| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055449 | A. Building<br>B. Wing | 10/21/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Covina Rehabilitation Center | 261 W. Badillo Street<br>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 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>44114<br><br>Based on interview and record review, the facility failed to revise a care plan (CP) for one of three sampled residents (Resident 1) when Licensed Vocation Nurse 1 (LVN 1) failed to provide safe seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) management for Resident 1 while Resident 1 experienced a seizure on 10/9/2024 as indicated in Resident 1's CP titled, Seizure Disorder and the facility's policies and procedures (P&P) titled, Emergency Procedure -Seizure Management and Care Plans, Comprehensive Person-Centered.<br><br>This failure had the potential to result in inconsistent provision of treatments and services, unmet individualized needs for Resident 1, and the potential to affect Resident 1's physical and psychosocial well-being.<br><br>Cross Reference F684<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 04/22/2022 and readmitted Resident 1 on 06/30/2024, with diagnoses that included respiratory failure (a serious condition that happens when your lungs cannot get enough oxygen into your blood or remove enough carbon dioxide [byproduct of metabolism], or both cannot be kept at normal levels), tracheostomy (a procedure where a hole is made through the front of the neck to allow breathing to help air and oxygen reach the lungs), and anoxic brain injury (brain injury from lack of oxygen to the brain).<br><br>During a review of Resident 1's History and Physical (H&P), dated 07/01/2024, the H & P indicated Resident 1 did not have the capacity to understand or make decisions.<br><br>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 08/02/2024, the MDS indicated Resident 1 had severely impaired cognition (ability to think and process information). The MDS indicated Resident 1 required substantial/maximal assistance (helper lifted or held trunk or limbs and provided more than half the effort) for showering/bathing and personal hygiene. The MDS indicated Resident 1 depended (helper provided all the effort or the assistance of two helpers was required for the resident to complete the activity) on staff (any nursing staff in general).<br><br>(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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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1's CP titled, Seizure Disorder, the CP indicated Resident 1 was at risk for injury, ineffective breathing pattern secondary to seizure activity, date initiated 08/15/2022 with a target date of 07/31/2024, the interventions indicated to provide a safe environment and keeping the environment free of safety hazards.<br><br>During a review of Resident 1's SBAR (Situation, background, assessment, recommendation, a verbal or written communication tool that helps provide essential and concise information regarding a resident), dated 10/9/2024, timed at 3:47 p.m. The SBAR indicated Resident 1 had unspecified convulsions (the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking) and had facial twitching, jerking, and muscle spasms.<br><br>During an interview on 10/18/2024 at 2 p.m. with LVN 1, LVN 1 stated LVN 1 was called to Resident 1's room when Resident 1 was seizing, LVN 1 stated LVN 1 wrapped a tongue depressor and inserted the tongue depressor in Resident 1's mouth.<br><br>During a concurrent interview and record review on 10/21/2024, at 12:35 p.m. with LVN 2, the facility's P&P titled Care Plan, Comprehensive Person-Centered, revised March 2023 was reviewed. LVN 2 stated, LVN 1 should not have placed any object in Resident 1's mouth. LVN 2 stated the facility's P&P indicated Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions changes. LVN 2 stated the CP for Resident 1 was not updated [after Resident 1's change of condition].<br><br>During a concurrent interview and record review on 10/21/2024, at 3 p.m. with Registered Nurse (RN) 1), the facility's P&P titled, Emergency Procedure - Seizure Management, revised August 2018 and Care Plan, Comprehensive Person-Centered revised March 2023 was reviewed. RN 1 stated the P&P titled, Emergency Procedure - Seizure Management, indicated Do not attempt to place objects in the resident's mouth, and LVN 1 should not have inserted anything into Resident 1's mouth. RN 1 stated the P&P titled, Care Plan, Comprehensive Person-Centered indicated Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions changes. RN 1 stated the CP for Resident 1 was not revised and should have been revised after a change of condition like when a resident experienced a seizure.<br><br>During a concurrent interview and record review on 10/21/2024 at 3:30 p.m. with the Administrator (ADM), the facility's P&P titled, Emergency Procedure - Seizure Management, revised August 2018 and the P&P titled Care Plan, Comprehensive Person-Centered revised March 2023 were reviewed. The P&P titled, Emergency Procedure - Seizure Management, indicated Do not attempt to place objects in the resident's mouth. The ADM stated the facility's P&P titled Care Plan, Comprehensive Person-Centered indicated Assessments of residents are ongoing, and CP are revised as information about the residents and the residents' conditions changes. The ADM stated Resident 1's CP was not updated [after a change of condition].<br><br>During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised March 2023, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>44114<br><br>Based on interview and record review, the facility failed to provide safe seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) management for one of three sampled residents (Resident 1) as indicated in the facility's policy and procedure (P&P) titled, Emergency Procedure -Seizure Management and Resident 1's CP titled, Seizure Disorder. On 10/9/2024 Resident 1 experienced a seizure and Licensed Vocation Nurse (LVN 1) wrapped a tongue depressor and inserted the tongue depressor in Resident 1's mouth.<br><br>This failure had the potential to result in chocking to Resident 1 and the potential to result in a decline in Resident 1's physical well-being.<br><br>Cross Reference F657<br><br>Findings:<br><br>During a review of Resident 1's Admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 04/22/2022 and readmitted Resident 1 on 06/30/2024, with diagnoses that included respiratory failure (a serious condition that happens when your lungs cannot get enough oxygen into your blood or remove enough carbon dioxide [byproduct of metabolism], or both cannot be kept at normal levels), tracheostomy (a procedure where a hole is made through the front of the neck to allow breathing to help air and oxygen reach the lungs), and anoxic brain injury (brain injury from lack of oxygen to the brain).<br><br>During a review of Resident 1's History and Physical (H&P), dated 07/01/2024, the H & P indicated Resident 1 did not have the capacity to understand or make decisions.<br><br>During a review of Resident 1's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 08/02/2024, the MDS indicated Resident 1 had severely impaired cognition (ability to think and process information). The MDS indicated Resident 1 required substantial/maximal assistance (helper lifted or held trunk or limbs and provided more than half the effort) for showering/bathing and personal hygiene. The MDS indicated Resident 1 depended (helper provided all the effort or the assistance of two helpers was required for the resident to complete the activity) on staff (any nursing staff in general).<br><br>During a review of Resident 1's CP titled, Seizure Disorder, the CP indicated Resident 1 was at risk for injury, ineffective breathing pattern secondary to seizure activity, date initiated 08/15/2022 with a target date of 07/31/2024, the interventions indicated to provide a safe environment and keeping the environment free of safety hazards.<br><br>During a review of Resident 1's SBAR (Situation, background, assessment, recommendation, a verbal or written communication tool that helps provide essential and concise information regarding a resident), dated 10/9/2024, timed at 3:47 p.m. The SBAR indicated Resident 1 had unspecified convulsions (the body muscles contract and relax rapidly and repeatedly, resulting in uncontrolled shaking) and had facial twitching, jerking, and muscle spasms.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/18/2024 at 2 p.m. with LVN 1, LVN 1 stated LVN 1 was called to Resident 1's room when Resident 1 was seizing. LVN 1 stated LVN 1 wrapped a tongue depressor and inserted the tongue depressor in Resident 1's mouth. LVN 1 stated, this action was not safe for Resident 1.<br><br>During a concurrent interview and record review on 10/21/2024, at 12:35 p.m. with LVN 2, the facility's P&P titled Emergency Procedure - Seizure Management., revised August 2018. LVN 2 stated the P&P indicated, Do not attempt to place objects in the resident's mouth. LVN 2 stated, LVN 1 should not have placed any object in Resident 1 mouth [while Resident 1 was having a seizure].<br><br>During a concurrent interview and record review on 10/21/2024, at 2:39 p.m. with LVN 1, LVN 1 stated the facility's P&P titled, Emergency Procedure - Seizure Management., revised August 2018 indicated, Do not attempt to place objects in the resident's mouth. LVN 1 stated I should not have placed an object in Resident 1's mouth.<br><br>During a concurrent interview and record review on 10/21/2024, at 3 p.m. with Registered Nurse (RN) 1), the facility's P&P titled, Emergency Procedure - Seizure Management, revised August 2018 and Care Plan, Comprehensive Person-Centered revised March 2023 were reviewed. RN 1 stated the P&P titled, Emergency Procedure - Seizure Management, indicated Do not attempt to place objects in the resident's mouth, and LVN 1 should not have inserted anything into Resident 1's mouth because this was not safe for the resident.<br><br>During a concurrent interview and record review on 10/21/2024 at 3:30 p.m. with the Administrator (ADM), the facility's P&P titled, Emergency Procedure - Seizure Management, revised August 2018 was reviewed. The P&P indicated Do not attempt to place objects in the resident's mouth.<br><br>During a review of the facility's P&P titled, Emergency Procedure - Seizure Management, revised August 2018. The P&P indicated, Personnel will assist in safety measures for a resident who is having a seizure, do not attempt to place objects in residents mouth. |