STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555654	A. Building B. Wing	07/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Presbyterian Intercomm Hosp Dp/Snf	12401 Washington Blvd. 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview and record review, the facility failed to promote care that maintained dignity and respect for one of one sampled residents (Resident 11) by failing to ensure Resident 11's drainage bag (a tube that removes fluid from the body into a collection bag connected to the resident that stored body fluids) from the stomach that was hanging from on the resident's bed frame was not exposed to the public and uncovered. This deficient practice had the potential to affect the resident's psychosocial (emotional and mental status) being and deprive the resident from dignity. Findings: During initial tour of the facility, on 7/12/24 at 6:48 pm, Resident 11 was observed in the room, laying lying in bed, with a catheter bag hanging on the right side of the residents' bed, exposed to the public and un-covered was with cloudy sediments (matter that settles in the bottom of the tube or bag) in the tubing and bag, was observed. During a review of Resident 11's Face Sheet Report (an admission record), indicated Resident 11 was admitted to the facility on [DATE]. During a review of Resident 11's History and Physical dated 7/19/24, indicated Resident 11 had a history of paraesophageal hernia (part of stomach moves up to the chest area) status post [after] repair with gastrojejunostomy (GJ, a feeding device place in the stomach to bypass the mouth, throat and stomach) tube placement. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 6/25/24, indicated Resident 11's cognition (intellectual activity such as thinking, reasoning, or remembering) was moderately intact, that needed maximal assistance (helper does more than half the effort) with lower body dressing and toilet hygiene. During a review of Resident 11's Patient Transfer Orders Active Orders on 7/14/24, indicated Miscellaneous Nursing: gastrostomy port (a surgical opening through the skin of the abdomen to the stomach) drain to drainage bag (catheter bag) by gravity. Gastrostomy site cleanse with normal saline (electrolyte fluid) and cover with dry dressing daily and as needed. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview with Licensed Vocational Nurse 1 (LVN 1), on 7/12/24 at 7:16 pm, LVN 1 stated Resident 11's catheter bag did not have a dignity cover. LVN 1 stated catheter bags should always have a privacy bag and it was important for Resident 11's dignity. During an interview with the Director of Nursing (DON) on 7/13/24 at 6:37 pm, the DON stated catheter bags should be covered at all times, it did not matter if urine or whatever bodily fluids were contained in the bag, for dignity reasons, the catheter bag should always be covered. A review of the facility's policy and procedure titled Patient Rights and Responsibilities - E.87200.704, approved on 12/16/2021, indicated the facility believed that patients have certain rights and responsibilities while under the care and services (of the facility). Patients had the rights to: considerate and respectful care and to be made comfortable.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to report an allegation of abuse to the Department of Health Services (DHS a government agency that promotes and protects the health of all people and their communities) and the state agencies within the two-hour time frame as indicated in the facility's policy and procedure for one of two sampled residents (Resident 69). The Licensed Vocational Nurse (LVN) 2 did not report to the Director of Nursing (DON) when Resident 69 reported to LVN 2 that a staff member (unknown) yelled and was mean to Resident 69. This deficient practice violated the resident's rights to be free from any form of abuse and the potential for Resident 69 not to be protected and to further experience mental and emotional abuse that could lead to a psychosocial (mental and emotional being) and decline. Findings: During a review of Resident 69 Face Sheet Report indicated Resident 21 was admitted to the facility on [DATE]. During a review of Resident 69's Admission History and Physical record, dated 7/10/2024, indicated Resident 69 was awake, alert and oriented and diagnosis that included acute (severe and sudden in onset) cerebral vascular accident (a loss of blood flow to part of the brain), hypertension (elevated blood pressure) and coronary artery disease (a condition that affects your heart) , hemiplegia and hemiparesis (muscle weakness on one side of the body) following a cerebral infarction (a stroke), congestive heart failure (CHF, the heart doesn't pump blood as well as it should) and major depressive disorder (feelings of sadness and/or a loss of interest in activities once enjoyed). During a record review of Resident 69's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 7/13/2024, indicated Resident 69 was cognitively (intellectual activity such as thinking, reasoning, or remembering) intact, had clear speech, had the ability to express ideas and wants and had the ability to understand others. The MDS indicated Resident 69 needed partial assistance (staff provided some support) with self-care (bathing, dressing and using the toilet) and was impaired on one side of the residents upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities. During an observation and interview with LVN 2 on 7/13/2024 at 10:01 AM, Resident 69 was at bedside and reported experiencing leg cramps a few days ago (unknown date). Resident 69 stated he requested from Nurse 1 (N1) (unknown) to assist him in sitting up in a chair next to the resident's bed. Resident 69 stated N1 yelled at him and stated, you are not going anywhere. Resident 69 stated N1 was mean and yelled at him stating You are going to stay where you are at and that was that!. Resident 69 stated he felt disrespected and berated and it was not a pleasant experience. Resident 69 stated being yelled at felt as some type of verbal abuse. During an interview on 7/13/2024 at 10:56 AM with the Director of Nursing (DON), the DON stated LVN 2 informed him about Resident 69's allegation of abuse. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/13/2024 at 1:50 PM with Registered Nurse (RN) 2, RN 2 stated Resident 69 was alert and oriented and was able to make his own decisions. During an interview on 7/13/2024 at 3:19 PM with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated Resident 69 was awake, alert and oriented and had never heard Resident 69 make up stories. During an interview on 7/13/2024 at 4:29 PM, the DON stated abuse was defined as any type of financial, physical, sexual, neglect or verbal abuse. DON stated, he was aware of the allegation of abuse reported by Resident 69, but At this time, the allegation of abuse has not been reported to the Department of Health (DPH) and the state agencies. DON stated it was important to report any allegation of abuse because it needs to be escalated for proper authorities to ensure the safety of the resident and needs were meet so it (abuse) does not happen again. During a review of the facility's policy and procedure titled Abuse, Neglect, and Misappropriation of Property - E69010.001, dated 10/13/2022, indicated each resident has the right to be free from abuse, corporal punishment (physical punishment), and involuntary seclusion (separation of a resident from other residents or locked to her/his room against their will) period. Residents must not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies service the resident, family member(s), legal guardians, friends, or other individuals. All employees of long-term care facilitys are mandated reporters of elder or dependent abuse as set forth under Section 15655 of the Welfare and Institutions Code and in accordance to State Operations Manual for Long Term Care Facilities 2017. Additionally, 483-13 (b) of the State operations Manual for Long Term Care Facilities, 2017 requires that alleged violations within the facility and the result of internal investigations be reported to the Department of Health Services. Investigation/Reporting: mandated reporters are required to report incidents of known or suspected abuse: all alleged violations - immediately but no after than 2 hours - if the alleged violation involves abuse .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to ensure one of two closed sampled residents (Resident 13), received notification of the transfer/discharge from the facility and the reasons for the move in writing. As a result of this failure the facility deprived Resident 13 the right to be informed regarding transfer and discharge from the facility. Findings: During a review of Resident 13's Facesheet Report (AR, Admission Record), the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation with rapid ventricular rate (a-fib with RVR, an abnormal heart rhythm). The AR indicated Resident 13's was discharged from the facility to General Acute Care Hospital (GACH) on 4/20/2024. During a concurrent interview and record review on 7/14/2024 at 2:44 PM with the Director of Nursing (DON), of the electronic medical record (EMR) indicated Resident 13 was not notified in writing of Resident 13's transfer/discharge to GACH. The DON stated Resident 13 was discharged back to the cardiac unit of the GACH due to the resident experiencing worsening edema (swelling caused by too much fluid trapped in the body's tissues) and A-fib with RVR. The DON stated the facility did not have a discharge/transfer notification document during the time that Resident 13 was discharged from the facility. The DON stated a discharge/transfer notification document had not been developed yet. During a review of the facility's Transitional Care Unit Notice of Proposed Transfer/Discharge (Transfer/Discharge Notice), The Transfer/Discharge Notice indicated the document was created on 6/18/2024. During an interview on 7/14/2024 at 3:11 PM with the DON, the DON stated the facility did not have a policy and procedure (P&P) for providing notification to residents about their transfer/discharge. The DON stated the facility was currently developing that policy.

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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** 44027 Based on observation, interview, and record review, the facility failed to assess the risk for accidental choking for one of one sampled resident (Resident 116), for the ability to chew food and safely eat a regular textured diet (all food textures that people with no chewing or swallowing issues eat) who had missing top teeth and dentures. This failure had the potential for Resident 116 to choke on her food and result in accidental death. Findings: During a review of Resident 116's Face sheet Report (AR, Admission Record), the AR indicated Resident 116 was admitted to the facility on [DATE] with the diagnosis of chest pain. During a review of Resident 116 ' s TCU History and Physical (H&P), dated 7/8/2024, the H&P indicated, the reason Resident 116 was admitted to the facility was to receive Physical Therapy (PT, therapy that is used to preserve, enhance, or restore movement and physical function impaired, Occupational Therapy (OT, helps you improve your ability to perform daily tasks), and Wound Care (treatment of a wound). During a concurrent observation and interview on 7/12/2024 at 8:02 pm, with Resident 116 ' s Resident Representative (RR) 1 in Resident 116 ' s room, Resident 116 was missing her top teeth. RR 1 stated Resident 116 was also missing the top dentures which was at Resident 116 ' s home. RR 1 stated RR 1 was concern for Resident 116 because the facility was serving Resident 116 meals with meat that was whole (not cut up). RR 1 stated Resident 116 almost choked on the chicken that was not cut up which was served for dinner (on 7/12/2024). During a concurrent interview and record review on 7/13/2024 at 2:44 pm, with Registered Nurse (RN) 1, the electronic medical record (EMR) failed to indicate Resident 116 was missing her top teeth and dentures. RN 1 stated Resident 116 was receiving regular textured meals in which the meat was not cut up. During an interview on 7/13/2024 at 4:05 pm, with the Assistant Director of Nursing (ADON), the ADON stated the reason it was important for the nursing staff to assess resident ' s (in general) teeth was because the assessment would determine the resident ' s (in general) ability to chew food. The ADON stated there was a risk residents (in general) could aspirate if they could not chew the food correctly. The ADON stated if residents (in general) were missing their top teeth, Speech Therapy (ST) should assess the resident to determine they could tolerate their diet. The ADON stated Resident 116 ' s medical EMR failed to indicate Resident 116 was assessed by ST. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/14/2024 at 8:58 am, with RN 2, RN 2 stated RN 2 assessed Resident 116 ' s ability to chew her food on 7/13/24 at 5pm, because the Surveyor had informed facility staff Resident 116 was having difficulty chewing her food. RN 2 stated Resident 116 was not able to gum her food (chewing food without teeth). RN2 stated RN2 ordered a trial tray for Resident 116 to determine what textured diet was safe for Resident 116. RN 2 stated Resident 116 did well with the soft and bite size texture (used if you are not able to bite off pieces of food safely but are able to chew bite-sized pieces down into little pieces that are safe to swallow). RN 2 stated nursing should examine a resident ' s (in general) mouth upon admission. RN 2 stated sometimes residents come without their dentures. RN 2 stated nursing should watch them to monitor if the ordered diet texture is safe for them. During a review of Resident 116 ' s Patient Transfer Orders, the Patient Transfer Orders indicated Resident 116 ' s diet texture was changed to soft and bite-sized on 7/13/2024 at 6:28 pm. During a review of the facility's policy and procedure (P&P) titled, Medical-Surgical Standards of Care, revised 3/28/2024, the P&P indicated, Utilizing nursing process, registered nurse provides a systematic exam assessing patient's condition/needs, identifying actual and/or potential health related problems in order to evaluate, develop and implement an individualized plan of care. The P&P indicated, It is policy that all patients receive quality care which is individualized and appropriate based on developmental level. The P&P indicated, Transitional care unit (TCU) will complete a head-to-toe assessment minimally every 24 hours.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in the kitchen. During initial tour of the kitchen, an opened container of salad was observed unlabeled with the name of the food item and dated of when the food was prepared or to be discarded. This failure had the potential for improper food storage, which could lead to foodborne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins). Findings: During an initial tour of the kitchen, on [DATE] at 5:55 PM, with the Supervisor Food Services (SFS) an opened container of salad, wrapped in clear plastic wrap, was observed in the facility ' s cold production refrigerator. The container was unlabeled with the name of the food item and dated of when the food was prepared or to be discarded. The SFS stated the container of salad might be a staff ' s personal salad. The SFS stated the container should not be stored in the cold production container if it was a staff person ' s salad. The SFS stated all food items should be dated and labeled. The DSD stated the food item could be expired. During an interview on [DATE] at 10:07 AM, with the System Director Infection Preventionist (SDIP), the SDIP stated the food items in the refrigerator should be labeled and dated to know if the food is expired. The SDIP stated residents could be exposed to foodborne illnesses if residents were served expired food. During a review of the facility ' s policy and procedure (P&P) titled, Patient Floor stock Food Supplies, revised [DATE], the P&P indicated, All perishable food will be dated to ensure food safety. The P&P indicates, Items not commercially labeled will have a label affixed stating date and contents . The P&P indicated, Staff food must be kept separate from the patient food. Staff shall not store their food in the patient refrigerator or freezers.