but did not indicate actual shift start/end time or actual meal break start/end time. 5. On 11/29/2025, indicated there was no DON or RN signature. During a concurrent record review of the DON's timecard and interview with the DON on 12/4/2025 at 12:44 PM, the DON stated she would always sign in on the Department Heads Daily Sign-in Sheet with the security guard upon entrance to the facility. During a concurrent interview and record review of the Department Heads Daily Sign-in Sheet with the security guard (SG) 1 on 12/4/2025 at 12:50 PM, SG 1 stated sign in for department heads from previous months are with the Business Office Manager indicated there was no RN in the facility on the following dates: On 10/18/2025, indicated there was no DON signature. 2. On 10/19/2025, indicated there was no DON signature. 3. On 10/26/2025, indicated there was no DON signature. 4. On 11/16/2025, indicated there was no DON signature. 5. On 11/22/2025, indicated there was no DON signature. 6. On 11/29/2025, indicated there was no DON signature. A review of the facility's policy and procedure (P&P) titled Departmental Supervision, dated 8/2006 indicated the DON is on duty during the day shift Monday (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	through Friday at a minimum as due to their duties schedule will may vary. The P&P indicated during the absence of the DON, a Nurse Supervisor/ Charge Nurse is responsible for the supervision of all nursing department activities including the supervision of direct care staff. The P&P indicated in a skilled nursing facility with fewer than 60 beds, a DON can serve as the Charge Nurse. The P&P indicated the DON is responsible for ensuring that the facility provides quality care to the residents.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews and record reviews, the facility failed to ensure that accurate and current nurse staffing data [total number and actual hours worked by licensed (Registered Nurses [RNs], License Vocational Nurses [LVNs]) and unlicensed nurses (Certified Nursing Assistant [CNAs])] were posted daily at the beginning of each shift (11 PM - 7 AM, 6:30 AM - 3 PM, and 3 PM - 11 PM) to care for 30 residents of 30 residents. These deficient practices of posting inaccurate and outdated nurse staffing data had the potential to mislead and prevent residents and families from verifying the facility's daily staffing levels. This could result in distrust and a perceived lack of accountability in maintaining accurate and adequate staffing necessary for timely resident care. Findings: During an observation on 12/02/2025 at 9:30 AM, an untitled facility document was observed posted in the facility's front lobby. The document posted in the front lobby indicated the Facility Census was 30. The facility document indicated the nursing staffing information according to licensed nurses and unlicensed nurses per category (RNs, LVNs, CNAs,) directly responsible for resident care each shift (6:30 AM-3 PM, 3 PM-11 P, 11 PM-7 AM). The document did not indicate the actual time worked on 12/01/2025, for each category and type of nursing staff. During a subsequent observation on 12/2/2025 at 5PM, the same untitled facility document was observed posted in the facilities front lobby. The document had not had any revisions or updates from the original observation on 12/02/2025 at 9:30 AM. During a concurrent observation and interview on 12/3/2025 at 9:16 AM with Director of Staff Development (DSD), DSD stated the untitled document posted in the facility's front lobby was a staffing projection (based on future staffing need) prepared by the night shift nurse for the following day. The DSD stated the nurse preparing the document would fill out the projected hours based on the facility's schedule. The DSD stated the facility would not update the posted staffing hours during the day as they were only posting the projected staffing nursing hours. During an interview on 12/4/2025 at 12:25 PM with Director of Nursing (DON), DON stated the facility was only posting the projected staffing nursing hours daily in the facility's front lobby and in front of the nursing station. The DON stated if the actual nursing staffing hours were not posted accurately, it could result in the residents and the visitor/resident's representatives not to know the actual number of nursing staff working on that specific day that will provide care to the residents which was a misleading information. During a review of the facility's Policy and Procedure (P&P) Posting Direct Care Daily Staffing Number, with a revision date of July 2016, the P&P indicated the following information; within two hours of the beginning of each shift, the number of licensed nurses (RNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for the resident care is posted in a prominent location (accessible to residents and visitors) and in clear and readable format; and the information recorded on the form shall include among other details The actual time worked during that shift for each category and type of nursing staff.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to follow safe and proper food storage practices in accordance with professional standards for food service safety and the facility's policy and procedure (P&P) by failing to label and date food items and discard expired food inside the facility's kitchen. This failure had the potential to cause food-borne illness (illness caused by the ingestion of contaminated food or beverages) and adversely affect the health of the residents. Findings: During a concurrent observation and interview on 12/1/2025 at 8:43 with the Dietary Supervisor (DS) in the kitchen, the following were found: An opened five pounds (a unit of weight) container of sour cream with use by 11/30/2025 label on the lid inside the refrigerator. An opened unlabeled and undated two bags of carrots inside the refrigerator. A tray of unlabeled and undated individually prepared ice cream cups with a marking 11/19 on the clear plastic wrap covering the tray inside the freezer. An opened unlabeled and undated one gallon (a unit of volume) of corn oil under a kitchen table. During the facility's initial observation of the kitchen on 12/1/2025 at 8:50 AM, an open five pounds container of sour cream was observed with a use by label date 11/30/2025 in the refrigerator. In a concurrent interview the DS stated she would discard sour cream today and it should not be used. During the same observation of the kitchen on 12/1/2025 at 8:51 AM, two opened bags of carrots were observed exposed in the refrigerator without an opened date or used by date written on the bags of carrots. The DS stated there was no need for open or use by date because carrots were produce. The DS stated she knows when the carrots go bad by visual check. During an observation of the kitchen freezer on 12/1/2025 at 8:54 AM, a tray of unlabeled and undated individually prepared ice cream cups with a marking 11/19 on the clear plastic wrap covering the tray with no used by date. The DS stated there was no need for use by date because ice cream was stored in the freezer and it was frozen. During the same observation of the kitchen on 12/1/2025 at 9 AM, an opened unlabeled and undated one gallon (a unit of volume) of corn oil under a kitchen table. The DS stated the corn oil should have open date so that staff know how long to use it for and when it will be discarded. During a review of the facility's policy and procedure (P&P) titled, Food receiving and storage, dated 10/2017, the P&P indicated, All foods stored in the refrigerator or freezer will be covered, labeled and dated.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 3) reviewed for resident's rights did not have Advance Directive (a legal document for stating medical wishes if one was unable to communicate) in resident's medical chart. This deficient practice had the potential to result in misinformation of medical care and treatment and not honoring resident's wishes in cases where the resident and/or responsible party was unable to participate in making healthcare decisions. Findings: During a review of Resident 3's admission Record indicated the resident was admitted on [DATE] with diagnoses that included disorder of brain, cellulitis (a bacterial infection of the skin and the tissues beneath the skin) of right lower limb, and type 2 diabetes mellitus (happens when the body cannot use insulin correctly and sugar builds up in the blood) with diabetic neuropathy (nerve damage in people with diabetes). During a review of Resident 3's History and Physical (H&P), dated 8/7/2025, indicated the resident was able to make decisions for activities of daily living. During a review of Resident 3's Physician Orders for Life-Sustaining Treatment (POLST, a written medical order from a physician, nurse practitioner, or a physician assistant which specifies what a patient's lifesaving treatment wishes are) dated 3/21/2025 indicated resident had an Advance Directive. The POLST did not indicate the date of the Advance Directive. During a review of Resident 3's Advance Directive Acknowledgement form dated 8/6/2025 indicated the form was incomplete. The form did not indicate if a copy of Resident 3's Advance Directive was provided to the facility. During a concurrent interview and record review of Resident 3's Advance Directive Acknowledgment form and POLST on 12/2/2025 at 2:26 PM, Social Services Director (SSD) verified resident's form and POLST was not completed and a copy of Resident 3's Advance Directive was not in resident's medical chart. SSD stated the advance directive should be in the chart and Resident 3 had an advance directive. SSD stated Resident 3's Advance Directive was probably in overflow medical records. SSD stated it was important to have the advance directive in resident's chart because in the case of an emergency, if the staff find resident unresponsive the staff would know what resident's wishes were. During an interview on 12/4/2025 at 12:39 PM, the Director of Nursing (DON) stated it was important for resident's Advance Directive to be in the medical chart, to ensure everyone was aware what the resident's code status (refers to a patient's pre-determined wishes for medical intervention if their heart or breathing stops, typically decided upon hospital admission) was and what the resident's requests would be in case of an emergency. A review of the facility's policy and procedure (P&P) titled Advance Directive, dated 12/2016 indicated advance directives will be respected in accordance with state law and facility policy. The P&P indicated the nurse supervisor will be required to inform emergency medical personnel of resident's advance directive regarding treatment options and provide such personnel with a copy of such directive when transfer from the facility via ambulance or other means is made.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to set the Alternating Pressure Mattress (APM, mattress that provides pressure redistribution by filling and un-filling air cells within the mattress so that contact points with the body are reduced) according to the resident's weight as indicated in the manufacturer's recommendation and physicians orders for one of one sampled residents (Resident 14) reviewed for pressure ulcer (skin injury due to prolonged unrelieved pressure or skin friction). Resident 14's mattress was observed set for 350 pounds (lbs.) while the resident weights 99lbs. This deficient practice had the potential for Resident 14 to develop worsened or new pressure ulcer or injury and/or delay the resident's wound to heal. Findings: During a review of Resident 14's admission Record (AR), the AR indicated the facility originally admitted Resident 14 on 5/10/2023 and most recently readmitted on [DATE] with diagnoses that included type 2 diabetes mellitus (DM2 - a condition that results in too much sugar circulating in the blood), muscle weakness (when your muscles can't work with the expected amount of force). During a review of Resident 14's History and Physical (H&P), dated 4/27/2025, the H&P indicated Resident 14 has fluctuating capacity to understand and make decisions. During a review of Resident 14's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 10/31/2025, the MDS indicated Resident 14's cognition (ability to think, remember, and reason) was moderately impaired. The MDS indicated Resident 14 needed supervision assistance in eating. The MDS indicated resident 14 is at risk for developing pressure ulcers. During a review of Resident 14's Order Summary Report (OSR), the OSR indicated the physician ordered on 4/25/2025, without an end date, indicated an order for Low Air Loss mattress (LALM-a type of the APM) keep setting between 80-150 pounds every shift for wound management. During a review of Resident 14's care plan for Resident 14's at risk for skin breakdown initiated 12/1/2025 indicated Resident 14 is at risk for re-occurring pressure injury Resident 14 needs continues use of LAL bed mattress due to history of resolved pressure injury. The care plan intervention included LAL bed mattress setting to be at 80lbs - 150 lbs. for preventative measures. During an observation on 12/01/2025 at 9:20 AM in Resident 14's room, Resident 14 was observed lying in bed with the head of the bed slightly elevated the LAL mattress was observed set at Firm for 350lbs. During a concurrent observation and interview on 12/1/2025 at 11:15 AM with Licensed Vocational Nurse (LVN 1) in Resident 14's room, Resident 14 was lying in bed with the head of bed slightly elevated and the LAL mattress setting was set at Firm 350 lbs. LVN 1 confirmed Resident 14's mattress setting was for a 350 lbs. resident. LVN 1 stated, she did not know what the correct setting for Resident 14's LAL mattress the Treatment Nurse (TN) was in charge of adjusting the LAL mattress settings for the residents. During a concurrent interview and observation on 12/01/2025 at 11:21 AM with TN 1 in Resident 14's room, TN 1 stated Resident 14's LAL mattress should always be in the correct setting according to the Resident 14's Physician order based on resident's 14's weight range. TN 1 stated, Resident 14's LALM setting should be between 80-150 pounds maximum to help Resident 14 prevent further occurrence of a pressure injury as Resident 14 was not mobile and had a previous Sacro coccyx pressure injury in the past. TN 1 stated, he did not know why the LALM was set at 350 lbs., which was not the correct setting for the Resident 14. During a review of manufacture's guidelines for Drive-Med Aire Melody control unit, indicated the following: - The Med Aire Melody Alternating Pressure and Low Air Loss Mattress as indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. During a review of the facility's Policy and Procedure (P&P) Low Pressure Mattress, Utilization and Management dated 12/12/2024, the P&P indicated the following information: Low -pressure mattresses will be made available to patients at risk for pressure injuries based on clinical assessment. The policy further indicated the staff must ensure proper use, cleaning, and maintenance of these mattresses according to manufactures guidelines to ensure functionality and safety.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an assessment was completed and documented after dialysis (a treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to) for one of one sampled resident (Resident 7) reviewed for quality of care. This failure had the potential to put Resident 1 at risk for hypotension (low blood pressure [BP- the force of your blood pushing against your artery walls, like water in a hose]), bleeding, and access site (area on the body where the dialysis machine hooks up to the blood for dialysis) complications leading to hospitalization. Findings: During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 9/21/2022 and was readmitted on [DATE] with diagnoses that included but not limited to end stage renal disease (ESRD - an irreversible kidney failure), heart failure (when the heart can't pump enough blood to meet the body's needs, leading to symptoms like shortness of breath, fatigue, and swelling), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 7's Care Plan (CP), initiated 10/22/2025, the CP indicated Resident 7 is on dialysis due to the diagnosis of ESRD. The CP indicated Resident 7 would have no complications from dialysis treatment. The CP interventions indicated to document the date, time and condition of resident returning to the facility from dialysis and to monitor the resident's right groin access site for swelling, pain, bleeding, itching, signs and symptoms of infection. During a review of Resident 7's Physician order dated 11/1/2025, the Physician order indicated Resident 1 had scheduled dialysis every Tuesday, Thursday, and Saturday starting 10/28/2025. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool) dated 11/12/2025, the MDS indicated Resident 7 had moderately impaired cognition (ability to think, reason, and function). The MDS indicated Resident 7 had ESRD and was on dialysis. During a concurrent interview and record review on 12/3/2025 at 1:25 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 7's dialysis resident communication record, dated 11/29/2025 was reviewed. The record did not indicate Resident 7's post dialysis vital signs (basic measurements including body temperature, pulse rate, respiration rate, and blood pressure), assessment of access site, dressing, and condition of resident were documented. LVN 1 stated the licensed nurse on duty should have assessed the resident and completed the dialysis resident communication record after the resident returned from dialysis. LVN 1 stated assessment of residents' post dialysis is important to ensure any changes in residents' conditions are monitored. LVN 1 stated access site assessment for swelling, redness, bleeding and dislodgement is important to ensure residents' safety and prevent potential complications. During an interview on 12/4/2025 at 12:39 p.m. with the Director of Nursing (DON), the DON stated that licensed nurses must perform post dialysis assessment upon the resident's return from dialysis and document the findings in the dialysis resident communication record form. The DON stated post dialysis assessment and documentation is important to be able to monitor resident's condition after dialysis and to prevent complications that may lead to hospitalization. During a review of the facility's policy and procedure (P&P) titled, Renal dialysis, care of resident, Hemodialysis access site, diet/fluid restrictions, care plan, dated 06/2009, the P&P indicated, Facility Licensed Nurse will complete the baseline information, pre and post dialysis section of the Nurses Dialysis Communication Record.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for fourteen (14) out of eighteen (18) resident rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 15, and 16). The 14 resident rooms consisted of 14 -two (2) bed capacity rooms. This deficient practice had the potential to impact the ability of the staff to provide safe nursing care and privacy to the residents. Findings: During an interview with the Administrator (ADM) on 12/1/2025 at 10:44 AM, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) this year. A review of the facility's letter to request for additional room waiver dated 12/1/2025 indicated the size of the rooms caused no negative outcome with regards to the health, safety, and welfare of all the residents in the facility. The request indicated the following resident bedrooms were: room [ROOM NUMBER] (2 beds) 2 residents 134.42 sq. ft. 67.21 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 134.42 sq. ft. 67.21 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 131.99 sq. ft. 66 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 131.99 sq. ft. 66 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 135.63 sq. ft. 67.82 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 139.27 sq. ft. 69.64 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 147.74 sq. ft. 73.87 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 135.63 sq. ft. 67.82 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 135.63 sq. ft. 67.82 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 135.63 sq. ft. 67.82 sq. ft. room [ROOM NUMBER] (2 beds) 2 residents 147.74 sq. ft. 73.87 sq. ft. room [ROOM NUMBER] (2 beds) 1 resident 135.63 sq. ft. 67.82 sq. ft. room [ROOM NUMBER] (2 beds) 0 residents 138.05 sq. ft. 69.03 sq. ft. During an interview with the ADM on 12/3/2025 at 3:20 PM, the ADM stated there have been no complaints regarding care and services from residents, resident families, and staff about the room size. During an observation from 12/1/2025 to 12/4/2023, Rooms 1, 2, 3, 4, 5, 6, 7, 8, 10, 12, 13, 14, 15, and 16 had adequate space, nursing care, comfort, and privacy to the residents. The residents residing in the affected rooms were observed to have enough space for the residents to move freely inside the rooms. Each resident inside the affected rooms had beds and bedside tables with drawers. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,), or canes. The room size did not affect the care and services provided to the residents when nursing staff were observed providing care to the residents. During an interview on 12/3/2025 at 3:08 PM, Resident 3 stated he had enough space in room [ROOM NUMBER] to move in and out with a wheelchair. A review of the facility's policy and procedure titled Accommodation of Needs, dated 4/2019 indicated resident has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences. The P&P indicated reasonable accommodations of individual needs and preferences meant the facility's efforts to individualize the resident's physical environment including resident's bedroom and bathroom. The P&P indicated the facility will evaluate the resident's unique needs and make environmental accommodations to the extent reasonable.		