

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Covina Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 261 W. Badillo Street Covina, CA 91723	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</b></p> <p>Based on interview and record review, the facility failed to promptly (punctually [with little or no delay]) notify the responsible party (RP) for one of five sampled residents (Resident 3) who experienced a change of condition (COC- a sudden clinically important deviation from a resident/patient's baseline in physical, behavioral, or functional domains), as indicated in the facility's policy and procedure (P&amp;P) titled, Change in a Resident's Condition or Status, by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure Licensed Vocational Nurse (LVN) 2 notified Resident 3's RP (RP 1), promptly when LVN 2 noted bruising (mark on the skin caused by blood trapped under the surface because of injury to small blood vessels but does not break the skin) to Resident 3's right knee on 7/15/2024 at 2:34 pm.</li> <li>2. Ensure facility staff notified RP 1 on 7/17/2024 when the results of Resident 3's electromagnetic radiation (X-ray- type of radiation that creates picture of the inside of the body) showed that Resident 3 sustained a fracture (a complete or partial break in a bone) to the proximal (closer to head) phalanx (toe bone) of the great toe (big toe).</li> </ol> <p>These failures resulted in a delay of informing and making RP 1 aware of Resident 3's change in condition timely and prevented RP 1 from being included in decision making regarding Resident 3's plan of care.</p> <p>Findings:</p> <p>During a review of Resident 3's Admission Record (AR), the AR indicated, the facility admitted Resident 3 to the facility on [DATE], with diagnoses that included Alzheimer's Disease (progress disease that affects through, memory, and language, beginning with mild memory loss that leads to the loss of the ability to carry on conversation and respond to the environment), encephalopathy (disease of the brain that alters brain function or structure), and dysphagia (difficulty or discomfort in swallowing).</p> <p>During a review of Resident 3's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 6/19/2024, the MDS indicated, Resident 3 had severely impaired cognition (ability to think, remember, and function). The MDS indicated, Resident 3 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) on staff for eating, oral, toileting and personal hygiene, upper and lower body dressing, putting on and taking off footwear, and rolling left and right in bed.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3's COC/Interact Assessment Form (Situation-Background-Assessment-Recommendation [SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations]), dated 7/15/2024 at 2:34 pm, the COC/SBAR Form indicated, Resident 3 was weak and lethargic (abnormal sleepiness or deep unresponsiveness and inactivity), and noted with one bruise (mark on the skin caused by blood trapped under the surface as a result of injury to small blood vessels but does not break the skin) on the right knee. The COC/SBAR Form indicated, Resident 3's hospice (care that focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) was notified on 7/15/2024 at 2:20 pm. The COC/SBAR Form indicated, no documentation that RP 1 was notified.</p> <p>During a review of Resident 3's Interdisciplinary Team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) Narrative dated 7/17/2024 at 3:54 pm, the IDT Narrative indicated, on 7/17/2024, the IDT met and discussed Resident 3's condition. The IDT Narrative indicated, Resident 3 had bluish discolorations to the right knee and right foot. The IDT Narrative indicated, Resident 3's Responsible Party (RP 1), was present at bedside and notified of plan. The IDT Narrative indicated, staff did not report any fall incident involving Resident 3, and Resident 3 was unable to tell staff how the discolorations occurred. The IDT Narrative indicated, the Certified Nursing Assistant (CNA), unidentified, found discoloration to Resident 3's right knee and right foot, measuring one (1) by one (1) centimeter (cm- unit of measurement) and 8.3 cm by 6.2 cm, respectively, while changing Resident 3's brief and notified LVN 2. The IDT Narrative indicated, Resident 3 was unable to give a description of the incident.</p> <p>During a review of Resident 3's Progress Notes (PN) dated 7/17/2024 at 3:38 pm, the PN indicated, on 7/16/2024 at 2:45 pm, the Registered Nurse Supervisor (RNS), unidentified, notified the DON that RP 1 was at Resident 3's bedside and was concerned about Resident 3's right knee and foot discoloration. The PN indicated, the facility would obtain an X-ray order from Resident 3's physician (Medical Doctor [MD] 1) and would call Resident 3's family and MD 1 with the results.</p> <p>During a review of Resident 3's PN dated 7/17/2024 at 9:49 pm, the PN indicated, (on 7/17/2024), at 3:45 pm, Resident 3 had a fracture to the right proximal phalanx of the great toe with soft tissue (refers to skin, muscle, fat, and/or blood vessel that connects, supports, or surrounds bones and organs) swelling.</p> <p>During a telephone interview on 7/30/2024 at 2:15 pm with RP 1, RP 1 stated the facility did not notify RP 1 on 7/15/2024 when the facility found Resident 3's bruising to the right knee and foot. RP 1 stated RP 1 saw the bruising to Resident 3's right knee and foot while visiting Resident 3 on the afternoon of 7/16/2024. RP 1 stated RP 1 asked a nurse (unidentified) about the bruising and the nurse got the Director of Nursing (DON). RP 1 stated the DON informed RP 1 that DON had not been informed about Resident 3's bruising until seeing it with RP 1 on 7/16/2024. RP 1 stated on 7/18/2024, the hospice staff not the facility staff, notified RP 1 that Resident 3 sustained a foot fracture. RP 1 stated it was very stressful to see Resident 3's bruising to the right knee and foot and the facility staff not knowing what happened to Resident 3 regarding the bruising.</p> <p>During an interview on 7/31/2024 at 3:31 pm, with CNA 1, CNA 1 stated while changing Resident 3's brief on 7/15/2024 (time unknown), CNA 1 noticed a bruise on Resident 3's right knee. CNA 1 stated CNA 1 did not notice a bruise on Resident 3's right foot. CNA 1 stated CNA 1 immediately reported the bruising to LVN 2.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 7/31/2024 at 3:36 pm with LVN 2, LVN 2 stated on 7/15/2024, unable to recall time, CNA 1 reported to LVN 2 that Resident 3 had bruising to Resident 3's right knee. LVN 2 stated LVN 2 reported Resident 3's right knee bruising to the hospice nurse right away. LVN 2 stated LVN 2 did not observe the bruising to Resident 3's right foot at that time. LVN 2 stated LVN 2 did not report Resident 3's right knee bruising to any other staff including the DON until 7/16/2024 (a day later) after RP 1 noticed the bruising while at Resident 3's bedside. LVN 2 stated LVN 2 did not notify RP 1 about the bruising (on 7/15/2024).</p> <p>During a concurrent interview and record review on 7/31/2024 at 4:18 pm with the DON, Resident 3's COC/SBAR Form dated 7/15/2024 and PN dated 7/16/2024 were reviewed. The DON stated LVN 2 did not make the DON aware of Resident 3's bruising to the right knee and foot until the afternoon of 7/16/2024 when RP 1 was visiting Resident 3. The DON stated LVN 2 did not notify RP 1 about Resident 3's bruising on 7/15/2024 when LVN 2 first noted the bruising. The DON stated LVN 2 did not notify RP 1 about Resident 3's right foot X-ray results on 7/17/2024. The DON stated it was important to ensure residents' responsible parties were notified of residents' changes in condition on the same day to keep them informed so they could be participants of the plan of care. The DON stated not notifying RP 1 of Resident 3's right knee bruising on 7/15/2024 and right foot X-ray results on 7/17/2024 kept RP 1 out of the loop and unable to ask questions or be a participant in Resident 3's plan of care.</p> <p>During a review of the facility's P&amp;P titled, Change in a Resident's Condition or Status, undated, the P&amp;P indicated, the facility promptly notified the residents, his or her attending physician, and the resident's representative of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc). The P&amp;P indicated, a significant change of condition was a major decline or improvement in the resident's status that would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (was not self-limiting), impacted more than one area of the resident's health status, and required facility review and/or revision to the care plan. The P&amp;P indicated, unless otherwise instructed by the resident, a nurse notified the resident's representative when the resident was involved in an accident or incident that resulted in an injury including injuries of an unknown source, and there was a significant change in the resident's physical, mental, or psychosocial status. The P&amp;P indicated, except in medical emergencies, notifications will be made within 24 hours of a change occurring in the resident's medical/mental condition or staff.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46687</p> <p>Based on interview and record review, the facility failed to report an injury of unknown origin/source (the source of the injury was not observed by any person and could not be explained by the resident) immediately, but not later than 24 hours to the Administrator (ADM) of the facility, the California Department of Public Health (CDPH), local law enforcement, and Ombudsman (resident advocate who investigates, reports, and helps settle complaints) as indicated in the facility's policy and procedure (P&amp;P) titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, for one of five sampled residents (Resident 3).</p> <p>This failure violated the mandated reporting timeframe and had the potential to compromise Resident 3's safety and could result in further injuries potentially related to abuse for Resident 3.</p> <p>Findings:</p> <p>During a review of Resident 3's Admission Record (AR), the AR indicated, the facility admitted Resident 3 to the facility on [DATE], with diagnoses that included Alzheimer's Disease (progress disease that affects through, memory, and language, beginning with mild memory loss that leads to the loss of the ability to carry on conversation and respond to the environment), encephalopathy (disease of the brain that alters brain function or structure), and dysphagia (difficulty or discomfort in swallowing).</p> <p>During a review of Resident 3's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 6/19/2024, the MDS indicated, Resident 3 had severely impaired cognition (ability to think, remember, and function). The MDS indicated, Resident 3 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) on staff for eating, oral, toileting and personal hygiene, upper and lower body dressing, putting on and taking off footwear, and rolling left and right in bed.</p> <p>During a review of Resident 3's Change of Condition (COC- a change in the resident's health or functioning that requires further assessment and intervention)/Interact Assessment Form (Situation-Background-Assessment-Recommendation [SBAR- a written communication tool that helps provide essential, concise information, usually during crucial situations]), dated 7/15/2024, timed at 2:34 pm, the COC/SBAR Form indicated, Resident 3 was weak and lethargic (abnormal sleepiness or deep unresponsiveness and inactivity), and noted with one bruise (mark on the skin caused by blood trapped under the surface as a result of injury to small blood vessels but does not break the skin) on the right knee. The COC/SBAR Form indicated, Licensed Vocational Nurse (LVN) 2 notified Resident 3's hospice (care that focuses on the care, comfort, and quality of life of a person with a serious illness who is approaching the end of life) nurse on 7/15/2024 at 2:20 pm.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 3's Interdisciplinary Team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents) Narrative dated 7/17/2024, timed at 3:54 pm, the IDT Narrative indicated, the IDT met and discussed Resident 3's condition. The IDT Narrative indicated, Resident 3 had bluish discolorations to the right knee and right foot. The IDT Narrative indicated, Resident 3's Responsible Party (RP 1), was present at bedside and notified of the plan of care. The IDT Narrative indicated, staff did not report any fall incident involving Resident 3, and Resident 3 was unable to tell staff how the discolorations occurred. The IDT Narrative indicated, Certified Nursing Assistant (CNA) 1 found discoloration to Resident 3's right knee measuring one (1) by 1 centimeter (cm- unit of measurement) and discoloration to Resident 3's right foot measuring 8.3 cm by 6.2 cm while changing Resident 3's brief. The IDT Narrative indicated, CNA 1 notified LVN 2. The IDT Narrative indicated, Resident 3 was unable to give a description of the incident.</p> <p>During a review of Resident 3's PN dated 7/17/2024, timed at 9:49 pm, the PN indicated, (on 7/17/2024), at 3:45 pm, Resident 3 had a fracture (a complete or partial break in a bone) to the right proximal (closer to head) phalanx (toe bone) of the great toe (big toe) with soft tissue (refers to skin, muscle, fat, and/or blood vessel that connects, supports, or surrounds bones and organs) swelling.</p> <p>During an interview on 7/31/2024 at 3:31 pm with CNA 1, CNA 1 stated while changing Resident 3's brief on 7/15/2024, unable to recall time, CNA 1 noticed a bruise on Resident 3's right knee. CNA 1 stated CNA 1 did not notice a bruise on Resident 3's right foot at that time. CNA 1 stated CNA 1 immediately reported the bruising to LVN 2.</p> <p>During a telephone interview on 7/31/2024 at 3:36 pm with LVN 2, LVN 2 stated on 7/15/2024, unable to recall time, CNA 1 reported to LVN 2 that Resident 3 had bruising to Resident 3's right knee. LVN 2 stated LVN 2 reported Resident 3's right knee bruising to the hospice nurse right away. LVN 2 stated LVN 2 did not observe the bruising to Resident 3's right foot at that time. LVN 2 stated LVN 2 did not report Resident 3's right knee bruising to the Administrator. LVN 2 stated LVN 2 reported Resident 3's right knee bruising to the Director of Nursing (DON) on 7/16/2024 after RP 1 noticed the bruising while at Resident 3's bedside.</p> <p>During an interview on 7/31/2024 at 4:18 pm with the DON, the DON stated the facility investigated Resident 3's right foot fracture, but the origin/source of the injury could not be determined. The DON stated there were no witnesses to the incident and Resident 3 could not tell staff what happened. The DON stated the DON could not say for certain how the injury occurred. The DON stated the DON did not report Resident 3's injury of unknown origin to the CDPH and/or inform the ADM so the injury could be reported to the CDPH. The DON stated, in general, if a resident sustained an injury of unknown origin, the facility needed to inform the physician and family, complete the Change of Condition (COC) Form, and report the injury to the CDPH immediately. The DON stated staff needed to report injuries of unknown origin to the CDPH for safety purposes so the facility could attempt to prevent further occurrences.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&amp;P titled, Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, revised 3/2023, the P&amp;P indicated, if resident abuse or injury of unknown source was suspected, the suspicion must be reported immediately to the ADM and to other officials according to state law. The P&amp;P indicated, the ADM or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: the state licensing/certification agency responsible for surveying/licensing the facility, the local/state ombudsman, the resident's representative, law enforcement officials, the resident's attending physician, and the facility medical director. The P&amp;P indicated, immediately was defined as within two hours of an allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that did not involve abuse or result in serious bodily injury. The P&amp;P indicated, upon receiving any allegations of injury of unknown source, the ADM was responsible for determining what actions, if any, were needed for the protection of residents. The P&amp;P indicated, all allegations were thoroughly investigated, and that the ADM initiated investigations.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</b></p> <p>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&amp;P) titled, Nail Care, for two of five sampled residents (Residents 1 and 3) by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure assigned Certified Nursing Assistants (CNAs) trimmed and cleaned the fingernails of Resident 1 who required substantial/maximal assistance (helper did more than half the effort, helper lifted or held trunk or limbs and provided more than half the effort) with personal hygiene.</li> <li>2. Ensure assigned CNAs notified assigned Licensed Vocational Nurses (LVNs) regarding Resident 1's and Resident 3's long and overgrown toenails.</li> <li>3. Ensure assigned LVNs notified the Social Services Assistant (SSA) that Resident 1 and Resident 3 needed to be referred and seen by a podiatrist (medical specialist who helps with problems that affect the feet or lower legs) for cleaning and trimming of Resident 1's and Resident 3's long and overgrown toenails.</li> </ol> <p>These failures had the potential to cause injuries and infections to Resident 1 and Resident 3.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses that included encounter for surgical aftercare following surgery on the digestive system (organs that take in food and liquids and break them down into substances that the body can use for energy, growth, and tissue repair), cholecystitis (the swelling/inflammation of the gallbladder [a small pear shaped organ on the right side of the abdomen]), and pneumonia (an infection that inflames air sacs in one or both lungs which may fill with fluid).</li> </ol> <p>During a review of Resident 1's untitled care plan (CP), initiated on 7/10/2024, the CP indicated, Resident 1 had self-care deficits and needed assistance with activities of daily living (ADL- the tasks of everyday life fundamental to caring for oneself). The CP interventions included for staff to assist Resident 1 with grooming and trimming of fingernails and to assist with ADLs as needed.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 7/15/2024, the MDS indicated Resident 1 was cognitively (ability to think, remember, and function) intact. The MDS indicated, Resident 1 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) on staff for lower body dressing and putting on and taking off footwear. The MDS indicated, Resident 1 required substantial/maximal assistance with oral hygiene, toileting hygiene, showering/bathing, upper body dressing, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 7/31/2024 at 11:32 am with Resident 1, Resident 1's fingernails and toenails were long and overgrown. Resident 1's fingernails were yellow in color and had black substance under the fingernails. Resident 1 stated Resident 1 just had a shower prior to the interview. Resident 1 stated Resident 1's fingernails and toenails had not been trimmed or cleaned since Resident 1 had been admitted to the facility. Resident 1 stated Resident 1 did not like how long Resident 1's fingernails and toenails were.</p> <p>During a concurrent observation and interview on 7/31/2024 at 11:36 am with Registered Nurse Supervisor (RNS) 1, Resident 1's fingernails and toenails were observed. RNS 1 stated residents' fingernails (in general) needed to be cleaned and trimmed at least once a week and as needed. RNS 1 stated toenails needed to be trimmed and cleaned once a month and as needed. RNS 1 stated the facility's podiatrist came out once a month to trim and clean toenails. RNS 1 stated Resident 1's fingernails were overgrown and dirty. RNS 1 stated there was a yellow film on top of Resident 1's fingernails and black substance under Resident 1's fingernails. RNS 1 stated Resident 1's toenails were overgrown and needed to be trimmed. RNS 1 stated RNS 1 could not tell if Resident 1's toenails were dirty because they were yellow in color had had black substance on them.</p> <p>During an interview on 7/31/2024 at 11:49 am with RNS 1, RNS 1 stated the podiatrist last visited the facility on 7/6/2024. RNS 1 stated Resident 1's toenails did not get trimmed (on 7/6/2024) because Resident 1 was admitted to the facility on [DATE]. RNS 1 stated the podiatrist should have been called so Resident 1's toenails could be trimmed and cleaned. RNS 1 stated if residents' (in general) fingernails and toenails were long, overgrown, and dirty it put residents at risk for infection and injury. RNS 1 stated CNAs were supposed to clean and trim residents' fingernails and clean residents' toenails.</p> <p>During an interview on 7/31/2024 at 11:51 am with the SSA, the SSA stated the podiatrist was not scheduled to visit the facility until 8/21/2024. The SSA stated if a resident's toenails needed to be trimmed before the scheduled visit, staff were supposed to inform the SSA so the SSA could have the podiatrist come sooner.</p> <p>2. During a review of Resident 3's AR, the AR indicated, the facility admitted Resident 3 to the facility on [DATE], with diagnoses that included Alzheimer's Disease (progress disease that affects through, memory, and language, beginning with mild memory loss that leads to the loss of the ability to carry on conversation and respond to the environment), encephalopathy (disease of the brain that alters brain function or structure), and dysphagia (difficulty or discomfort in swallowing).</p> <p>During a review of Resident 3's untitled CP, initiated on 1/3/2022, and revised on 1/7/2024, the CP indicated, Resident 3 required extensive to total assistance with ADL. The CP interventions included for staff to assist Resident 3 with grooming and trimming of fingernails and to assist with ADLs as needed.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Resident 3 had severely impaired cognition. The MDS indicated, Resident 3 was dependent on staff for eating, oral, toileting and personal hygiene, upper and lower body dressing, putting on and taking off footwear, and rolling left and right in bed.</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 7/31/2024 at 12:08 pm with CNA 1, Resident 3's toenails were observed. CNA 1 stated Resident 3's toenails were overgrown but was not dirty. CNA 1 stated when toenails were overgrown and needed trimming, CNA 1 needed to inform the licensed nurse.</p> <p>During a concurrent observation and interview on 7/31/2024 at 12:35 pm with RNS 1, Resident 3's toenails were observed. RNS 1 stated Resident 3's toenails were overgrown and needed to be trimmed. RNS 1 stated Resident 3's toenails needed to be kept clean and trimmed to prevent infection and injury.</p> <p>During an interview on 7/31/2024 at 5:22 pm with the Director of Nursing (DON), the DON stated the assigned CNA cleaned and trimmed residents' fingernails as needed during morning care when the residents' fingernails were long. The DON stated residents' fingernails needed to be kept cleaned and trimmed to prevent injury like skin tears and infections. The DON stated the podiatrist visited the facility to trim residents' toenails once every two months and as needed. The DON stated toenails needed to be kept cleaned and trimmed to prevent injuries and cuts to the feet and prevent infections.</p> <p>During a review of the facility's P&amp;P titled, Nail Care, undated, the P&amp;P indicated, the facility ensured residents' nails were clean and trimmed to reduce the risk of infection and promote dignity. The P&amp;P indicated, staff conducted weekly body checks to check nail condition. The P&amp;P indicated, nail trimming and filing as indicated.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Covina Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 261 W. Badillo Street Covina, CA 91723	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</b></p> <p>Based observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed in accordance with the facility's policy and procedure and the Centers for Disease Control and Preventions (CDC- the nation's leading science-based, data-driven, service organization that protects the public's health) guidelines by failing to:</p> <ol style="list-style-type: none"> <li>1. Ensure five of seven sampled staff members (Certified Nursing Assistant [CNA] 1, CNA 2, CNA 3, Housekeeper [HK] 1, and Registered Nurse Supervisor [RNS] 1 performed hand hygiene (procedures that included the use of alcohol-based hand rubs [ABHR- an alcohol-containing preparation designed for application to the hands to inactivate microorganisms and/or temporarily stop their growth] and/or hand washing with soap and water) before entering residents rooms and after providing care to three of five sampled residents (Residents 2, 3, and 4).</li> <li>2. Ensure seven of seven sampled staff members (CNA 1, CNA 2, CNA 3, CNA 6, HK 1, Occupational Therapist [OT] 1, and Physical Therapist Assistant [PTA] 1) donned (to put on) personal protective equipment (PPE- equipment worn to minimize exposure to a variety of hazards) before entering residents rooms on enhanced barrier precautions (EBP- infection control intervention designed to reduce transmission of multi-drug resistant infections that requires wearing a gown and glove during patient care and when in contact with resident's belongings and equipment) to provide care for three of five sampled residents (Resident 2, 3, and 4).</li> </ol> <p>These failures had the potential to result in cross-contamination (the physical movement or transfer of harmful bacteria [single-celled microorganism] from one person, object, or place to another) among residents and staff and the spread of infection throughout the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> <li>1. During a review of Resident 3's Admission Record (AR), the AR indicated, the facility admitted Resident 3 to the facility on [DATE], with diagnoses that included Alzheimer's Disease (progress disease that affects through, memory, and language, beginning with mild memory loss that leads to the loss of the ability to carry on conversation and respond to the environment), encephalopathy (disease of the brain that alters brain function or structure), and dysphagia (difficulty or discomfort in swallowing).</li> </ol> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 3's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 6/19/2024, the MDS indicated, Resident 3 had severely impaired cognition (ability to think, remember, and function). The MDS indicated, Resident 3 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) on staff for eating, oral, toileting and personal hygiene, upper and lower body dressing, putting on and taking off footwear, and rolling left and right in bed. During a concurrent observation and interview on 7/31/2024 at 12:06 pm, in Resident 3's room, CNA 1 was observed entering Resident 3's room without performing hand hygiene or donning gown and gloves. CNA 1 proceeded to provide patient care to Resident 3. CNA 1 stated Resident 3 was on EBP, which meant CNA 1 needed to perform hand hygiene before entering the room and wear gown and gloves when providing care to aid in infection control. CNA 1 stated if CNA 1 did not wear gown and gloves and perform hand hygiene, CNA 1 could get Resident 3 sick and other residents sick by potentially spreading germs.</p> <p>During a concurrent observation and interview on 7/31/2024 at 12:21 pm with CNA 2 and CNA 3, in Resident 3's room, CNA 2 and CNA 3 entered Resident 3's room without performing hand hygiene. CNA 2 stated CNA 2 and CNA 3 were going to pull up and reposition Resident 3 in bed. CNA 2 and CNA 3 donned gloves but did not don gowns before providing care to Resident 3. CNA 2 stated Resident 3 was on EBP and at the very minimum, staff needed to perform hand hygiene upon entering and exiting Resident 3's room. CNA 2 stated CNA 2 forgot to perform hand hygiene before entering Resident 3's room and did not wear a gown before providing care to Resident 3. CNA 3 stated CNA 3 forgot to perform hand hygiene before entering Resident 3's room and did not wear a gown before providing care to Resident 3. CNA 2 stated CNA 2 and CNA 3 needed to follow EBP to prevent the spread of infection in the facility. CNA 2 stated not following EBP could get other residents sick.</p> <p>During a concurrent observation and interview on 7/31/2024 at 12:35 pm with RNS 1, in Resident 3's room, RNS 1 entered Resident 3's room without performing hand hygiene or donning a gown. RNS 1 proceeded to remove Resident 3's blankets to assess Resident 3's fingernails, toenails, and legs. RNS 1 stated Resident 3 was on EBP and RNS 1 was supposed to perform hand hygiene before entering the room and wear a gown and gloves when providing any sort of care to Resident 3. RNS 1 stated not wearing the appropriate PPE or performing hand hygiene could potentially spread infection from RNS 1 to other residents.</p> <p>2. During a review of Resident 4's AR, the AR indicated, the facility admitted Resident 4 to the facility on [DATE], with diagnoses that included Type 2 Diabetes Mellitus (DM2- a condition that happens because of a problem in the way the body regulates and uses sugar as fuel), acute kidney failure (when the kidneys suddenly stop working due to complication of another serious illness), and hemiplegia (paralysis of one side of the body) of the left side following a cerebral vascular accident (CVA- also known as a stroke- disruption of blood flow to the brain due to problematic vessels that cause lack of blood supply and oxygen to the brain).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 had moderately impaired cognition. The MDS indicated, Resident 4 was dependent on staff for eating, toileting and personal hygiene, showering/bathing self, upper and lower body dressing, and putting on/taking off footwear. The MDS indicated, Resident 4 required substantial/maximal assistance (helper did more than half the effort, helper lifted or held trunk or limbs and provided more than half the effort) with oral hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 7/31/2024 at 12:17 pm with HK 1, HK 1 was observed entering Resident 4's room without performing hand hygiene. HK 1 put a pillow in Resident 4's closet and exited the room. HK 1 did not perform hand hygiene upon exiting Resident 4's room. HK 1 stated there was a sign next to Resident 4's door that indicated Resident 4 was on EBP. HK 1 stated HK 1 needed to perform hand hygiene upon entering and exiting Resident 4's room to prevent and protect Resident 4 from infection. HK 1 stated HK 1 needed to wear gown and gloves when HK 1 was doing anything in Resident 4's room.</p> <p>During an observation on 7/31/2024 at 11:58 pm in Resident 4's room, Resident 4 was receiving care from the OT 1 and PTA 1. OT 1 and PTA 1 were touching Resident 4. OT 1 and PTA 1 were wearing gloves but were not wearing a gown while providing care to Resident 4.</p> <p>During an interview on 7/31/2024 at 12:01 pm, with OT 1 and PTA 1, PTA 1 stated Resident 4 was on EBP. PTA 1 stated PTA 1 and OT 1 were providing therapy services to Resident 4. PTA 1 stated PTA 1 was not wearing a gown while providing care to Resident 4. OT 1 stated OT 1 was not wearing a gown while providing care to Resident 4. OT 1 stated OT 1 and PTA 1 were supposed to wear the appropriate PPE when working with residents (in general) to stop the spread of infection otherwise residents could get sick.</p> <p>3. During a review of Resident 2's AR, the AR indicated, the facility originally admitted Resident 2 to the facility on [DATE], and readmitted Resident 2 on 10/12/2022, with diagnoses that included Stage 4 pressure ulcer (PU- most severe form of pressure ulcer; wound that reaches the muscles, ligaments, and/or bones) of sacral (referring to sacrum [triangle-shaped bone in the lower spine] region, chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should), and dementia (progressive impaired ability to think, remember or make decisions that interferes with doing everyday activities).</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2 had severely impaired cognition. The MDS indicated, Resident 2 was dependent on staff for eating, oral and personal hygiene, toileting hygiene, upper and lower body dressing, and putting on and taking off footwear.</p> <p>During an observation on 7/31/2024 at 11:45 am, CNA 6 was observed providing a bed bath to Resident 2. There was a sign next to Resident 2's door indicating Resident 2 was on EBP. CNA 6 was not wearing a gown or gloves while providing the bed bath to Resident 2. CNA 6 refused to be interviewed.</p> <p>During a concurrent observation and interview on 7/31/2024 at 11:49 am with RNS 1, RNS 1 observed CNA 6 giving Resident 2 a bed bath. RNS 1 stated Resident 2 was on EBP. RNS 1 stated CNA 6 was not wearing a gown or gloves while providing a bed bath to Resident 2. RNS 1 stated CNA 6 posed an infection control risk to Resident 2 and could spread infection to Resident 2 by not wearing the appropriate PPE.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 7/31/2024 at 5:04 pm with the Infection Prevention Nurse (IPN), the IPN stated residents EBP were supposed to be used during patient care for residents with open wounds, indwelling catheter (catheter which is inserted into the bladder, via the urethra or abdomen and remains in situ to drain urine), and dialysis (treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to) patients because they were more susceptible to infection. The IPN stated all staff were needed to perform hand hygiene before entering and upon exiting EBP rooms to ensure no germs were spread. The IPN stated when staff had to touch anything surrounding a resident on EBP or perform patient care, staff needed to don gown and gloves to prevent the spread of infection and cross contamination. The IPN stated when staff did not follow EBP when indicated, then residents on EBP were at risk for new infections and staff could potentially spread infection from resident to resident.</p> <p>During an interview on 7/31/2024 at 5:22 pm with the Director of Nursing (DON), the DON stated it was important for staff to don the appropriate PPE when indicated to prevent the transmission of infection from one resident to another. The DON stated hand hygiene was important to prevent the spread of infection.</p> <p>During at review of the facility's policy and procedure (P&amp;P) titled, Handwashing/Hand Hygiene, revised 4/2023, the P&amp;P indicated, the facility considered hand hygiene the primary means to prevent the spread of infection. The P&amp;P indicated, all staff followed the handwashing/hand hygiene procedure to help prevent the spread of infections to other staff, residents, and visitors. The P&amp;P indicated, to use ABHR containing at least 70% alcohol or alternatively, soap and water for the following situations: before and after coming on duty, before and after direct contact with residents, after contact with a resident's intact skin, after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident, before applying non-sterile gloves, after removing gloves, and before and after entering isolation precaution settings. The P&amp;P indicated, hand hygiene was the final step after removing and disposing of PPE.</p> <p>During a review of the P&amp;P titled, Enhanced Barrier Precautions (EBPs), dated 6/5/2024, the P&amp;P indicated, EBPs were utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. The P&amp;P indicated, EBPs were used as an infection prevention and control intervention to reduce the spread of MDROs to residents. The P&amp;P indicated, EBPs targeted gown and glove use during high contact resident care activities that included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care. The P&amp;P indicated, EBPs were indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.</p> <p>During a review of the CDC website titled Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/2024, the CDC website indicated, healthcare personnel may need to clean their hands as often as 100 times during a work shift to keep themselves, patients, and staff safe. The CDC website indicated, healthcare personnel should clean their hands immediately before touching a patient, after touching a patient or patient's surroundings, and immediately after glove removal.</p> <p>[<a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety/">https://www.cdc.gov/clean-hands/hcp/clinical-safety/</a>]</p>		