

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055764	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2022
NAME OF PROVIDER OR SUPPLIER WHITTIER PACIFIC CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S PICKERING AVENUE WHITTIER, CA 90602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00776203 Representing the Department: Health Facilities Evaluator Nurse: 44018 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were identified for the complaint number: CA00776203 (Refer to Ftags F686 and F732).	F 000	Whittier Pacific Care Center makes it best efforts to operate in full compliance with both Federal and State regulations. Nothing included in this plan of correction is an admission otherwise. Whittier Pacific Care Center has submitted this plan of correction in order to comply with its regulatory obligation and does not waive any objection to the merit or form of allegation contained herein. The submission of this plan of correction constitutes our allegation for compliance.		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide wound treatment as ordered on	F 686	Corrective Action Resident 1 is no longer at the facility. The Director of Nursing gave an inservice to the treatment nurse on 5/6/2022 regarding proper body assessment, treatment and documentation of residents with admitted and acquired wounds. Identification of Others The Director of Nursing and the RN Supervisor randomly selected 10 sample residents with treatment orders on 5/6/22 to ensure appropriate treatments were provided and assessment and documentation were completed. There was no problem identified. Measures To Prevent Recurrence The Director of Nursing gave an inservice to the treatment nurse and licensed nurses on 5/6/22 regarding treatment policy and procedure and pressure sore documentation. During the inservice, the DON trained	5/6/22 5/6/22 5/6/22	

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

TITLE

(X6) DATE

Administrator

5/13/22

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085764	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2022
NAME OF PROVIDER OR SUPPLIER WHITTIER PACIFIC CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S PICKERING AVENUE WHITTIER, CA 90602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 686	<p>Continued From page 1</p> <p>two days (3/20/22 and 3/21/22) for one of three sampled residents (Resident 1), who had a pressure ulcer (painful wound caused as a result of pressure or friction) to the sacral region (low back) unstageable (full-thickness skin and tissue loss in which actual depth of the ulcer is completely obscured by slough-yellow, tan, green or brown and/or eschar-tan, brown, or black, in the wound bed) and failed to reassess the resident's pressure ulcer upon readmission to the facility on 3/18/22 by measuring the wound size.</p> <p>This deficient practice had the potential for the resident's pressure ulcer to worsen and/or develop a serious infection.</p> <p>Findings:</p> <p>A review of the Resident 1's Admission Record indicated the resident was initially admitted to the facility on 2/1/22 and readmitted on 3/18/22 with diagnoses that included urinary tract infection (UTI, an infection of the bladder and urinary system) and pressure ulcer sacral region, unstageable.</p> <p>A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 2/7/22, indicated the resident had moderate impairment in cognitive skills (ability to make daily decisions) and required total dependence (full staff performance every time) from staff for bed mobility, transfers, dressing, and personal hygiene.</p> <p>A review of Resident 1's care plan titled, "Actual Pressure Sore," dated initiated on 2/4/22, indicated the resident had an unstageable pressure ulcer to his sacrococcyx and an</p>	F 686	<p>the staff on how to properly document measurement and assessment of wounds.</p> <p>The DON will repeat the inservices monthly for 3 months and then quarterly and as needed.</p> <p>Monitoring Performance</p> <p>The treatment nurse will continue to assess wounds weekly using our weekly body check form and our weekly wound progress form. This process will be monitored and reviewed by the Director of Nursing and/or designee for 3 months to ensure compliance. All findings will be corrected immediately and will be reported during our monthly Quality Assurance meeting for evaluation and further action.</p>	05/6/22-8/6/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055764	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2022
NAME OF PROVIDER OR SUPPLIER WHITTIER PACIFIC CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S PICKERING AVENUE WHITTIER, CA 90602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	<p>Continued From page 2</p> <p>intervention to administer treatment as ordered.</p> <p>A review of Resident 1's Wound Progress Report on 2/4/22 at 3:35 p.m., indicated the facility would reposition frequently and provide adequate skin care daily. The report also indicated that the facility was unable to reposition the resident due to a neck fracture and would have to turn and position as "log (logrolling is a maneuver used to move a patient without flexing the spinal column)," and that the wounds were at high risk for decline.</p> <p>A review of Resident 1's wound consult's weekly assessment titled, "Trunk Wound Assessment," dated 3/2/22, indicated the resident's unstageable pressure ulcer to the sacrococcyx measured at 5 centimeters (cm, a unit of measurement) in length, 5 cm in width, and 0.4 cm depth.</p> <p>A review of Resident 1's physician's order, dated 3/5/22, indicated an order for the facility to transfer the resident to a general acute care hospital (GACH) with a seven (7) day bed hold.</p> <p>A review of Resident 1's Admission Reassessment, dated 3/19/22 (14 days after hospitalization), indicated that the resident had an unstageable pressure ulcer to sacrum. There was no documentation indicating that the wound was measured upon readmission (3/18/22) on the record.</p> <p>A review of Resident 1's physician's order, dated 3/19/22, indicated to treat sacrococcyx (tail bone) unstageable pressure injury by cleaning with normal saline (NS, sterile salt solution), pat dry, apply hydrogel gel (clear wound gel dressing helps provide the optimal environment for natural</p>	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065764	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2022
NAME OF PROVIDER OR SUPPLIER WHITTIER PACIFIC CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S PICKERING AVENUE WHITTIER, CA 90602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 686	<p>Continued From page 3</p> <p>wound healing), cover with dry dressing every day shift for 30 days.</p> <p>A review of Resident 1's Treatment Administration Record (TAR), for the month of March 2022, there was no documentation indicating that the resident received treatment on 3/20/22 and 3/21/22 to the sacrococcyx pressure ulcer as ordered.</p> <p>During an interview on 3/22/22 at 11:02 a.m., a Licensed Vocational Nurse 1 (LVN 1) stated that she did not provide wound care to Resident 1 and that the wound care nurse was the one who provided wound treatment to the residents. LVN 1 stated that treatment nurse was on vacation (on 3/20/22 and 3/21/22) and that another treatment nurse should have provided wound care to Resident 1.</p> <p>During an interview on 3/22/22 at 11:57 a.m., Treatment Nurse 1 (TN 1) stated that Resident 1 was supposed to receive treatment for pressure ulcers on 3/20/22 and 03/21/22, to prevent the pressure ulcers from worsening and to prevent potential infection of the wounds.</p> <p>A review of the facility's undated policy and procedure (P&P) titled, "Treatment Policy and Procedure," indicated to ensure that all licensed nurses follow the proper procedure in rendering treatments to protect both the resident and staff from bacterial cross-contamination. The P&P indicated that treatments shall be provided according to the following procedures but not limited to: reading the order transcribed on the resident's treatment record, proceeding with treatment order, and documenting treatment record after treatment was completed.</p>	F 686			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085764	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2022
NAME OF PROVIDER OR SUPPLIER WHITTIER PACIFIC CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S PICKERING AVENUE WHITTIER, CA 90602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 732 SS=B	<p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:</p> <p>(i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced</p>	F 732	<p>Corrective Action Upon notification, the Director of Nursing updated and posted the nurse staffing hours at each station immediately.</p> <p>Identifying Potentially Affected Residents No residents have been affected by this deficient practice.</p> <p>Measures To Prevent Recurrence The Director of Nursing provided an inservice to the licensed staff on 5/6/22 regarding the policy and procedure on daily staffing and posting. During the inservice the Director of Nursing emphasized the importance of making the residents and families aware of the daily nursing hours.</p> <p>Monitoring Performance The DON and/or Designee will do visual rounds daily for four weeks to ensure that the nursing hours are completed and posted. All progress will be discussed during our monthly Quality Assurance meeting.</p>	3/22/22 5/6/22 5/6/22- 6/6/22	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055764	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/22/2022
NAME OF PROVIDER OR SUPPLIER WHITTIER PACIFIC CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7716 S PICKERING AVENUE WHITTIER, CA 90602		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 732	<p>Continued From page 5</p> <p>by: Based on observation, interview and record review, the facility failed to ensure the daily posting of nursing staff hours were updated/completed at the beginning of each shift in accordance with federal requirements.</p> <p>This deficiency had the potential for visitors and residents to not be aware of the actual nursing hours provided during each shift accurately.</p> <p>Findings:</p> <p>During an observation and interview on 3/22/22 at 10:10 a.m., the Director of Nursing (DON) stated that the facility's nursing staff hours posted, dated 3/21/22, in Nurse ' s Station 1 was not updated or changed (to reflect 3/22/22). The DON stated that the payroll clerk or charge nurse were responsible for updating and posting the staffing information every day at 9 a.m. The DON stated the staffing information was not updated and the last time payroll clerk or charge nurse updated the information was on 3/21/22. The DON stated that she will update the information.</p> <p>A review of the facility's policy and procedure titled, "Skilled Nursing Facility (SNF) Staffing," dated 7/2/18, indicated that the daily staffing posting will be posted in the SNF to meet State mandated hours for staffing.</p>	F 732			