STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055449	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covina Rehabilitation Center	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 37198 Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for one of six sampled residents (Resident 6). This deficient practice had the potential to result in the delay of care for Resident 6 when Resident 6 was unable to reach the call light to call staff for assistance. Findings: During a review of Resident 6's Admission Record (AR), the AR indicated, the facility admitted Resident 6 on 5/24/2022, with diagnoses of hemiplegia (weak or paralyzed on one side of the body) and hemiparesis (weakness or inability to move on one side of the body) following nontraumatic subarachnoid hemorrhage (bleeding in the area between the brain and the thin tissues that cover and protect it) affecting right dominant side (the side of the body that is used more), respiratory failure (occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body) with hypoxia (lack of oxygen), and dysphagia (difficulty or discomfort in swallowing). During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/10/2024, the MDS indicated, Resident 6 was sometimes understood by others and had the ability to sometimes understand others. The MDS indicated, Resident 6 was dependent (helper did all the effort) on staff for toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. During an observation on 8/27/2024 at 1:13 pm with Resident 6, Resident 6 was lying in bed with the head of bed elevated. Resident 6 pointed to the call light which was dangling off the bed to the right side of Resident 6. Resident 6 was able to move the left arm but unable to move the right arm. Resident 6 was motioning that the call light was not accessible due to unable to move right arm. During an interview on 8/27/2024 at 1:15 pm with the Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated Resident 6 called for assistance by using the call light. LVN 4 stated Resident 6 would either use the call light or motion for someone who was in the hallway. LVN 4 stated the call light needed to be on Resident 6's left side. LVN 4 stated it was important to have the call light near Resident 6 to get the assistance needed when Resident 6 called for help. LVN 4 stated if the call light was not accessible to Resident 6, Resident 6 would get uncomfortable and not be able to get the assistance needed. (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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Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure (P&P) titled, Call Lights, the P&P indicated, all staff shall know how to place the call light for a resident and how to use the call light system. The P&P indicated, nursing and care duties included ensuring that the call light was within the resident's reach when in his/her room or when on the toilet.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198 Based on interview and record review, the facility failed to promptly (quickly/timely) notify the physician for two of six sampled residents (Resident 2 and 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 Resident 2's untitled care plan (CP) for fall risk, Resident 3's untitled CP for urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag), and the facility's policies and procedures (P&P) titled, Change in a Resident's Condition or Status, by failing to: 1. Ensure Registered Nurse (RN) 3 and Licensed Vocational Nurse (LVN) 7 notified Resident 3's primary physician/medical doctor (MD) when Resident 3 was noted with bleeding and blood clots (gel-like clumps of blood) after the removal of Resident 3's urinary catheter 2 on 6/18/2024 at 3 pm. 2. Ensure RN 4 and LVN 8 notified Resident 2's Medical Doctor/Primary Physician (MD) 1 on 8/28/2024 at 5:40 am, after Resident 2 fell to the floor and Resident 2's medical pole (a device that holds a bag(s) of Gastrostomy Tube [G-tube- tube inserted through the belly that brings nutrition directly to the stomach] feeding in place while it is being administered through the G-tube) was found on top of Resident 2. 3. Ensure RN 4 and LVN 8 endorsed (to report) to the oncoming shift (7 am to 3 pm shift) that MD 1 had not been notified regarding Resident 2's fall on 8/28/2024. As a result, on 6/18/2024, at 9:20 pm, approximately six (6) hours after staff (unidentified) noted Resident 3 with blood clots, Resident 3 became tachycardic (increased heart rate), had scant urine output (reduced amount of urine produced) and developed hypovolemia (a decrease in the volume of circulating blood in the body) and hypotension (having abnormally low blood pressure). Resident 3 was transferred to General Acute Care Hospital (GACH) 1 via emergency medical services (EMS) on 6/18/2024 for further evaluation. This failure had the potential to delay the provision of necessary care and services for Resident 3. This failure prevented MD 1 from being informed of Resident 2's fall and injuries and prevented MD 1 from providing orders as needed which had the potential to cause harm to Resident 2. Cross Reference F689 and F842 1. During a review of Resident 3's Admission Record (AR), the AR indicated, the facility originally admitted Resident 3 on 6/9/2022, and readmitted Resident 3 on 8/1/2024, with diagnoses that included respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (lack of oxygen), attention to tracheostomy (a procedure where a hole is made at the front of the neck that provides an alternative airway for breathing), and benign prostatic hyperplasia (enlarged prostate [part of the male reproductive system]) with lower urinary tract symptoms (trouble urinating or urinating too often). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's untitled CP, revised on 7/1/2024, the CP indicated, Resident 3 had an indwelling urinary catheter. The CP interventions included for staff to monitor Resident 3's urine for sediment (specks that make the urine look cloudy), cloudiness, odor, blood, and amount of output (amount of urine produced) and to notify Resident 3's physician and responsible party if Resident 3 had a COC. During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/18/2024, the MDS indicated, Resident 3's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 3 had an indwelling (urinary) catheter. During a review of Resident 3's COC/Interact Assessment Form (Situation-Background-Assessment-Recommendation [SBAR]), dated 6/18/2024, timed at 3:22 pm, the COC/SBAR Form indicated, on 6/18/2024, at 3 pm, the treatment nurse noted resident with bleeding to Foley catheter (indwelling catheter) after unsuccessful attempt of flushing (resistance met). The COC/SBAR indicated, blood clots were noted when the urinary catheter was removed, and that the urinary catheter was discontinued due to swelling and bleeding. The COC/SBAR indicated LVN 7 endorsed the COC to the PM shift staff (3 pm - 11 pm). During a review of Resident 3's COC/ SBAR, dated 6/18/2024, timed at 10:06 pm, the COC/SBAR indicated, (on 6/18/24), at 8:40 pm, Resident 3 had tachycardia (increased heart rate), scant urine output, and hypovolemia after the removal of the urinary catheter. The COC/SBAR indicated Resident 3 was hypotensive. The COC/SBAR indicated, the facility contacted the paramedics (EMS), and Resident 3 was transferred to GACH 1 Emergency Department (ED) on 6/18/2024 at 9:20 pm. During a review of Resident 3's GACH 1 ED Note (EDN), dated 6/18/2024, timed at 10:17 pm, the EDN indicated, Resident 3 was brought in by ambulance for evaluation of gross (visible to the naked eye) blood and tachycardia following urinary catheter removal. The EDN indicated, per nursing home documentation, Resident 3 had been exhibiting distress (great mental or physical suffering) from pain status post (after an intervention) indwelling catheter removal. The EDN indicated, Resident 3 was hypotensive, tachycardic, and had diffuse edema (widespread swelling) throughout his body, prompting a call for EMS. The EDN indicated, Resident 3's indwelling catheter removal and gross blood after removal evidentially (based on evidence) elevated Resident 3's heart rate which was currently elevated in the ED. The EDN indicated, the plan of care for Resident 3 was to obtain a Computerized Tomography (CT- medical imaging technique used to obtain detailed internal images of the body) urogram (a type of scan that examines the urinary system) and replace the urinary catheter for continuous bladder irrigation (a flushing of the bladder with sterile fluid to prevent blood clots from forming and blocking the outflow of urine). During a review of Resident 3's GACH 1 Consultation Note (CN) by the urologist (a doctor who specializes in diagnosing and treating conditions of the urinary tract and reproductive system), dated 6/19/2024, timed at 8:20 pm, the CN indicated, Resident 3's chief complaint was hematuria (presence of blood in the urine). The CN indicated Resident 3 had chronic retention (a condition where a person can urinate but is unable to fully empty their bladder) with gross hematuria (blood is visible in the urine) likely from the indwelling catheter trauma. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2024 at 12:28 pm with LVN 7, LVN 7 stated on 6/18/2024, LVN 7 was going to flush Resident 3's indwelling catheter but met resistance during flushing. LVN 7 stated as soon as LVN 7 pulled out Resident 3's indwelling catheter tubing from Resident 3, blood and blood clots came out (from Resident 3's urethra [tube through which urine leave the body]). LVN 7 stated the bleeding was going on for 30 minutes. LVN 7 stated LVN 7 left a message for the responsible party but did not contact the physician. During an interview on 8/29/2024 at 1:09 pm with RN 5, RN 5 stated when bleeding from the indwelling catheter insertion/removal happened, staff was supposed to contact and report to the physician so that the physician could give the staff directions on what to do. RN 5 stated the PM shift staff did not notify MD 2 regarding Resident 3's bleeding and blood clots (on 6/18/2024 at 3 pm) because they assumed the AM shift staff already contacted MD 2. RN 5 stated the PM shift staff only left a message for Resident 3's physician on 6/18/2024 at 9:45 pm after Resident 3 was already transferred to GACH 1 via EMS. During an interview on 8/29/2024 at 1:37 pm with RN 3, RN 3 stated RN 3 paged MD 2 on 6/18/2024, unable to recall time, but did not speak to MD 2. RN 3 verified there was no documentation in Resident 3's clinical record about RN 3 paging MD 2. RN 3 stated if it (paging MD 2) was not documented, it was not done. During an interview on 9/5/2024 at 2:49 pm with MD 2, MD 2 stated the facility did not notify MD 2 about Resident 3's COC on 6/18/2024 during the 7 am to 3 pm shift. MD 2 stated the facility notified MD 2 later that night on 6/18/2024 after the facility transferred Resident 3 to GACH 1. MD 2 stated Resident 3 should have been transferred to the ED right away when the staff noted the blood clots. MD 2 stated Resident 3 was having gross hematuria and could have had a bladder infection that had to be taken cared of right away. 2. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included difficulty walking (problems with joints, bones, circulation, or pain making it difficult to walk properly), generalized muscle weakness (weakness of muscles caused by lack of exercise, ageing, injury, or disease), respiratory failure with hypoxia, and attention to tracheostomy. During a review of Resident 2's Admission Assessment (AA), dated 8/15/2024, timed at 8:10 pm, the AA indicated, Resident 2 required two-person assistance with transfers. The AA indicated, Resident 2 was dependent (helper did all the effort or the assistance of 2 or more helpers was required for the resident to complete the activity) with showering, oral hygiene, grooming, and dressing. The AA indicated, Resident 2 was alert, but unable to understand comprehension and not oriented to person, place, and time. During a review of Resident 2's Fall Risk Assessment (FRA), dated 8/15/2024, timed at 8:10 pm, the FRA indicated, Resident 2 was at high risk for fall due to inability to stand without assistance, unsteady gait (balance), poor sitting or standing balance, and intermittent confusion. During a review of Resident 2's untitled CP, initiated 8/16/2024, the CP indicated, Resident 2 was at risk for falls and injury. The CP interventions included for staff to visibly observe Resident 2 frequently and notify MD 1 as indicated. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's COC/SBAR dated 8/28/2024 at 7:48 am, the COC/SBAR indicated the SBAR was initiated but not filled out completely (left blank). During an interview on 8/28/2024 at 10:20 am with Resident 2, Resident 2 answered questions by nodding head up and down for yes, and side to side for no. Resident 2 stated Resident 2 fell because Resident 2 was trying to get out of bed. Resident 2 stated Resident 2's right hand and right eye hurt. Resident 2 stated Resident 2 was stressed and anxious. Resident 2 was not able to state how much pain Resident 2 had or how Resident 2 fell . During a concurrent observation and interview on 8/28/2024 at 10:59 am with LVN 2 and LVN 7, Resident 2's skin was observed. LVN 2 stated Resident 2 had new discoloration on the lateral (outer) side of the right eye. LVN 2 stated there was new discoloration to Resident 2's right middle finger. LVN 2 stated the discoloration was very dark blue and purple like a deep contusion (bruise). LVN 2 stated Resident 2 had a new scab-like wound to the right thumb. LVN 2 stated the scab appeared to be still forming because the middle of the wound appeared to still be open. LVN 2 stated the discoloration on Resident 2's right eye and wound on Resident 2's right hand could be a result of the fall Resident 2 sustained earlier that morning (on 8/28/24 at 5:40 am) because those injuries were not present on 8/27/2024. LVN 7 stated LVN 7 documented Resident 2's new discoloration and wound were most likely sustained from the fall earlier that morning. Both LVN 2 and LVN 7 stated they had not spoken to MD 1 regarding Resident 2's fall. Both LVN 2 and LVN 7 stated they assumed RN 4 and LVN 8 (from 11 pm to 7 am shift on 8/27/2024) had spoken to MD 1 regarding Resident 2's fall. During a telephone interview on 8/28/2024 at 2:52 pm with LVN 8, LVN 8 stated CNA 4 had been sitting on a chair by Resident 2's room door the entire shift because Resident 2 was moving around a lot and seemed agitated. LVN 8 stated CNA 4 left to go change another resident and when no one was watching Resident 2, Resident 2 fell . LVN 8 stated on 8/28/2024 at around 5:40 am, LVN 8 was at the medication cart down the hall from Resident 2's room, when the janitor (unidentified) called for help because Resident 2 was on the floor. LVN 8 stated LVN 8 immediately went to Resident 2's room and found Resident 2 on the floor. LVN 8 stated Resident 2 was positioned on Resident 2's right side with Resident 2's back facing the room door. LVN 8 stated Resident 2's medical pole was on top of Resident 2. LVN 8 stated Resident 2's GT formula tubing was wrapped around Resident 2's abdomen. LVN 8 stated Resident 2's ventilator (a machine that helps a resident breathe or breathes for the resident) was almost pulled out. LVN 8 stated LVN 8 asked RN 4 to notify MD 1 about Resident 2's fall. During a telephone interview on 8/28/2024 at 3:36 pm with RN 4, RN 4 stated when Resident 2 fell on [DATE] at around 5:40 am, RN 4 did a head-to-toe assessment but did not notice any discoloration to Resident 2's right eye or hands. RN 4 stated RN 4 left a message for MD 1 but did not speak to MD 1 about Resident 2's fall and any potential injuries. RN 4 stated RN 4 did not inform the on-coming nurses from the 7 am to 3 pm shift that MD 1 had not been reached and that assessments and documentation had not been completed regarding Resident 2's fall. RN 4 stated it was important to notify MD 1 and complete assessments and fill out the appropriate documentation when residents (in general) fell so the appropriate care, treatment, and monitoring could be provided to the resident. RN 4 stated it was important to endorse to the oncoming shift that RN 4 had not reached MD 1 so staff could attempt to reach MD 1 for any potential orders needed after Resident 2 fell to the floor. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/28/2024 at 4:29 pm, with the Director of Nursing (DON), Resident 2's COC/SBAR and PN dated 8/28/2024 were reviewed. The DON stated the COC/SBAR and PN indicated no documentation that the licensed nurse notified MD 1 about Resident 2's fall. The DON stated if staff spoke with MD 1, the staff needed to document the notification in Resident 2's PN. The DON stated if staff were unable to reach MD 1, staff was supposed to call MD 1 again or call the DON so the Medical Director could be reached. During a review of the facility's P&P titled, Change in a Resident's Condition, revised 4/2021, the P&P indicated, the facility promptly notified the resident, his or her attending physician, and the resident 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&P indicated, the nurse notified the resident's attending physician or physician on call when there had been a (an): accident or incident involving the resident, discovery of injuries of unknown source, significant change in the resident's physical/emotional/mental condition, need to transfer the resident to a hospital/treatment center, and/or specific instruction to notify the physician of changes in the resident's condition. The P&P indicated, prior to notifying the physician or healthcare provider, the nurse made detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. During a review of the facility's P&P titled, Catheter Care, Urinary, revised 8/2022, the P&P indicated, to observe the resident for complications associated with urinary catheters. The P&P indicated, report unusual findings to the physician if urine has an unusual appearance (i.e., color, blood, etc.) and in the event of bleeding, or if the catheter was accidentally removed.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to protect the personal property of one of six sampled residents (Resident 3) from theft and loss by failing to inventory (make a complete list of) Resident 3's personal belongings on admission as indicated in the facility's policy and procedure (P&P) titled, Personal Property. This deficient practice placed Resident 3's personal belongings at risk of theft and loss and could negatively affect Resident 3's psychosocial well-being. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated, Resident 3 was originally admitted to the facility on [DATE], and readmitted on [DATE], with a diagnosis that included dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks). During a review of Resident 3's Inventory List - Resident Clothing and Possessions (ILRCP) on discharge date d 1/15/2024, timed at 10:34 AM, the ILRCP indicated, Resident 3 was discharged with three blankets, one feet machine, and one foot pillow. During a review of Resident 3's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 7/18/2024, the MDS indicated, Resident 3's cognitive abilities (ability to think, learn, and process information) were severely impaired. During an interview on 8/27/2024 at 2:35 PM with Registered Nurse (RN) 1, RN 1 stated RN 1 did not find a recent ILRCP form for Resident 3. RN 1 stated Resident 3 was readmitted to the facility on [DATE] but there was no ILRCP form completed on admission. RN 1 stated an ILRCP form needed to be completed upon Resident 3's admission. RN 1 stated when family members brought items from home for residents, staff were to update the resident's ILRCP form. RN 1 stated staff were to ensure the name of the resident were on the resident's belongings to identify the owner of the belonging/item. RN 1 stated the risk of not completing an ILRCP form upon resident's admission was that the resident's belongings could go missing. RN 1 stated it could make the resident feel upset if the resident's belongings went missing and were not logged on the ILRCP form. During an interview on 8/27/2024 at 3:00 PM with the Social Services Director (SSD), the SSD stated the ILRCP form was updated whenever items were brought in for the resident. The SSD stated Social Services were responsible for updating the list on the ILRCP form. The SSD stated when the resident was admitted , discharged , or when new resident items were brought in the facility, the ILRCP form needed to be completed/updated. The SSD stated the ILRCP form was used to respect the resident and individuals who bring in resident's personal belongings. The SSD stated the risk of not updating the ILRCP form was that there would be no documentation of new resident items/belongings. The SSD stated when a resident lost a personal belonging in the facility and the personal belonging was not listed on the ILRCP form, it would make the residents feel disrespected because the facility did not respect the resident's personal belongings. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/2024 at 11:07 AM with the Director of Nursing (DON), the DON stated staff were to log items into the ILRCP form. The DON stated a recent ILRCP form was not completed for Resident 3 and stated the most recent ILRCP form was dated 1/15/2024. The DON stated an ILRCP form needed to be completed on admission and stated the risk of not completing an ILRCP form was that a resident's personal belongings could go missing. During a review of the facility's P&P titled, Personal Property, revised 3/2023, the P&P indicated, the resident's personal belongings and clothing were inventoried and documented upon admission and updated as necessary.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on observation, interview, and record review, the facility failed to ensure one of six sampled residents (Resident 2) remained free from physical restraint (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to a resident's body, cannot be easily removed by a residents, and restricts the resident's freedom of movement or access to their body) for use of convenience (the result of any action that has the effect of alerting a resident's behavior and requires a lesser amount of care or effort, and is not in a resident's best interest) as indicated in the facility's policy and procedure (P&P) titled, Physical Restraint, by failing to: 1. Ensure Registered Nurse (RN) 4, Licensed Vocational Nurse (LVN) 2, LVN 6, and Certified Nurse Assistant (CNA) 3 did not wrap a towel around Resident 2's right arm and inside the freedom splint (adjustable, multipurpose soft external device that helps restrict elbow movement), causing the splint to further restrict Resident 2's right elbow from bending. 2. Ensure assigned nursing staff monitored and documented Resident 2's right arm while the freedom splint was being used to ensure safety during use of the restraint. These failures had the potential to cause physical injuries and psychosocial (mental, emotional, social, and spiritual effects) harm to Resident 2 from the improper use of the physical restraint. Cross Reference F656 Findings: During a review of Resident 2's Admission Record (AR), the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included difficulty, generalized muscle weakness, respiratory failure (serious condition that makes it breathe on one's own) with hypoxia (low level of oxygen in the body that causes confusion, restlessness, and difficulty breathing), and attention to tracheostomy (incision made in the windpipe to relieve an obstruction to breathing) and gastrostomy tube (g-tube- tube inserted through the belly that brings nutrition directly to the stomach). During a review of Resident 2's Admission Assessment (AA) dated 8/15/2024, timed at 8:10 pm, the AA indicated, Resident 2 required two-person assistance with transfers. The AA indicated, Resident 2 was dependent (helper did all effort or the assistance of 2 or more helpers was required for the resident to complete the activity) with showering, oral hygiene, grooming, and dressing. The AA indicated, Resident 2 was alert, but unable to understand comprehension and not oriented to person, place, and time. During a review of Resident 2's physician order (PO) dated 8/16/2024, the PO indicated, an order for a freedom splint to right upper extremity (right arm) daily for prevention of pulling out life-sustaining tubes. The PO indicated, the facility obtained informed consents after explanation of the risks and benefits and verified with the physician. (continued on next page)

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	055449	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s care plans in Resident 2's clinical record, there was no documented evidence a care plan for the use of the freedom splint or restraint was developed. During a concurrent interview and observation on 8/27/2024 at 1 pm with LVN 2, Resident 2's right arm freedom splint was observed with the middle point of the splint at Resident 2's elbow. There was a towel wrapped around Resident 2's arm, and the splint was wrapped over the towel. LVN 2 stated the towel was wrapped inside the splint, so the splint was more padded. LVN 2 stated LVN 2 kept the towel wrapped around Resident 2's arm with the splint otherwise the splint slid down to Resident 2's wrist. LVN 2 stated the towel kept the splint in place so Resident 2 could not bend Resident 2's arm and pull on her g-tube or tracheostomy. During a concurrent observation and interview on 8/27/2024 at 1:22 pm with RN 1 and LVN 2, Resident 2's freedom splint was observed. RN 1 stated Resident 2 was not supposed to have a towel wrapped around Resident 2's right arm, inside of the splint because it made Resident 2's elbow movement more restricted. RN 1 stated Resident 2 could not bend Resident 2's elbow at all when the towel was inside of the splint. During a concurrent observation and interview on 8/27/2024 at 5:01 pm with LVN 6 and CNA 3, Resident 2's right arm freedom splint was observed. CNA 3 stated there was a towel wrapped inside of the restraint. CNA 3 stated the restraint stopped Resident 2 from bending Resident 2's arm so Resident 2 did not pull out the tracheostomy tube or g-tube. CNA 3 stated the towel was wrapped inside of the splint when CNA 3 started CNA 3's shift at 3 pm. CNA 3 stated the towel was always wrapped around the inside of Resident 2's restraint when CNA 3 was working. CNA 3 stated the towel caused Resident 2 to not bend Resident 2's elbow so Resident 2 could not pull-out Resident 2's tracheostomy tube. During the same interview on 8/27/2024 at 5:01 pm with LVN 6, LVN 6 stated the towel was not part of Resident 2's freedom splint restraint and was not intended to be used with it. LVN 6 stated the towel was in the freedom splint restraint to hinder Resident 2 from bending Resident 2's elbow. LVN 6 stated without the towel, Resident 2 could still bend Resident 2's elbow and pull Resident 2's tracheostomy tube. During a follow-up interview on 8/27/2024 at 5:35 pm with LVN 6, LVN 6 stated nursing staff needed to monitor the use of Resident 2's freedom splint restraint for safety and skin breakdown as nursing interventions. LVN 6 stated nursing staff did not document the monitoring of the freedom splint restraint. LVN 6 stated (in general) restraints needed to be released every two hours and as needed to check the resident's skin to make sure there were no issues and to check for circulation of the restrained area. LVN 6 stated Resident 2's freedom splint restraint was supposed to be worn as designed otherwise it could cause injury to Resident 2. (continued on next page)

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/28/2024 at 12:15 pm with the Director of Nursing (DON), the DON stated a freedom splint was used to stop residents from pulling out life-sustaining tubes like tracheostomies. The DON stated a freedom splint was considered a restraint. The DON stated when staff used a restraint, staff were supposed to observe the site being restrained and document in the resident's medical record to monitor for safety and prevent harm. The DON stated the freedom splint could cause circulation problems if the splint was too tight or there was a towel wrapped inside of the splint. The DON stated nursing staff needed to document the staff observations/assessment and monitoring of the restraint every two hours and as needed in the medication administration record (MAR) and/or progress notes. The DON stated when staff were not using Resident 2's restraint as it was intended to be used or staff were not monitoring and documenting Resident 2's restraint, it was a safety risk for skin breakdown and circulation problems. The DON stated if Resident 2 developed skin breakdown or circulation problems from the use of the restraint, it could cause pain and discomfort, infection, and emotional distress. During an interview on 8/28/2024 at 1:12 pm with the Director of Staffing Development (DSD), the DSD stated the freedom splint was designed to be applied directly to the arm to restrict the elbow from bending but not completely hinder the bending of the elbow. The DSD stated it was intended to prevent injury from the resident pulling on lines and tubes and causing self-harm. The DSD stated if a towel was wrapped around Resident 2's arm and the freedom splint was placed over the towel, then the splint would cause more restriction to the elbow than intended. The DSD stated Resident 2's elbow movement was inhibited rather than somewhat restricted. The DSD stated Resident 2's elbow could become contracted (a condition of shortening and hardening of muscles, tendons, or other tissues, often leading to deformity and rigidity of joints), develop circulation problems, or the towel could rub against Resident 2's skin and cause skin injury. The DSD stated the DSD had not provided an in-service on the use of the freedom splint. The DSD stated licensed nurses needed to document the monitoring of any restraint in the MAR and in the progress notes. During a review of the facility's P&P titled, Physical Restraint, revised 3/2021, the P&P indicated, physical restraints may be used for brief periods to administer necessary treatment of a therapeutic, non-continuous nature, however the immobilization was to be removed immediately after the administrations of such treatments. The P&P indicated, the plan of care shall specify the reason for the use of the restraint, the type, when and where it was to be used. The P&P indicated, licensed nurses were to document weekly in the licensed nurses' notes the use and effectiveness of physical restraints. The P&P indicated, CNAs were to document the use of restraints on the CNA notes. The P&P indicated, staff members were to be in-serviced on proper application of restraints.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on observation, interview, and record review, the facility failed to develop and implement the care plans (CP) for one of six sampled residents (Resident 2), based on the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, by failing to: 1. Ensure nursing staff developed and implemented a CP for Resident 2 ' s use of physical restraint (any manual method, physical or mechanical device, equipment, or material that is attached or adjacent to a resident ' s body, cannot be easily removed by a residents, and restricts the resident ' s freedom of movement or access to their body) with a freedom splint (adjustable, multipurpose soft splints that helps restrict elbow movement to protect tubes, intravenous [IV- soft, flexible tube placed inside a vein to administer fluids and medication directly to the bloodstream] sites, or wounds) when an order for the restraint was placed on 8/16/2024. 2. Ensure Licensed Vocational Nurse (LVN) 7 developed and implemented CP for Resident 2 ' s right forearm skin tear (a wound that happens when the layers of skin separate or peel back), right-hand scab (dry, rough, protective crust that forms over a cut or wound during healing) on 8/16/2024, and a right hand skin tear on developed 8/17/2024, when the wounds were first observed. 3. Ensure Registered Nurse (RN) 1 and LVN 5 revised Resident 2 ' s untitled care plan that addressed Resident 2 ' s fall (move downward, typically rapidly and freely without control, from a higher to a lower level) risk status and implement new interventions to prevent further falls and injuries to Resident 2 and after Resident 2 ' s first fall on 8/19/2024. These failures had the potential cause physical and psychosocial (mental, emotional, social, and spiritual effects) harm to Resident 2, cause Resident 2 to be unnecessarily restrained for use of convenience (the result of any action that has the effect of alerting a resident ' s behavior and requires a lesser amount of care or effort, and is not in a resident ' s best interest), had the potential for Resident 2 to sustain further falls and injuries, and had the potential for Resident 2 to not receive the necessary care and treatment for Resident 2 ' s skin wounds. Cross Reference: F689 and F842 Findings: 1. During a review of Resident 2 ' s Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included difficulty walking, generalized muscle weakness (weakness of muscles caused by lack of exercise, aging, injury, or disease), respiratory failure (a serious condition that makes it hard to breathe on one ' s own) with hypoxia (low level of oxygen [colorless, odorless gas] in the body that causes confusion, restlessness, and difficulty breathing), tracheostomy, gastrostomy (g-tube), and dependence on respirator-ventilator. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Admission Assessment (AA) dated 8/15/2024 timed at 8:10 pm, the AA indicated Resident 2 was confused, required g-tube feeding, and required two-person (staff) assistance during transfers. The AA indicated Resident 2 was dependent (helper did ALL the effort. Resident did none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity) with showering, oral hygiene, grooming, and dressing. The AA indicated Resident 2 was alert but was unable to understand and was not oriented to person, place, and time. During a review of Resident 2 ' s Order Summary Report (OSR, active as of 8/27/2024), the OSR indicated on 8/16/2024, Resident 2 had an order for freedom splint to right upper extremity (right arm) daily for prevention of pulling out life-sustaining tubes. The OSR indicated informed consents were obtained after explanation of the risks and benefits and was verified with the physician. During a review Resident 2 ' s untitled care plans (CP), the CP indicated there was no CP for freedom splint or restraints. During a concurrent interview and observation on 8/27/2024 at 1 pm, with LVN 2, Resident 2 ' s right arm freedom splint was observed. Resident 2 had a freedom splint on her right arm with the middle point of the splint at the elbow. There was a towel wrapped around Resident 2 ' s arm, and the splint was wrapped over the towel. LVN 2 stated there was a towel wrapped inside the splint, so the splint was more padded. LVN 2 stated LVN 2 kept the towel wrapped around Resident 2 ' s arm with the splint otherwise the splint slid down to Resident 2 ' s wrist. LVN 2 stated the towel kept the splint on so Resident 2 could not bend Resident 2 ' s arm and pull on her g-tube or tracheostomy. During a concurrent observation and interview on 8/27/2024 at 1:22 pm, with RN 1 and LVN 2, Resident 2 ' s freedom splint was observed. RN 1 stated Resident 2 was not supposed to have a towel wrapped around Resident 2 ' s right arm, inside of the splint because it made Resident 2 ' s elbow movement more restricted. RN 1 stated Resident 2 could not bend Resident 2 ' s elbow at all when the towel was inside of the splint. RN 1 proceeded to remove the towel that was wrapped around Resident 2 ' s arm, inside of the splint. RN 1 then placed the freedom splint back on Resident 2 ' s arm at the elbow, without the towel wrapped around Resident 2 ' s arm. During an observation and interview on 8/27/2024 at 5:01 pm, with LVN 6 and CNA 3, Resident 2 ' s right arm freedom splint was observed. CNA 3 stated there was a towel wrapped inside of the restraint. CNA 3 stated the restraint stopped Resident 2 from bending Resident 2 ' s arm so Resident 2 did not pull out the tracheostomy tube or g-tube. CNA 3 stated the towel was wrapped inside of the splint when CNA 3 stated CNA 3 ' s shift at 3 pm. CNA 3 stated the towel was always wrapped around the inside of Resident 2 ' s restraint when CNA 3 was working. CNA 3 stated the towel caused Resident 2 to not bend Resident 2 ' s elbow so Resident 2 could not pull-out Resident 2 ' s tracheostomy tube. During the same interview, LVN 6 stated the towel was not part of Resident 2 ' s freedom splint restraint and was not intended to be used with it. LVN 6 stated the towel was in the restraint to hinder Resident 2 from bending Resident 2 ' s elbow. LVN 6 stated without the towel, Resident 2 could still bend Resident 2 ' s elbow and pull on Resident 2 ' s tracheostomy tube. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2024 at 12:15 pm with the Director of Nursing (DON), the DON stated (in general) when a resident had a restraint like a freedom splint, there was supposed to be a CP made to show there was potential for injury or entrapment. The DON stated the CP should be development to attempt least restrictive measures first before restraining Resident 2, such as monitoring the Resident 2. The DON stated if a resident has skin conditions or skin wounds like scabs and skin tears, they needed to be care planned so that all staff were aware of the wounds and knew what interventions to take for Resident 2 to prevent further wounds. 2. During a review of Resident 2 ' s Admission Reassessment ([NAME]) dated 8/16/2024 at 2:20 pm, the [NAME] indicated Resident 2 had a right forearm skin tear that was 1.5 centimeters (cm- unit of measurement). The [NAME] indicated Resident 2 had a right hand interdigital (between fingers) skin tear. [NAME] indicated the size of the skin tear was not specified. During a review of Resident 2 ' s COC/Interact Assessment Form (SBAR [Situation, Background, Assessment/Evaluation, Request/Management Plan]) dated 8/17/2024 at 9:00 am. The SBAR indicated Resident 2 got agitated and sustained a self-inflicted skin tear on the wrist of the right hand. The SBAR did not indicate the size of Resident 2 ' s skin tear. During a concurrent observation and interview on 8/27/2024 at 1:22 pm, with LVN 2, Resident 2 ' s right arm was observed. LVN 2 stated Resident 2 had right forearm skin tear that was 1.5 cm in length. LVN 2 stated Resident 2 had a right hand skin tear to the back of Resident 2 ' s right hand. LVN 2 stated Resident 2 was being treated for a right hand interdigital skin tear that had since scabbed. During a concurrent interview and record review on 8/27/2024 at 5:35 pm, with LVN 6, LVN 6 stated Resident 2 did not have a CP for the freedom splint. LVN 6 stated Resident 2 needed to have a CP for the freedom splint so that all staff could follow the care. LVN 6 stated without a CP, staff many did not know what interventions to provide to Resident 2. LVN 6 stated there no CP for Resident 2 ' s skin wounds. LVN 6 stated if there was order to treat the wounds there should be a CP so staff knew what to do to prevent the wounds from getting worse. LVN 6 stated without any CP, there was no roadmap on the plan of care. 3. During a review of Resident 2 ' s Fall Risk Assessment (FRA) dated 8/15/2024 timed at 8:10 pm, the FRA indicated Resident 2 had intermittent confusion, poor safety awareness, had no history of falls, was unable to stand without assistance, had unsteady gait (pattern of a person ' s walk, balance), and had poor sitting or standing balance. The FRA indicated Resident 2 was at high risk for falls. During a review of Resident 2 ' s baseline care plan (CP) titled, Safety/Fall Risk, completion date 8/15/2024, the CP indicated safety devices included side rails (metal or plastic bars positioned along the side of a bed used to reduce the risk of falls), floor mats, bed alarm, and a low bed. The CP did not indicate goals for Resident 2. The CP indicated nursing interventions included to keep the call light within reach, utilizing safety devices as ordered and release of devices during care and activity as needed, and the use of alternative or less restrictive measures prior to utilization of restraints. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2 ' s Progress Notes (PN) dated 8/19/2024 timed at 11:05 am, and signed by RN 1, the PN indicated RN 1 was notified by charge nurse (unidentified) Resident 2 was found sitting on the floor. The PN indicated the bed was in the lowest position, and an assessment was performed. The PN indicated Resident 2 was put back to bed and Resident 2 ' s Medical Doctor/Primary Provider (MD) 1 was notified. The PN indicated MD 1 gave instruction to just monitor Resident 2. During a review of Resident 2 ' s CPs, there was no CP that addressed Resident 2 ' s fall (found sitting on the floor) that occurred on 8/19/2024 or interventions developed to help prevent a future fall for Resident 2. During a concurrent interview and record review on 8/27/2024 at 2:25 pm, with RN 1, Resident 2 ' s PN dated 8/19/2024 timed at 11:05 am were reviewed. RN 1 stated Resident 2 was able to scoot Resident 2 ' s body and was very weak on the left side of Resident 2 ' s body. RN 1 stated (in general) if a resident could not ambulate (like Resident 2) and was found out of bed on the floor, [the incident] was considered a fall. RN 1 stated moving in a downward motion from a higher surface to a lower surface, like from the bed to the floor, was considered a fall. RN 1 stated Resident 2 ' s CP needed to be updated to include the new fall and interventions. During a telephone interview on 8/27/2024 at 3:05 pm, with LVN 5, LVN 5 stated on 8/19/2024 Resident 2 was found sitting on the floor, on the floor mats, on Resident 2 ' s knees. LVN 5 stated LVN 5 did not update Resident 2 ' s CP because, It was the RN Supervisor ' s responsibility to update the CP. During a concurrent interview and record review on 8/28/2024 at 5:11 pm, with the Director of Nursing (DON), Resident 2 ' s Electronic Health Records (EHR) dated 8/19/2024 were reviewed. The DON stated RN 1 and LVN 5 did not update and revise Resident 2 ' s CP after Resident 2 sustained a fall on 8/19/2024. The DON stated (in general) when a resident fell , the above measures were supposed to be taken to prevent another fall and potential injury in the future. During a review of the facility ' s P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2023, the P&P indicated a comprehensive, person-centered CP included measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs was developed and implemented for each resident. The P&P indicated the interdisciplinary team (IDT- group of health care professionals with various areas of expertise who work together toward goals of their residents), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered CP for each resident. The P&P indicated CP interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The P&P indicated the comprehensive, person-centered CP included measurable objectives and timeframes, described the services that were to be furnished to attain or maintain the resident ' s highest practicable physical, mental, and psychosocial well-being, built on the resident ' s strengths, and reflected currently recognized standards of practice for problem areas and conditions. The P&P indicated CP interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. The P&P indicated, when possible, the interventions addressed the underlying source(s) of the problem area(s), not just symptoms or triggers. The P&P indicated assessments of residents were ongoing and CP were to be revised as information about the residents and the resident ' s condition changed. The P&P indicated the IDT reviewed and updated the care plan when there had been a significant change in the resident ' s condition and when the desired outcome was not met.

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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** 46687 Based on observation, interview, and record review, the facility failed to provide care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) for one of six sampled residents (Resident 2), who was at high risk for falls, and as indicated in the facility's policies and procedures (P&P) titled, Safety and Supervision of Residents, and Falls and Fall Risk, Managing, by failing to: Ensure Resident 2's bed alarm/pad alarm (sensor pad device placed under a resident's bottom containing sensors that triggers an alarm when it detects a change in pressure, used as an early alert when a resident is trying to get out of bed) was working/functioning on the morning of 8/28/2024 prior to Resident 2 sustaining a fall. As a result of this failure, on 8/28/2024 at approximately 5:40 am, Resident 2 fell to the floor, Resident 2's medical pole (a device that holds a bag(s) of Gastrostomy Tube [G-tube- tube inserted through the belly that brings nutrition directly to the stomach] feeding in place while it is being administered through the g-tube) was found on top of Resident 2. Resident 2 sustained discoloration/bruises (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 Resident 2's right eye and right hand, developed a scab (dry, rough, protective crust that forms over a cut or wound during healing) on the right thumb, and had bruising on Resident 2's right lower leg. Resident 2 was anxious, stressed, and had pain (unrated) on Resident 2's right hand and right eye. Cross Reference F580, F656 and 842 Findings: During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included difficulty walking, generalized muscle weakness (weakness of muscles caused by lack of exercise, aging, injury, or disease), respiratory failure (a serious condition that makes it hard to breathe on one's own) with hypoxia (low level of oxygen [colorless, odorless gas] in the body that causes confusion, restlessness, and difficulty breathing), tracheostomy, gastrostomy (g-tube), and dependence on respirator-ventilator (a machine that helps a person breathe or breaths for the person). During a review of Resident 2's Admission Assessment (AA) dated 8/15/2024 timed at 8:10 pm, the AA indicated Resident 2 was confused, required G-tube feeding, and required two-person (staff) assistance during transfers. The AA indicated Resident 2 was dependent (helper did ALL the effort. Resident did none of the effort to complete the activity, or the assistance of 2 or more helpers was required for the resident to complete the activity) with showering, oral hygiene, grooming, and dressing. The AA indicated Resident 2 was alert but was unable to understand and was not oriented to person, place, and time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Fall Risk Assessment (FRA) dated 8/15/2024 timed at 8:10 pm, the FRA indicated Resident 2 had intermittent confusion, poor safety awareness, had no history of falls, was unable to stand without assistance, had unsteady gait (pattern of a person's walk, balance), and had poor sitting or standing balance. The FRA indicated Resident 2 was at high risk for falls. During a review of Resident 2's baseline care plan (CP) titled, Safety/Fall Risk, completion date 8/15/2024, the CP indicated safety devices included side rails (metal or plastic bars positioned along the side of a bed used to reduce the risk of falls), floor mats, bed alarm, and a low bed. The CP indicated nursing interventions included utilizing safety devices as ordered and release of devices during care and activity as needed. During a review of Resident 2's Order Summary Report (OSR), the active OSR indicated on 8/16/2024, Resident 2 had an order for bed alarm to be on for safety precautions per Resident 2's family request. During a review of Resident 2's Progress Notes (PN) dated 8/19/2024 timed at 11:05 am and signed by Registered Nurse 1 (RN 1), the PN indicated RN 1 was notified by charge nurse (unidentified) Resident 2 was found sitting on the floor. The PN indicated the bed was in the lowest position, and an assessment was performed. The PN indicated Resident 2 was put back to bed and Resident 2's Medical Doctor/Primary Provider (MD) 1 was notified. The PN indicated MD 1 gave instruction to just monitor Resident 2. During an observation and interview on 8/28/2024 at 10:20 am with Resident 2, Resident 2 was lying in bed in Resident 2's room. Resident 2 had a dark red bruise on Resident 2's right eye, and a dark purple on Resident 2's right hand knuckle. Resident 2 was able to answer yes or no to questions asked by nodding of head. Resident 2 nodded yes to Resident 2 falling this morning. Resident 2 indicated Resident 2 hit Resident 2's right hand and head. Resident 2 indicated Resident 2 was in pain (unable to rate) and Resident 2's right eye and right hand hurt. Resident 2 indicated Resident was stressed, anxious, and tried to get out of bed. During a concurrent observation and interview on 8/28/2024 at 10:59 am, with Licensed Vocational Nurse 2 (LVN 2) and LVN 7, Resident 2's skin was observed. LVN 2 stated Resident 2 had new discoloration on the lateral (outer) side of the right eye. LVN 2 stated there was new discoloration to Resident 2's right middle finger. LVN 2 stated the discoloration was very dark blue and purple like a deep contusion (bruise). LVN 2 stated Resident 2 had a new scab-like wound to the right thumb. LVN 2 stated the scabbed appeared to be still forming because the middle of the wound appeared to be opened. LVN 2 stated the discoloration and wound found on Resident 2's right eye and right hand could be a result of the fall Resident 2 sustained earlier that morning (8/28/2024) because they were not present on Resident 2 on 8/27/2024. LVN 7 stated LVN 7 documented Resident 2's new discoloration and wound were most likely sustained from the fall. During a concurrent observation and interview won 8/28/2024 at 11:20 am, with LVN 2 and LVN 7, Resident 2's pad alarm on the bed was observed. LVN 2 and LVN 7 lifted Resident 2 off the pad alarm. LVN 7 stated the pad alarm is supposed to sound when pressure was removed from the pad. LVN 7 stated the alarm was not working. (continued on next page)

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	055449	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 8/28/2024 at 2:52 pm, with LVN 8, LVN 8 stated on 8/28/2024, CNA 4 was sitting on a chair by Resident 2's room door all shift because Resident 2 seemed agitated and was moving around a lot. LVN 8 stated CNA 4 got up to go change another resident (unidentified) and that was when Resident 2 fell , (8/28/2024) at around 5:40 am. LVN 8 stated no staff was watching Resident 2 when Resident 2 fell . LVN 8 stated LVN 8 was by LVN 8's assigned medication cart, located down the hall from Resident 2's room, when LVN 8 heard the facility's janitor (unidentified) called for help because the janitor saw Resident 2 out of bed [on the floor]. LVN 8 stated LVN 8 went to Resident 2's room and found Resident 2 on the floor. LVN 8 stated Resident 2's medical pole was found on top of Resident 2. LVN 8 stated Resident 2's feed tubing was wrapped around Resident 2's body and around Resident 2's abdomen. LVN 8 stated Resident 2's left shoulder, back, and right knee were, really red. LVN 8 stated Resident 2's ventilator tubing was almost pulled out. LVN 8 stated Resident 2 had a pad alarm, but the alarm did not sound when Resident 2 got out of bed. LVN 8 stated the pad alarm (placed on the bed and underneath a resident) was supposed to sound by making a loud noise when pressure was removed (resident lifts body away from the pad) from the pad. LVN 8 stated the pad alarm sound alerted the staff and CNAs (in general) assisted residents before the fall and harm could occur. LVN 8 stated LVN 8 asked RN 4 if it was safe to move Resident 2 because Resident 2 had, a lot of redness, and Resident 2 had blood from a new laceration (cut on the skin) located on Resident 2's right hand. During a telephone interview on 8/28/2024 at 3:36 pm, with RN 4, RN 4 stated RN 4 worked from 11 pm to 7 am and Resident 2 was very confused. RN 4 was in the hallway with LVN 8 on 8/28/2024 at about 5:40 am, about four rooms away from Resident 2's room. RN 4 stated RN 4 heard a noise and went to Resident 2's room. RN 4 stated Resident 2 was on the floor on Resident 2's right side. RN 4 stated Resident 2's medical pole was found on top of Resident 2. RN 4 stated CNA 4 was sitting at Resident 2's door but went to go change another resident. RN 4 stated Resident 2 fell when no staff was supervising Resident 2. RN 4 stated RN 4 had CNA 4 sitting at Resident 2's door because Resident 2 was restless and trying to get up out of bed prior to the fall. RN 4 stated it was important to provide supervision to Resident 2 to keep Resident 2 safe and to prevent Resident 2 from falling or getting hurt. RN stated Resident 2's pad alarm was not sounding when RN 4 found Resident 2 on the floor after falling. RN 4 stated the pad alarm was supposed to warn staff that Resident 2 was trying to get out of bed so they could help Resident 2 before Resident 2 fell and/or got hurt. RN 4 stated if the pad alarm had been working as it was intended to, it was possible Resident 2's fall and injuries could have been avoided. On 8/28/2024 at 4:02 pm and at 4:28 pm CNA 4 was contacted for an interview, but CNA 4 was not reached. During an interview on 8/28/2024 at 4:29 pm, with the DON, the DON stated pad alarms were designed to warn staff when a resident got up out of bed and for staff to quickly provide assistance to the resident before they had an accident such as a fall. The DON stated pad alarms were supposed to sound when a resident removed pressure from the pad, indicating the resident was getting up from bed. The DON stated staff were supposed to ensure pad alarms were working as intended at the beginning of every shift and as needed. The DON stated it was possible for Resident 2's fall and injuries to be avoided if Resident 2's pad alarm was working properly on 8/28/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Falls and Fall Risk, Managing, revised 3/2023, the P&P indicated based on previous evaluations and current data, staff would identify interventions related to the resident's specific risks and causes and try to prevent the resident from falling, and try to minimize complications from falling. The P&P indicated position change alarms (pad alarms) would not be used as the primary or sole intervention to prevent falls, but rather would be used to assist the staff in identifying patterns and routines of the resident, and the use of alarms would be monitored for efficacy and staff would respond to alarms in a timely manner. During a review of the of facility's undated P&P titled, Alarm Monitor, the P&P indicated the facility may use an alarm monitor as a less restrictive measure to alert staff and provide immediate assistance as needed. The P&P indicated the staff would apply the alarm to the resident, following the manufacture's instruction, to ensure its functionalists.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to ensure two of six sampled residents (Resident 2 and Resident 3) electronic medical record (EHR) contained accurate and complete information by failing to: 1. Ensure staff completed and documented a 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]) and a care plan (CP) after Resident 3 sustained a cut on the finger during trimming of fingernails. 2. Ensure Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 5 completed and documented a head-to-toe assessment, pain risk assessment (PRA), COC/SBAR form, and neurological checks (neuro checks- evaluates brain and nervous system function when there is accident, injury, or illness) after Resident 2 first fell on [DATE] at approximately 11:05 am. 3. Ensure RN 4 and LVN 8 completed a COC/SBAR form, completed a PRA, head-to-toe assessment, and begin neuro checks immediately and consistently and documented in Resident 2's EHR after Resident 2 fell to the floor on 8/28/2024 at 5:40 am. These failures had the potential for Residents 2 and 3 to not receive the necessary care and treatment due to an incomplete and inaccurate medical record. Cross Reference F580 and F689 Findings: 1. During a review of Resident 3's Admission Record (AR), the AR indicated, the facility originally admitted Resident 3 on 6/9/2022, and readmitted Resident 3 on 8/1/2024, with diagnoses that included respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (lack of oxygen), attention to tracheostomy (a procedure where a hole is made at the front of the neck that provides an alternative airway for breathing), and benign prostatic hyperplasia (enlarged prostate [part of the male reproductive system]) with lower urinary tract symptoms (trouble urinating or urinating too often).During a review of Resident 3's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/18/2024, the MDS indicated Resident 3's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 3 required substantial/maximal assistance (helper lifted or held trunk or limbs and provided more than half the effort) with oral hygiene, toileting hygiene, showering/bathing self, upper body dressing, lower body dressing, and personal hygiene. During a telephone interview on 8/26/2024 at 4:10 pm with Resident 3's Responsible Party (RP) 1, RP 1 stated Certified Nursing Assistant (CNA) 3 informed RP 1 about Resident 3's finger sustaining a cut during trimming of Resident 3's fingernails. RP 1 stated RP 1 saw Resident 3's finger bleeding when CNA 3 informed RP 1. RP 1 stated RP 1 could not remember the exact date when it happened. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2024 at 4:34 pm with CNA 3, CNA 3 stated CNA 3 was cutting Resident 3's fingernails approximately two to three months ago and Resident 3 sustained a small cut on the finger which bled a lot. CNA 3 stated CNA 3 did not remember when it exactly happened, and CNA 3 did not remember who CNA 3 reported the cut to or if the incident was documented. CNA 3 stated it was very important for staff to document in the chart any incidents that occur for communication reasons. During a concurrent interview and record review on 8/28/2024 at 4:47 pm with the Medical Records Director (MRD), the MRD was not able to find COC/SBAR, CP, or any other documentation in Resident 3's clinical records regarding the cut on Resident 3's finger. During an interview on 8/28/224 at 5:12 pm with RN 5, RN 5 stated RN 5 did not remember when Resident 3's finger sustained a cut. RN 5 stated if a finger got cut, there needed to be a COC/SBAR done. RN 5 stated a COC/SBAR and a CP for the cut finger should have been done. 2. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included difficulty walking, generalized muscle weakness, respiratory failure with hypoxia, and attention to tracheostomy. During a review of Resident 2's Admission Assessment (AA) dated 8/15/2024, timed at 8:10 pm, the AA indicated, Resident 2 required two-person assistance with transfers. The AA indicated, Resident 2 was dependent (helper did all effort or the assistance of 2 or more helpers was required for the resident to complete the activity) with showering, oral hygiene, grooming, and dressing. The AA indicated, Resident 2 was alert, but unable to understand comprehension and not oriented to person, place, and time. During a review of Resident 2's Progress Notes (PN) dated 8/19/2024 at 11:05 am, and signed by RN 1, the PN indicated, the charge nurse (unidentified) notified RN 1 that Resident 2 was found sitting on the floor. The PN indicated, Resident 2 had no skin tear, no new skin discoloration, no swelling, and no redness. The PN indicated, the facility staff notified MD 1 and MD 1 ordered to just monitor Resident 2. During a review of Resident 2's untitled CP, the CP did not intake a CP was revised or implement when Resident 2 was found sitting on the floor on 8/19/2024. During a concurrent interview and record review on 8/27/2024 at 2:25 pm with RN 1, Resident 2's PN dated 8/19/2024 at 11:05 am was reviewed. RN 1 stated Resident 2 was able to scoot Resident 2's body and was very weak on the left of Resident 2's body. RN 1 stated (in general) if a resident could not ambulate (like Resident 2) and was found out of bed on the floor, that was considered a fall. RN 1 stated moving in a downward motion from a higher surface to a lower surface, like from the bed to the floor, was considered a fall. RN 1 stated when a resident had a fall, a SBAR needed to be completed. RN 1 stated the SBAR needed to be completed so appropriate monitoring of a resident could be done. RN 1 stated Resident 2's physician was notified but staff were not continuously monitoring Resident 2 after the fall on 8/19/2024. RN 1 stated the purpose of the monitoring was to observe and assess for new pain, skin discoloration/bruising, and head injury with neuro checks. RN 1 stated staff did not perform neuro checks on Resident 2 after the fall on 8/19/2024. RN 1 stated Resident 2's CP would need to be updated to include the fall incident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 8/27/2024 at 3:03 pm with LVN 5, LVN 5 stated on 8/19/2024, (at 11:05 am), Resident 2 was found sitting on the floor mats on Resident 2's knees. LVN 5 stated LVN 5 assessed Resident 2 after the fall but did not document the assessment. LVN 5 stated LVN 5 did not perform neuro checks on Resident 2. LVN 5 stated LVN 5 did not update Resident 2's CP care plan because, It was the RN Supervisor's responsibility to update the CP. During a concurrent interview and record review on 8/28/2024 at 5:11 pm, with the Director of Nursing (DON), Resident 2's EHR dated 8/19/2024 was reviewed. The DON stated RN 1 and LVN 5 did not create an incident report, perform neuro checks, complete a SBAR, PRA, or revise Resident 2's CP after Resident 2 sustained a fall on 8/19/2024. The DON stated (in general) when a resident fell , the above measures were supposed to be taken to prevent another fall and potential injury in the future. 3. During a review of Resident 2's FRA dated 8/28/2024 at 5:42 am, FRA indicated the FRA was initiated but was not completed (left blank). During a review of Resident 2's 72 Hour Neuro-Check Form (NCF) dated 8/28/2024 at 5:44 am, the NCF indicated neuro checks were not started on Resident 2 until 8/28/2024 at 7 am. During a review of Resident 2's PRA dated 8/28/2024 at 7:40 am, the PRA indicated the PRA was initiated but was not completed (left blank). During a review of Resident 2's SBAR dated 8/28/2024 at 7:48 am, the SBAR indicated the SBAR was initiated but was not completed (left blank). During an interview on 8/28/2024 at 10:20 am with Resident 2, Resident 2 answered questions by nodding head up and down for yes, and side to side for no. Resident 2 stated Resident 2 fell because Resident 2 was trying to get out of bed. Resident 2 stated Resident 2's right hand and right eye hurt. Resident 2 stated Resident 2 was stressed and anxious. Resident 2 was not able to state how much pain Resident 2 had or how Resident 2 fell . During an interview on 8/28/2024 at 10:27 am with LVN 7, LVN 7 stated Resident 2 had a fall earlier that morning and assessed new wounds to Resident 2's body. During a concurrent observation and interview on 8/28/2024 at 10:59 am with LVN 2 and LVN 7, Resident 2's skin was observed. LVN 2 stated Resident 2 had new discoloration on the lateral (outer) side of the right eye. LVN 2 stated there was new discoloration to Resident 2's right middle finger. LVN 2 stated the discoloration was very dark blue and purple like a deep contusion (bruise). LVN 2 stated Resident 2 had a new scab-like wound to the right thumb. LVN 2 stated the scabbed appeared to be still forming because the middle of the wound appeared to still be open. LVN 2 stated the discoloration and wound found on Resident 2's right eye and right hand could be a result of the fall Resident 2 sustained earlier that morning (on 8/28/2024 at 5:40 am) because those injuries were not present on Resident 2 on 8/27/2024. LVN 7 stated LVN 7 documented Resident 2's new discoloration and wound were most likely sustained from the fall earlier that morning (on 8/28/2024 at 5:40 am). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/28/2024 at 11:45 am with the Director of Nursing (DON), the DON stated when a resident was found on the floor, especially if unwitnessed, it was considered a fall. The DON stated whoever found the resident needed to inform the charge nurse (if not found by the charge nurse). The DON stated the physician and family needed to be notified. The DON stated nursing staff needed to perform neuro checks, PRA, and head-to-toe assessment. The DON stated the resident's CP needed to be revised and updated, and measures to prevent the fall from happening again needed to be implemented immediately. During a telephone interview on 8/28/2024 at 2:52 pm, with LVN 8, LVN 8 stated Resident 2 had new blood forming from a laceration on Resident 2's right hand at the knuckles at the time of the fall on 8/28/24 at 5:40 am. LVN 8 stated LVN 8 did not notice right eye discoloration at the time. LVN 8 stated LVN 8 did not perform an assessment or do neuro checks on Resident 2 right after the fall. LVN 8 stated LVN 8 opened a COC/SBAR form on Resident 2's electronic medical record (EHR) but did not complete it. During a telephone interview on 8/28/2024 at 3:36 pm with RN 4, RN 4 stated when Resident 2 fell on [DATE] at around 5:40 am, RN 4 did a head-to-toe assessment but did not notice any discoloration to Resident 2's right eye or hands. RN 4 stated RN did not document any assessments in Resident 2's EHR. RN 4 stated RN 4 did not complete a pain assessment on Resident 2. RN 4 stated RN 4 did not start neuro checks on Resident 2 immediately after the fall. RN 4 stated RN 4 did not inform the on-coming nurses from 7 am to 3 pm shift that assessments and documentation had not been completed regarding Resident 2's fall. RN 2 stated it was important to complete assessments and fill out the appropriate documentation when a resident had a fall so appropriate care, treatment, and monitoring could be provided to the resident. RN 4 stated if not, Resident 2 could have injuries that go assessed. During a concurrent interview and record review on 8/28/2024 at 4:29 pm with the DON, Resident 2's COC/SBAR dated 8/28/2024, PRA dated 8/28/2024, PN dated 8/28/2024, and NCF dated 8/28/2024 were reviewed. The DON stated Resident 2's SBAR regarding the fall earlier that morning was incomplete. The DON stated neuro checks should have been started and documented immediately after Resident 2 fell . The DON started neuro checks were to be done every 15 minutes for the first 30 minutes, every 30 minutes for one and half hours, every hour for two hours, then every two hours for four hours, every four hours for the next 16 hours, and then every eight hours for the next 48 hours. The DON stated Resident 2's neuro checks were not started until one hour and 20 minutes after Resident 2 fell . The DON stated when neuro checks were supposed to be performed every hour for two hours for Resident 2, they were done at 9:00 am and 11 am, which was two hours apart. The DON stated nursing staff started the every-two-hour neuro checks at 1 pm and did not perform the second two-hour neuro check. The DON stated if the neuro checks were not started immediately after an accident or potential head injury, head injuries could be missed. The DON stated RN 4 or LVN 8 needed to complete the forms and document in the PN what happened to Resident 2. The DON stated the PN or SBAR did not indicate Resident 2 had right eye discoloration. The DON stated the PN did not indicate MD 1 was made aware of potential head injury from the fall and no documentation about Resident 2's medical pole possibly hitting Resident 2's face and causing Resident 2's right eye discoloration. The DON stated if nursing staff were not doing and/or documenting important information in Resident's EHR when Resident 2 fell , it could cause a delay in care and cause MD 1 to be unaware of the full incident. The DON stated RN 4 and LVN 8 not documenting Resident 2's fall caused the rest of the staff to not be aware of what happened to Resident 2 and may provide inappropriate care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Charting and Documentation, revised 7/2017, the P&P indicated, all services provided to the resident, progress toward the CP goals, or changes in the resident's medical, physical, functional, psychosocial condition, shall be documented in the resident's medical record. The P&P indicated the medical record would facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated, events, incidents, or accidents involving the resident and objective observations should be documented in the resident's medical record. The P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. The P&P indicated, documentation procedures and treatments would include care-specific details including, the date and time of the procedure/treatment was provided, the name and title of the individuals who provided the care, the assessment data, and/or any unusual findings obtained during the procedure/treatment, how the resident tolerated the procedure/treatment, notification of the family, physician, or other staff if indicated, and the signature and title of the individual documenting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48905 Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedure titled, COVID-19 (highly contagious disease caused by the SARS-CoV-2 virus that is spread through inhalation or contact of droplet particles into eyes, nose, or mouth) Policy by failing to: 1. Ensure Maintenance Worker (MW) 1 donned on (put on) personal protective equipment (PPE, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) prior to entering a COVID-19 positive room. 2. Ensure Family Member (FM) 1 donned on PPE prior to entering a COVID-19 positive room. These failures had the potential to result in the spread of COVID-19 virus to residents, staff, and visitors in the facility. Findings: 1. During a concurrent observation and interview on 8/27/2024 at 12:39 PM in the hallway, MW 1 was observed to be in a COVID-19 positive room without a face shield. A purple sign was observed posted outside of the room that indicated Stop, Novel Respiratory Precautions (newly identified respiratory organism that causes acute respiratory infections which require the use of a N95 [PPE that is used to provide a tight seal on the person's face to prevent particles or liquid contamination of the face], face shield, gown, and gloves prior to entering the room). Clean hands, wear a gown, an N-95 and face shield or goggles, and gloves on entry. MW 1 stated MW 1 was unaware MW 1 had to wear a face shield before entering a COVID-19 positive room. MW 1 stated not wearing the correct PPE could spread COVID-19 virus to other residents. During an interview on 8/27/2024 at 12:47 PM with Registered Nurse (RN) 1, RN 1 stated MW 1 was not wearing a face shield when MW 1 entered a COVID positive room. RN 1 stated the risk of not donning on the proper PPE for a droplet precaution room (isolation precaution to prevent infection caused by viruses or bacteria that are transmitted through the air droplets by coughing, sneezing, talking, and close contact with an infected person) was that the virus could spread to others in the facility. During an interview on 8/27/2024 at 12:53 PM with the Infection Preventionist Nurse (IPN), the IPN stated the facility's COVID-19 outbreak started on 8/19/2024. The IPN stated if staff members were not wearing the correct PPE prior to entering a COVID-19 positive room, this put residents, staff members, and family members at risk for developing and spreading COVID-19. 2. During a concurrent observation and interview on 8/28/2024 at 11:50 AM with FM 1 and Licensed Vocational Nurse (LVN) 1 in the hallway, FM 1 was observed sitting inside a COVID-19 positive room without face shield and gloves. FM 1 stated no one informed FM 1 what to wear before entering the COVID-19 positive room. LVN 1 stated FM 1 was not wearing the appropriate PPE for a COVID-19 positive room. LVN 1 stated FM 1 needed to don face shield and gloves. LVN 1 stated the risk of not wearing the appropriate PPE was that COVID-19 virus could spread to others. (continued on next page)

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	055449	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covina Rehabilitation Center	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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/29/2024 at 10:50 AM with RN 3, RN 3 stated if family members or staff needed to enter a COVID-19 positive room, they were required to wear face shield, mask, gloves, and gown. RN 3 stated if family members or staff did not don the appropriate PPE, the virus could spread to others. During a review of the facility's policy and procedure (P&P) titled COVID-19 Policy, dated 5/1/2024, the P&P indicated, the facility must educate the staff on general infection control and prevention guidance for preventing and managing COVID. The P&P indicated, the facility regularly audited their health care providers adherence to appropriate PPE use. The P&P indicated, eye protection, which can be goggles or face shields, was considered when the facility was in an active outbreak.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to provide education for the Influenza (the Flu, contagious respiratory illness that affects the nose, throat, and lungs which can be prevented by getting the Flu vaccine) vaccine for one of six sampled residents (Resident 5). This failure had the potential to result in Resident 5 and/or Resident 5's responsible party being unaware of the benefits and potential side effects of the Flu vaccine. Findings: During a review of Resident 5's Admission Record (AR), the AR indicated, Resident 5 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks), chronic kidney disease (gradual loss of kidney function), and hypertension (high blood pressure) During a review of Resident 5's History and Physical (H&P, formal document of a medical provider's examination of a patient), dated 7/18/2024, the H&P indicated, Resident 5 did not have the capacity to understand and make decisions. During a concurrent interview and record review on 8/28/2024 at 2:59 PM with the Infection Preventionist Nurse (IPN), Resident 5's Immunization Report (IR) dated 10/5/2023 was reviewed. The IR indicated no education was provided to Resident 5 and/or Resident 5's responsible party when the Flu shot was administered to Resident 5 on 10/5/2023. The IPN stated the IR indicated, No, under education provided to the resident prior to administering the Flu shot. The IPN stated the risk of not providing education prior to administering a Flu shot was that the resident and/or responsible party would not be aware of possible side effects of the Flu vaccine and what possible symptoms to report to staff. During an interview on 8/29/2024 at 10:50 AM with Registered Nurse (RN) 3, RN 3 stated if the resident wanted a Flu shot, licensed staff needed to provide education and obtain consent prior to administering the Flu shot. RN 3 stated the purpose of providing education to the resident prior to providing the Flu shot was to ensure the resident was aware of the purpose of the Flu shot and to be aware of signs and symptoms of possible side effects or reaction to the Flu vaccine. During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccine dated 2021, the P&P indicated, prior to the vaccination, the resident or resident's legal representative was provided information and education regarding the benefits and potential side effects of the Flu vaccine. The P&P indicated, provision of education was documented in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to screen and offer the Coronavirus (COVID-19, highly contagious disease caused by the SARS-CoV-2 virus that is spread through inhalation or contact of droplet particles into eyes, nose, or mouth) vaccine to four of six sampled residents (Residents 1, 2, 4, and 5) as indicated in the facility's policy and procedure (P&P) titled, COVID-19 Policy. This failure had the potential to result in Residents 1,2,4, and 5 to develop COVID-19 and serious respiratory complications. Findings: 1. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included hyperlipidemia (high levels of cholesterol in the blood) and hypertension (HTN, high blood pressure). During a review of Resident 1's Immunization Record (IR) dated 2/6/2024, the IR indicated, Resident 1 was past due to receive the COVID-19 seasonal vaccine on 2/6/2024. During a review of Resident 1's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 7/5/2024, the MDS indicated, Resident 1's cognitive abilities (ability to think, learn, and process information) were severely impaired. During a review of Resident 1's Change of Condition form (COC) dated 8/21/2024, timed at 12:07 PM, the COC indicated, Resident 1 tested positive for COVID-19 on 8/21/2024 at 11:12 AM. 2. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included acute respiratory failure (inability to maintain adequate oxygen in the lung), emphysema (weakening and permanent enlargement of the air spaces in the lungs), and HTN. During a review of Resident 2's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 6/1/2024 at 2:39 AM, the H&P indicated, Resident 2 was alert and oriented to person, place, and time. During a review of Resident 2's COC dated 8/21/2024 at 1:40 PM, the COC indicated, Resident 2 tested positive for COVID-19 on 8/21/2024 at 1:00 PM. During a review of Resident 2's undated 2023-2024 COVID-19 Vaccine Record (CVR), the CVR was blank and not filled out. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 4's AR, the AR indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses that included atelectasis (collapse of part or all the lung) and acute respiratory failure. During a review of Resident 4's MDS dated [DATE], the MDS indicated, Resident 4's cognitive abilities were moderately impaired. During a review of Resident 4's COC dated 8/28/2024 at 10:30 AM, the COC indicated, Resident 4 tested positive for COVID-19 on 8/28/2024 at 9:30 AM. During a review of Resident 4's IR dated 11/16/2010, the IR indicated, Resident 4 was past due to receive the seasonal COVID-19 vaccine on 11/16/2010. 4. During a review of Resident 5's AR, the AR indicated, Resident 5 was originally admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included HTN, dementia (impaired ability to remember, think, or make decisions that interfere with doing everyday tasks), and atelectasis. During a review of Resident 5's MDS dated [DATE], the MDS indicated, Resident 5's cognitive abilities were severely impaired. During a review of Resident 5's COVID-19 Vaccination Record Card (CVRC) dated 2/22/2021, the CVRC indicated, Resident 5's most recent COVID vaccination was on 2/22/2021. During an interview on 8/28/2024 at 2:59 PM with the Infection Prevention Nurse (IPN), the IPN stated there was no documentation that Residents 1, 2, 4, and 5 were screened on admission for the COVID-19 vaccine. The IPN stated the CVRC must be filled out on admission, and when it was not filled out then the COVID-19 vaccine was not offered to the resident. The IPN stated the risk of not screening and offering the COVID-19 vaccine to residents on admission was that the resident could develop complications related to COVID-19. The IPN stated all vaccines needed to be offered on admission to ensure measures were taken to prevent infections. During an interview on 8/29/2024 at 10:50 AM with Registered Nurse (RN) 3, RN 3 stated the IPN, or RNs were responsible for screening newly admitted residents for the COVID-19 vaccine. RN 3 stated the purpose of screening for the COVID-19 vaccine was because residents were at a higher risk for getting sick and developing complications from COVID-19. RN 3 stated when residents get sick with COVID-19, residents could develop complications, such as, hospitalization s, desaturation (low oxygen in the blood), or sepsis (medical emergency that occurs when the body's immune system has an extreme response to an infection). During a review of the facility's P&P titled, COVID-19 Policy, dated 5/1/2024, the P&P indicated, staff educated residents, responsible parties, and staff members about the benefits of receiving the COVID-19 vaccination, risks of refusals, and to offer boosters regularly. The P&P indicated, COVID-19 vaccinations were offered to residents and staff. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's COVID-19 Mitigation Plan (MP, plan that lists actions to eliminate or reduce the impact of natural, technological, or human caused hazard or undesirable event) dated 9/7/2021, the MP indicated, COVID-19 vaccine boosters may be administered to residents who meet the criteria based on Centers for Disease Control and Prevention (CDC) and Medical Doctor (MD) recommendations. The MP indicated, an assessment of the resident to receive the vaccine will be done, and administration of the COVID-19 vaccine booster will be done promptly.