STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055764	A. BUILDING _____ B. WING _____	**05/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITTIER PACIFIC CARE CENTER	**7716 S PICKERING AVENUE WHITTIER, CA 90602**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the physician orders [REDACTED]. This deficient practice had the potential for further contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) for the resident. Findings: A review of Resident 1's Admission Record indicated the resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 1/28/2020, indicated the resident had severe impairment in cognitive skills. According to the MDS, Resident 1 was totally dependent (full staff performance every time) from staff for bed mobility, transferring, dressing, and eating. During a phone interview, on 3/16/2020 at 1:40 p.m., Family Member 1 (FM 1) stated when he would visit Resident 1 the resident would not have the splints on as requested by the family and as ordered by the physician to prevent contractures. During a phone interview, on 5/14/2020 at 9:30 a.m., the Director of Nurses (DON) stated she was unable to find any documentation indicating the RNA's were placing splint on at night as ordered for Resident 1. A record review of Resident 1's Physician Orders, dated 2/4/2020, indicated RNA to assist in the application of the right elbow extension splint twice a day (BID) three hours in the morning (9 a.m. to 12 p.m.) and three hours at night (9 p.m. to 12 a.m.) daily. RNA to observe for skin irritation. A record review of the facility's undated policy and procedure titled, Splinting, indicated upon the receipt of the splint, the therapist will apply the splint and make the necessary fitting adjustments. After the patient has been screened for the appropriateness of splinting, the charge nurse or the therapist will contact the physician to secure an evaluation order an treatment sessions for splint application, the monitoring of wear schedule, splint modifications as needed and instructions for the nursing staff.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's [MEDICAL CONDITION] (trach, tube inserted through a hole in the neck) was not dislodged during care for one of three sampled residents (Resident 1). This deficient practice resulted in Resident 1'[MEDICAL CONDITION] dislodged and requiring transfer to a General Acute Care Hospital (GACH). Findings: A review of Resident 1's Admission Record indicated the resident admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated [DATE], indicated the resident had severe impairment in cognitive skills. According to the MDS, Resident 1 was totally dependent (full staff performance every time) from staff for bed mobility, transferring, dressing, and eating. During an interview, on [DATE] at 12:45 p.m., the Director of Nurses (DON) stated a Certified Nursing Assistant 1 (CNA 1) informed her that she dislodged Resident 1'[MEDICAL CONDITION] changing Resident 1's brief (undergarment) and that a Respiratory Therapist (RT) reinserted the trach. The DON stated the staff notified her that Resident 1 transferred to a GACH. The DON stated the dislodgement could have been prevented. During a phone interview, on [DATE] at 10:20 a.m., a Registered Nurse 1 (RN 1) stated around 8 p.m. on [DATE] CNA 1 called and informed a Licensed Vocational Nurse 1 (LVN 1) that Resident 1 was pale and [MEDICAL CONDITION] dislodged. RN 1 stated when he entered Resident 1's room [MEDICAL CONDITION] in the RT 2's hands and he was attempting to replace the trach. RT 2 was unsuccessful. RT 1 was called and was able to replace Resident 1's trach. The staff started to use an AMBU bag (a device to provide pressured ventilation to persons who are not breathing or not breathing adequately) Resident 1 due to low oxygen saturation (a measurement of oxygen in the blood). RN 1 stated they called 911(emergency services) around 8:10 p.m., and paramedics arrived around 8:15 p.m. During a phone interview, on [DATE] at 12 p.m., LVN 1 stated on [DATE] when she arrived back to the nursing station after her lunch break she noticed they were calling a code (such as calling for help for someone under respiratory distress) on Resident 1. LVN 1 stated CNA 1 informed her while changing Resident 1, the resident turned purple. During a phone interview, on [DATE] at 10 a.m., CNA 1 stated she remembered when she finished changing Resident 1's briefs (after he had a bowel movement), the resident turned purple. CNA 1 stated it took about 15 minutes from start to finish in changing Resident 1's briefs. A review of Resident 1's Change of Condition/ Interactive Assessment Form, dated [DATE] indicated at 8 p.m., CNA 1 informed charge nurse that Resident 1's skin was pale in color. The charge nurse assessed the resident and the resident'[MEDICAL CONDITION] dislodged. RT was able to reinsert. Resident 1's oxygen fluctuating from 69% to 76% (normal 95% to 100%). Despite having oxygen and assisted breathing with the artificial manual breathing unit bag (AMBU bag, provides pressured ventilation to persons who are not breathing or not breathing adequately). Paramedics were called at 8:10 p.m. A review of the Prehospital Care Report Summary (a report from the local fire department), dated [DATE] indicated paramedics were called to the facility for a [MEDICAL CONDITION] low oxygen saturation. On arrival to the facility, the paramedics took over Cardio-Pulmonary Resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating). A review of a GACH record from the Emergency Department (ED), dated [DATE] indicated Resident 1, who [MEDICAL CONDITION], presented with [MEDICAL CONDITION] (heart stops beating). Paramedics reported to the ED that Resident 1'[MEDICAL CONDITION] dislodged for approximately 20 minutes and when paramedics arrived to the facility, staff was bagging Resident 1. A record review of the facility's undated policy and procedure titled, Turning Residents with [MEDICAL CONDITION] Site, indicated to: monitor if [MEDICAL CONDITION] site is intact and in place, monitor signs and symptoms of respiratory distress, monitor skin color change and head of bed elevated at all times for aspiration precautions and respiratory distress.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.