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	05/10/2024

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to ensure the resident's Advance Directives (AD, a written preferences regarding treatment options, a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions) and Consent for Medical Treatment (CMT, permission given before a resident receive any type of medical treatment, test or examination) were discussed and written information were provided to the residents and/or responsible parties for three of four sampled residents selected for advance directives care area (Residents 18, 192 and 35) in accordance with the facility's policy and procedure. These failures had the potential for facility staff to provide medical treatment and services against the resident's will. Findings: a. During a review of Resident 18's Admission Record (AR), the AR indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included anemia (decrease in the total amount of red blood cells in the blood) and hyperlipidemia (high level of fats in the blood). During a review of Resident 18's Minimum Data Set (MDS- a resident's assessment and care planning tool), dated 4/1/2024, the MDS indicated Resident 18 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 18 required total dependence (totally dependent with staff for assistance of activities of daily living) with eating, oral and toileting hygiene, shower, dressing and putting on or taking off footwear and personal hygiene. During a review of Resident 18's undated Advance Directive Acknowledgement form, the AD acknowledgement form was not completed. During an interview and concurrent record review on 5/7/2024 at 4:09 pm with the Social Service Director (SSD), the SSD stated Resident 18's AD Acknowledgement Form needed to be filled out completely. The DON stated it was the resident's right to formulate AD upon admission for the facility to provide care and treatment to meet Resident 18's wishes. The SSD stated the responsible party needed to be asked if there was an existing AD formulated by the resident. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2024 at 4:14 pm with the facility's Assistant Social Service Director (ASSD), ASSD stated the SSD was responsible to follow up the responsible party if Resident 18 had existing AD. The ASSD stated, Resident 18's AD Acknowledgement Form needed to be filled out completely to follow Resident 18's wishes and wants. During an interview on 5/9/2024 at 11:53 am with the facility's Director of Nursing (DON), the DON stated, Social Services needed to follow up if AD was formulated for Resident 18 upon admission. The DON stated, AD Acknowledgement Form needed to be filled out completely upon admission by Social Services to assess if Resident 18 executed an AD and follow up with the responsible party if the resident formulated an AD or not. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised 9/2022, the P&P indicated the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The P&P indicated Advance Directives are honored in accordance with state law and facility policy. 40438 b. During a review of Resident 192's AR, the AR indicated Resident 192 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (elevated sugar level in the blood) and osteoarthritis (occurs when flexible tissue at the ends of bones wears down). During a concurrent interview and record review on 5/7/2024 at 4:26 pm with the Registered Nurse Supervisor 2 (RN Sup 2), Resident 192's AD and consent for medical treatment acknowledgement forms were reviewed. Resident 192's AD and consent for medical treatment acknowledgement forms were not completed. RN Sup 2 stated the admitting nurse needed to complete the forms upon Resident 192's admission and acknowledged by the resident and or responsible party. RN Sup 2 stated treatment could not be started without the consent for medical treatment and not having AD would affect the nature of the care provided in an event of an emergency. During an interview on 5/8/2024 at 11:34 am with the RN Sup 3, RN Sup 3 stated, the resident's AD would provide the facility information on any treatment limitation the resident wishes and consent to medical treatment before the start of any treatment. During a concurrent interview and record review of Resident 192's clinical records from 4/30/2024 to 5/8/2024 with RN Sup 3 on 5/9/2024 at 9:31 am, Resident 192's admission assessment, licensed notes, social services notes, and progress notes were reviewed. RN Sup 3 stated there were no records indicating AD and consent for medical treatment were offered to Resident 192 or to the resident's responsible party upon admission. During an interview on 5/9/2024 at 11:54 am with the facility's DON, the DON stated, all residents should have an AD and consent to medical treatment acknowledgement form filled out completely upon admission. The DON stated, AD provide the facility directive for care and the consent for medical treatment provide the facility permission for staff to provide treatment and services to the resident. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Resident Rights, revised February 2021, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident rights to refuse any treatment and the right to be informed of potential medical consequences for refusal. Consent to treatment will be included in the admission agreement for all residents. During a review of the facility's P&P titled, Advance Directives, revised September 2022, the P&P indicated, The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. The P&P indicated Advance Directives are honored in accordance with state law and facility policy. 40913 c. During a review of Resident 35's AR, the AR indicated the facility admitted the resident on 2/26/2024 and readmitted on [DATE] with diagnoses that included diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and difficulty in walking. During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35 had moderate cognitive impairment and the resident required maximal assistance with bed mobility. The MDS indicated Resident 35 had one stage 4 pressure ulcer (wound that extends into the muscle and bone and causing extensive damage) on reentry. During a concurrent record review and interview on 5/8/2024 at 1:56 pm, the Social Services Assistant (SSA) stated Resident 35 did not have documentation that the resident's responsible party was asked regarding the availability of an advance directive. The SSA stated she contacted Resident 35's daughter today who had informed the SSA she would check if Resident 35 had an advance directive. The SSA stated the availability of an advance directive needed to be completed upon admission.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 14330 Based on interview and record review, Resident 33's notice of Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) of non-coverage did not have documented evidence of an informed decision from Resident 33's responsible party to pay for non-covered services after Resident 33 was discharged from Medicare Part A and Resident 33 continue to reside in the facility for one of one sampled resident (Resident 33). This deficient practice placed Resident 33 at risk for payment of out-of-pocket costs for non-coverage services while in the facility. Findings: During a review of Resident 33's Admission Record (AR), the AR indicated the facility readmitted Resident 33 on 3/6/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), chronic obstructive pulmonary disease ([COPD] a group of lung diseases that block airflow and make it difficult to breathe) and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). During a review of Resident 33's notice of SNF ABN of non-coverage, the SNF ABN indicated Resident 33's skilled nursing services under Medicare Part A would end on 2/20/24. The SNF ABN form indicated Resident 33's responsible party did not make an informed decision about financial responsibility for payment of non-covered services by not selecting one of the three options for the care listed before the SNF ABN was signed by the responsible party on 2/16/24. During a concurrent interview and a review of Resident 33's SNF ABN of non-coverage with the Administrator on 5/10/24 at 12:40 p.m., the Administrator stated it was important for Resident 33's responsible party to be aware of financial responsibility for payment of out -of- pocket costs of non-covered care or services before Resident 33 was to be discharged from Medicare Part A on 2/20/24. The Administrator stated the Business Office Manager (BOM) did not check that Resident 33's responsible party had selected the care option for non-coverage before signing the SNF ABN.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the certified nurse assistant (CNA) failed to protect the resident's rights by not closing the privacy curtain to ensure the resident was not visually exposed to the roommate while the CNA was cleaning the resident for one of one sampled resident (Resident 34) selected for privacy care area. This failure resulted in the violation of the resident's right for privacy. Findings: During a review of Resident 34's Admission Records (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hemiplegia (paralysis or weakness on one side of the body), hemiparesis (loss of strength on one side of the body) and cerebrovascular disease (a group of conditions that affect blood flow and the blood vessels in the brain). During a review of Resident 34's untitled Care Plan (CP), dated 3/25/2020, the CP indicated Resident 34 had self-care deficit for activities of daily living (ADL, activities related to personal care) because of cognitive deficits, communication deficits, and sensory deficits. The CP indicated an intervention for staff to maintain privacy and respect resident's rights. During a review of Resident 34's Minimum Data Sheet (MDS, a standardized assessment and care planning tool), dated 2/12/2024, the MDS indicated Resident 34 had severely impaired cognition (ability to understand) and dependent (helper does all of the effort, resident does none of the effort to complete the activity) on toileting and shower. The MDS indicated Resident 34 was incontinent (having no control) for bowel and bladder. During an observation on 5/8/2024 at 1:59 pm inside Resident 34's room, CNA 2 was cleaning Resident 34. Resident 34 was undressed and the privacy curtain was left open on the side of Resident 34's roommate. Resident 34's roommate was awake and looking at Resident 34 while being cleaned. During an interview on 5/8/2024 at 2:04 pm with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated, the privacy curtain should be closed all the way and fully covering the resident for dignity and privacy during care. During an interview on 5/8/2024 at 2:10 pm with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated, privacy curtains should be closed all around and fully cover the resident to provide privacy when providing care. During an interview on 5/9/2024 at 12:09 pm with the facility's Director of Nursing (DON), the DON stated, privacy curtains should be closed all around the resident when providing care. The DON stated, privacy curtains should not be left open in between residents for privacy and to maintain the dignity of the resident. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised February 2021, the P&P indicated, Residents are treated with dignity and respect at all times. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 During observation, interview, and record review, the facility failed to provide care and services to promote the healing of pressure ulcers (lesion/wound caused by unrelieved pressure that results in damage of underlying tissue) for three of four sampled residents (Residents 78, 241 and 35.) with existing pressure ulcers by failing to: a. Turn and reposition Residents 78 and 241 with an existing Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle). Residents 78 and Resident 241 required assistance with turning and repositioning. b. Ensure Resident 35's Low Air Loss Mattress (LAL- a bed mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) static setting was turned off while Resident 35 was lying in bed. These deficient practices had the potential to delay healing of Residents 78, 241 and 35's pressure ulcer. Findings: a. During a review of Resident 78's Admission Record (AR), the AR indicated the facility admitted the resident on 12/29/2023 and readmitted on [DATE], with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and chronic pain syndrome. During a review of Resident 78's Interdisciplinary Team (IDT) Wound Management Care Plan dated 1/8/2024, the Wound Management Care Plan indicated Resident 78 had one stage 4 sacro coccyx pressure ulcer (the fused sacrum and coccyx. Sacrum is the large, triangular bone at the base of the spine. Coccyx is the triangular arrangement of bone that makes up the very bottom portion of the spine below the sacrum) with an onset date of 12/29/2023. The Wound Management Care Plan indicated to reposition the resident every 2 hours or as often as necessary/indicated. During a review of Resident 78's care plan for Pressure Ulcer Stage 4 to the sacral coccyx area, initiated on 1/11/2024, the care plan indicated staff will follow bed mobility/Activities of Daily Living (ADL) standard of care. During a review of Resident 78's care plan for ADL, initiated on 1/11/2024, the care plan indicated for staff to assist the resident with turning and repositioning when needed. During a review of Resident 78's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 4/4/2024, the MDS indicated Resident 78 had severe cognitive (ability to understand) impairment. The MDS indicated Resident 78 was dependent with toileting hygiene and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left and right bed mobility. The MDS indicated Resident 78 had one stage 4 pressure ulcer that was present upon admission/reentry. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 78's Skin Progress Report dated 5/3/2024, the report indicated Resident 78 had one stage 4 pressure ulcer with the following measurement: length 5.3 centimeter (cm), width 7.9 cm, depth of 1 cm. During an observation on 5/9/2024 at 8:22 am, Resident 78 was lying in bed, facing his right side with a pillow under his left side. During an observation on 5/9/2024 at 10:25 am, Resident 78's daughter at the bedside. Resident 78 was lying in bed facing his right side with a pillow under his left side. During an observation 5/9/24 at 11:03 am, Resident 78 was lying in bed, facing the right side with a pillow under his left side. During a concurrent observation and interview on 5/9/24 at 12:10 pm, Resident 78 was lying in bed, facing the right side with a pillow under his left side. Certified Nursing Assistant 3 (CNA 3) stated Resident 78 was turned when she changed the resident in the morning, and she will reposition the resident again when she would change the resident's adult brief. In a concurrent interview with CNA 3 and the Director of Staff Development, CNA 3 stated Resident 78 would be turned two times in a shift or more depending on how often the adult brief needed to be changed. CNA 3 stated CNA 3 would turn and reposition Resident 78 later in the day since he had a urinary catheter and the adult brief would not get wet. During an interview on 5/9/24 at 12:15 pm, the Director of Staff Development (DSD) stated residents who were unable to reposition by themselves needed to be repositioned and turned every two hours. The DSD stated, repositioning every 2 hours promotes comfort and skin integrity for Resident 78. During a review of Resident 241's AR, the AR indicated the facility admitted the resident on 4/25/2024 with diagnoses that included stage 4 pressure ulcer of the sacral region, left hip and the right hip. During a review of Resident 241's Admission Reassessment dated [DATE], the Admission Reassessment indicated the resident had the following pressure ulcers: 1. Stage 4 on the right trochanter measuring 6.5 cm in length, 6.3 cm in width and 1.3 cm in depth. 2. Stage 4 on the left trochanter measuring 7.5 cm in length, 6.4 cm in width and depth was UTD (unable to be determined. 3. Stage 4 on the Sacrococcyx measuring 14 cm in length, 10.2 cm in width and depth was UTD. During a review of Resident 241's MDS dated [DATE], the MDS indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 241 was dependent with toileting and bed mobility. The MDS indicated Resident 241 had three stage 4 pressure ulcers present during admission. During a review of Resident 241's Wound Management Care Plan dated 5/3/2024, the care plan indicated for staff to reposition the resident every 2 hours or as often as necessary/indicated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/9/2024 at 9:29 am, Resident 241 was awake in bed, there was a pillow on her left side, the resident was facing her right side towards the door. During an observation on 5/9/2024 at 10:30 am, Resident 241 was lying in bed with a pillow on her left side, the resident was facing her right side towards the door. During an observation on 5/9/2024 at 12:15 pm, Resident 241 was lying in bed with a pillow on her left side, the resident was facing her right side towards the door. During an interview on 5/10/2024 at 3:04 pm, Certified Nursing Assistant 4 (CNA 4) stated Resident 241 refused turning and repositioning on 5/9/2024. CNA 4 stated she did not inform the licensed nurse that Resident 241 refused turning and repositioning. CNA 4 stated she needed to inform the assigned licensed nurse so the nurse can reinforce and encourage Resident 241 with turning and repositioning every 2 hours. CNA 4 stated she was aware Resident 241 had a pressure ulcers and turning and repositioning would help with the healing of the existing pressure ulcers. b. During a review of Resident 35's AR, the AR indicated the facility admitted the resident on 2/26/2024 and readmitted on [DATE] with diagnoses that included diabetes mellitus type 2 (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) and difficulty in walking. During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35 had moderate cognitive impairment and the resident required maximal assistance with bed mobility. The MDS indicated Resident 35 had one stage 4 pressure ulcer on reentry. During an observation on 5/7/2024 at 9:38 am with Licensed Vocational Nurse 4 (LVN 4) Resident 35 was lying in bed on her right side with the LAL mattress Static setting on. LVN 4 verified the LAL mattress static' setting was on. During a concurrent observation and interview on 5/9/2024 at 12:26 pm, Resident 35's LAL mattress static setting was on. The Treatment Nurse (TN) stated the static setting needed to be off. When asked, TN did not answer why the static setting needed to be off. During an interview on 5/10/2024 at 9:50 am, the Director of Staff Development stated the static setting of the LAL mattress needed to be off and this setting would only be used for positioning the resident and during patient care. During a concurrent observation, the DSD checked Resident 35's LAL mattress with the static setting off. The DSD turned on the static setting and stated DSD would check the mattress after 20 minutes. During an observation on 5/10/2024 at 10:16 am, more than 20 minutes later after the LAL mattress static setting was turned on, the DSD checked the mattress. The DSD stated the mattress felt firm. During a review of the LAL Operation Manual, the manual indicated to press the static mode from the touch panel to provide a firm surface that makes it easier for the patient to transfer or reposition. Press the static button again to switch back to alternating mode. The LAL system is designed for prevention, treatment and management of pressure ulcers. The LAL mattress pump is a smart pump simple to operate and easy to use, constantly providing pressure redistribution and support to patients. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled Prevention of Pressure Injuries dated April 2020, the P&P indicated to reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary team.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview and record review, the facility failed to assess and monitor the presence of white sediments (visible particles in the urine that could indicate infection or dehydration [fluid deficit]) in the urine for one of one sampled residents (Resident 58) with indwelling catheter (foley catheter [FC] - a tube inserted in the bladder to drain urine into a drainage bag) as indicated in the facility's policy and procedure, titled Foley Catheter Guidelines for Preventing Catheter Associated Urinary Tract Infections (CAUTI's) and the resident's care plan. This deficient practice had the potential for Resident 58 to receive no care or delayed care and treatment for urinary tract infection (UTI, condition in which bacteria invade and grow in any part the urinary system). Findings: During a review of Resident 58's admission record (AR), the AR indicated the facility admitted Resident 58 on 4/22/2022 and readmitted on [DATE] with diagnoses that included pressure ulcer stage four (ulcer that extends into the muscle and bone and causing extensive damage) of sacral region and respiratory failure (a condition when the lungs cannot get enough oxygen into the blood). During a review of Resident 58's untitled care plan initiated on 8/16/2022, the care plan indicated Resident 58 had a potential for unavoidable recurrent UTI related to FC use. The care plan interventions included for staff to notify physician for any signs and symptoms of UTI such as complaints of pain, burning, increase in frequency and urgency during urination, increased temperature, change in urine character, color, cloudy, odor, amount, clarity, etc. During a review of Resident 58's untitled care plan initiated on 11/18/2022, the care plan indicated Resident 58 was at risk for UTI secondary to use of FC due to neurogenic bladder (lack of bladder control) and wound management. The care plan interventions included for the nursing staff to monitor urine for sediments, cloudiness, odor, blood, and amount of output. During a review of Resident 58's Physician's Order Summary Report, dated 2/1/2023, the Physician's Order Summary Report indicated for nursing staff to monitor FC urinary drainage bag and document the following: color, consistency, odor, hematuria (blood in the urine), bladder distention, burning sensation and presence or absence of signs/symptoms of UTI every shift. During a review of Resident 58's History and Physical (H&P) assessment dated [DATE], the H&P indicated Resident 58 did not have the capacity to understand and make decisions. During a review of Resident 58's Minimum Data Set (MDS- a resident assessment and care planning tool), dated 2/2/2024, the MDS indicated Resident 58 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 58 required total dependence (totally dependent with staff for assistance of activities of daily living) with toileting hygiene, shower, lower body dressing and putting on or taking off footwear. (continued on next page)

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	055449	A. Building B. Wing	05/10/2024

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Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's Physician's Order Summary Report dated 3/4/2024, the Physician's Order Summary Report indicated to insert FC, French (a type of catheter) 22 (size of the catheter) attached to bedside drainage bag for urinary neurogenic bladder/wound management. During an observation on 5/7/2024 at 9:24 am, Resident 58 was asleep, lying in bed. Resident 58 had FC hanging on the right side of bed. Resident 58's FC tubing contained white sediments. During a concurrent observation and interview on 5/7/2024 at 9:25 am, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the FC tubing had white sediments. LVN 1 stated, Resident 58's FC needed to be monitored for signs and symptoms of UTI such as presence of sediments, cloudiness, hematuria, and fever by licensed nurses every shift, to prevent infection. During an interview on 5/9/2024 at 8:20 am, with Registered Nurse Supervisor 3 (RN Sup 3), RN Sup 3 stated Resident 58's FC needed to be monitored for signs and symptoms of infection such as presence of sediments, difficulty urination and hematuria by licensed nurses every shift to prevent UTI infection. During an interview on 5/9/2024 at 11:46 am with the facility's Director of Nursing (DON), the DON stated, licensed nurses needed to monitor the resident's foley catheter for presence of sediments, blood, pain during urination and signs and symptoms of UTI every 8 hours to prevent infection. During a review of the facility's undated Policy and Procedure (P&P) titled, Foley Catheter Guidelines for Preventing Catheter Associated Urinary Tract Infections (CAUTI's), the P&P indicated to monitor and report the clinical signs and symptoms of a urinary tract infection (with or without catheter) based on including odor, color, consistency, hematuria, bladder distension and burning sensation.

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	05/10/2024

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide necessary care and services for gastrostomy tube (GT, a tube inserted through the abdomen that delivers nutrition directly to the stomach) site as ordered by the physician and as indicated in the plan of care for one of one sampled resident (Resident 26) selected for tube feeding care area. This failure had the potential for complications related to tube feedings for Resident 26. Findings: During a review of Resident 26's Admission Records (AR), the AR indicated Resident 26 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included gastrostomy (an opening into the stomach from the abdominal wall), dysphagia (difficulty swallowing), and tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing). During a review of Resident 26's Care Plan (CP) titled Tube Feeding, initiated 8/19/2022, the CP indicated, Resident 26 was getting nutrition and hydration by GT feeding. The CP indicated Resident 26 was at risk for irritation at the GT site. The CP interventions included GT care daily and for staff to assess for redness, pain, swelling, increased temperature, discharge, and notify physician as needed. During a review of Resident 26's Minimum Data Sheet (MDS, a standardized assessment and care planning tool), dated 3/27/2024, the MDS indicated, Resident 26 had severely impaired cognition (ability to understand) and dependent (helper does all of the effort, resident does none of the effort to complete the activity) on oral and toileting hygiene, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 26 was on feeding tube for nutrition. During a review of Resident 26's Order Summary Report (OSR), dated 3/27/2024, the OSR indicated for licensed staff to clean Resident 26's GT site with normal saline (NS), pat dry, and cover with dry dressing daily every day shift, to monitor dressing integrity daily and to change dressing as needed when soiled or pulled out. During a concurrent observation and interview on 5/7/2024 at 10:18 am inside Resident 26's room with the Registered Nurse Supervisor 1 (RN Sup 1), RN Sup 1 stated, Resident 26's GT site did not have a dressing. RN Sup 1 stated GT site should be covered to prevent skin irritation around the GT site and to prevent the GT from pulling during turning and repositioning. During an interview on 5/9/2024 at 9:22 am with the Infection Preventionist Nurse (IPN), IPN stated, GT site should be covered as ordered to prevent infection and to prevent from pulling during care. During an interview on 5/9/2024 at 12:02 pm with the facility's Director of Nursing (DON), the DON stated Resident 26's GT site needed to be covered as ordered to absorb any leaks around the GT site and to prevent trauma from being dislodged during bed mobility. (continued on next page)

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	055449	A. Building B. Wing	05/10/2024

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F 0693 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, Gastrostomy/Jejunostomy Site Care, the P&P indicated, to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection, provide GT site care as ordered by physician.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to ensure the dialysis (procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances) emergency kit was readily available at the bedside for one of one sampled resident (Resident 51). This deficient practice had the potential for adverse consequences in the event of emergency bleeding from the dialysis access site for Resident 51. Findings: During a review of Resident 51's Admission Record, the record indicated the facility admitted the resident on 4/12/2024, with diagnoses that included end stage renal disease (ESARD a medical condition in which a person's kidneys cease functioning on a permanent basis) and type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine.) During a review of Resident 51's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 4/12/2024, the MDS indicated the resident had moderate cognitive impairment and required maximal assistance with rolling left and right, sit to lying and lying to sit types of bed mobility. During a concurrent observation and interview on 5/8/2024 at 2:40 pm, there was no dialysis emergency kit at Resident 51's bedside. Licensed Vocational Nurse 4 (LVN 4) searched for the emergency kit on top of the bedside table, inside the bedside drawer and inside the closet. LVN 4 stated there was no emergency dialysis kit at Resident 51's bedside. LVN 4 stated the bleeding kit needed to be at Resident 51's bedside in case of emergency bleeding from the dialysis access site. LVN 4 stated the emergency dialysis kit would contain gauze dressings, tape and clamp to stop the bleeding. During an observation on 5/8/2024 at 2:45 pm, Resident 51's dialysis access site located on the right chest area had an intact dressing. During a review of the facility's undated Policy and Procedure (P&P) titled Post-Dialysis - Emergency Bleeding Management, the P&P indicated emergency supplies will be available at the resident's bedside for management of bleeding from venous access sit that include: gauze dressing, wrap bandage, tape. If a resident has a central line, a [NAME] clamp will be available at bedside to manage bleeding.

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	055449	A. Building B. Wing	05/10/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40913 Based on interview and record review, the facility failed to ensure all nursing staff possess the competencies (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles successfully) and skill sets necessary to meet the residents' needs safely when the facility failed to: a. Ensure the competency skills evaluation included pressure ulcer prevention and management for two of two sampled Certified Nursing Assistants (CNAs 3 and 4). b. Ensure all direct care staff received in-service regarding pressure ulcer prevention and management that would include turning and repositioning and the operation of the low air loss mattress (LAL- a bed mattress designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown.) Findings: a. During an interview on 5/10/2024 at 3:06 pm, CNA 3 stated she did not receive training at the facility regarding pressure ulcer prevention and management. During a review of CNA 3's employee file on 5/10/2024 at 3:11 pm, the employee file indicated: CNA 3 was hired on 10/4/2023. CNA 3's Orientation Skills Checklist dated 10/4/2023 did not include skills related to pressure ulcer prevention and management. CNA 3's Certified Nursing Assistant Competency Checklist dated 10/5/2023 did not include skills related to pressure ulcer prevention and management. During a review of CNA 4's employee file on 5/10/2024 at 3:11 pm, the employee file indicated: CNA 4 was hired on 6/13/2023. CNA 4's Certified Nursing Assistant Competency Checklist dated 6/13/2023 did not include skills related to pressure ulcer prevention and management. During a concurrent interview on 5/10/2024 at 3:11 pm, the Director of Staff Development (DSD) stated the orientation checklist and competency checklist for CNAs 3 and 4 did not include skills related to pressure ulcer and management. The DSD stated one of the skills on the orientation and competency checklist indicated Proper Positioning and this would only refer how to properly position the resident when on the chair or bed to ensure proper alignment. During a review of the facility's in-service titled Turning and Repositioning, Skin Integrity and Comfort, Skin Management dated 5/4/2024, the in-service did not indicate CNA 4 was in- serviced. (continued on next page)

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	055449	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of the facility's training calendar dated 2024 and a concurrent interview with the DSD on 5/10/2024 at 4:08 pm, the training calendar did not indicate training regarding the use of low air loss mattress. The DSD stated the training calendar did not include training on the use of low air loss mattress. During a review of the facility's in-service titled Turning and Repositioning, Skin Integrity and Comfort, Skin Management dated 5/4/2024, the in-service did not include training on the use of low air loss mattress. During a review of the facility's Policy and Procedure (P&P) titled Competency Assessments dated May 2023, the P&P indicated each employee must demonstrate competency requirement related to skills, technique, and training necessary to provide nursing and related care and services for all resident in accordance with resident care plans.

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	055449	A. Building B. Wing	05/10/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 33) on psychotropic drugs (any drug that affects brain activities associated with mood, emotions, and behavior) was free from unnecessary medications by failing to ensure staff attempted a gradual dose reduction ([GDR] the stepwise tapering of a dose to determine if symptoms, condition, or risks can be managed by a lower dose or if the dose or medication can be discontinued) of Resident 33's Quetiapine Fumarate ([antipsychotic drug] a drug use to treat symptoms of psychosis or disconnection from reality) 25 milligram ([mg] unit of measurement) since ordered on 9/9/2022. This deficient practice placed Resident 33 at risk for adverse drug reaction (a harmful and unintended response to a medicine). Findings: During a review of Resident 33's Admission Record (AR), the AR indicated the facility readmitted Resident 33 on 3/6/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), chronic obstructive pulmonary disease ([COPD] a group of lung diseases that block airflow and make it difficult to breathe) and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). During a review of Resident 33's Physician Order Sheet (POS) dated 4/30/2024, the POS indicated for licensed staff to give Quetiapine Fumarate one tablet by mouth twice a day for schizoaffective disorder as manifested by constantly screaming. During a review of Resident 33's Medication Administration Record (MAR) for 5/1/2024 through 5/8/2024, the MAR indicated Resident 33 received Quetiapine Fumarate one tablet by mouth twice a day for schizoaffective disorder as manifested by constantly screaming. The MAR also indicated Resident 33 had one episode of screaming in the past eight days (5/1/2024-5/8/2024). During an observation on 5/7/2024 at 11:10 a.m., Resident 33 was lying in low bed with an oxygen inhalation at two liters (unit of measurement) per minute through nasal cannula (a device that delivers extra oxygen through a tube and into the nose). Resident 33 was non-communicative. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/9/2024 at 12:30 p.m., with the Director of Nursing (DON), Resident 33's medical record indicated Resident 33 was on Quetiapine Fumarate 25 mg twice a day for schizoaffective disorder as manifested by constant screaming since 9/9/2022. Resident 33 was readmitted to the facility on [DATE], with the same Physician Order for Quetiapine Fumarate dosage and target behavior symptom of constant screaming. The DON stated Resident 33's Physician Order for Quetiapine Fumarate dated 4/30/2024 was a clarification of order but it was the same Physician Order as of 9/9/2022. Resident 33's medical record had no documented evidence of a past or recent failed attempt of GDR for Quetiapine Fumarate since 9/9/2022, to medically justify that GDR would be clinically contraindicated for Resident 33. The DON stated GDR was necessary to determine if Resident 33 would benefit from the smallest dose of psychotropic medication for the treatment of behavioral problem to prevent adverse drug reaction. During a review of the facility's Policy and Procedures (P&P) titled, Tapering Psychotropic Medications and Gradual Dose Reduction dated 3/2023, the P&P indicated a resident who was admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner should attempt a GDR within the first year in two separate quarters (with at least one month between the attempts) unless clinically contraindicated. The P&P also indicated after the first year, the facility shall attempt GDR at least annually, unless clinically contraindicated.

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	055449	A. Building B. Wing	05/10/2024

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14330 Based on observation, interview and record review, the facility failed to ensure its binding arbitration agreements included selection of a neutral arbitrator and a venue convenient to both facility and resident/resident responsible party for two of two sampled residents (Residents 33 and 50). This deficient practice placed Residents 33 and 50 at risk for an unjust arbitration and delayed arbitration hearing in an event of an arbitration dispute. Findings: a. During a review of Resident 33's Admission Record (AR), the AR indicated the facility readmitted Resident 33 on 3/6/2024, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning), chronic obstructive pulmonary disease ([COPD] a group of lung diseases that block airflow and make it difficult to breathe) and schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood). During an observation on 5/7/2024 at 11:10 a.m., Resident 33 was lying in low bed with an oxygen inhalation at two liters (unit of measurement) per minute through nasal cannula (a device that delivers extra oxygen through a tube and into the nose). Resident 33 was non-communicative. During a concurrent interview and record review on 5/10/2024 at 12:11 p.m., with the Admission Coordinator (AC), the binding arbitration agreement for Resident 33 was reviewed. The facility's arbitration agreement form titled, Arbitration Agreement indicated it was signed by Resident 33's responsible party on 9/2/2019, when Resident 33 was originally admitted to the facility on [DATE]. The signed Arbitration Agreement of Resident 33 did not include information regarding selection of a neutral arbitrator and a venue convenient to both facility and resident/resident responsible party. The AC stated it was an old Arbitration Agreement form that was used by the previous Admission Director in 2019. b. During a review of Resident 50's AR, the AR indicated the facility readmitted Resident 50 on 9/28/2022, with diagnoses that included dementia and schizoaffective disorder. During an observation on 5/7/2024 at 11:40 a.m., Resident 50 was lying on her back in bed and was non-communicative. During a concurrent interview and record review on 5/10/2024 at 12:11 p.m., with the Admission Coordinator (AC), the binding arbitration agreement for Resident 50 was reviewed. Resident 50's Arbitration Agreement indicated it was signed by Resident 50's responsible party on 3/2/2021. The signed Arbitration Agreement of Resident 50 did not include information regarding selection of a neutral arbitrator and a venue convenient to both facility and resident/resident responsible party. The AC stated it was important for both facility and resident/resident's representative to have a neutral arbitrator for a fair arbitration hearing and a convenient location for the family to be able to attend the hearing.

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	055449	A. Building B. Wing	05/10/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438 Based on observation, interview, and record review, the facility failed to provide safe and sanitary environment to help prevent the development and transmission of communicable diseases (one that is spread from one person to another) for eight of eight sampled residents (Residents 191, 39, 38, 32, 30, 70, 8, and 2) selected for infection control care area, by failing to: a. Ensure signage was posted and PPE cart was provided to Resident 191 with a gastrostomy tube (GT, a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) on Enhanced Standard Precaution (ESP, an approach for the use of personal protective equipment [PPE- specialized equipment or clothing that protects against infectious materials] to reduce transmission of multidrug-resistant organisms [MDRO] between residents in skilled nursing facilities) in accordance with the facility's policy and procedure (P&P) and resident's care plan. b. Ensure signage was posted and PPE cart was provided to Resident 39 with Foley Catheter (FC- a common type of indwelling catheter, a soft, plastic or rubber tube that is inserted into the bladder to drain the urine) on ESP in accordance with the facility's P&P. c. Ensure the Infection Preventionist Nurse (IPN- a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment) changed gloves and performed hand hygiene in between resident care after touching the GT sites for Residents 38, 32, 30, and 70. d. Ensure Licensed Vocational Nurse 1 (LVN 1) changed gloves and perform hand hygiene in between provision of care to Residents 8 and 2. These failures had the potential to expose Residents 191, 39, 38, 32, 30, 70, 8, and 2 and other residents in the facility to infection. Findings: a. During a review of Resident 191's Admission Records (AR), the AR indicated Resident 191 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy. During a review of Resident 191's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 4/30/2024, the MDS indicated, Resident 191 had moderately impaired cognition (ability to understand) and required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, shower, upper and lower body dressing, and personal hygiene. The MDS indicated Resident 191 was on feeding tube for nutrition. During a review of Resident 191's untitled Care Plan (CP), dated 4/30/2024, the CP indicated Resident 191 was on GT feeding and was at risk for infection at GT site. The CP indicated a goal to minimize the risk of infection at GT site. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 191's untitled CP dated 5/7/2024, the CP indicated Resident 191 was placed on ESP due to high risk of infection with feeding tube and the CP interventions included for staff to post signage for ESP. During a concurrent observation and interview on 5/7/2024 at 9:24 am inside Resident 191's room with the Licensed Vocational Nurse 3 (LVN 3), Resident 191 was on GT feeding. Resident 191's room did not have ESP signage posted outside the room, and no cart for PPE was provided. LVN 3 stated Resident 191 should be on ESP because the resident had a GT and could easily acquire infection. During an interview on 5/9/2024 at 10:03 am with the IPN, the IPN stated residents (in general) with wounds, GT, Foley catheter, tracheostomy (an incision in the windpipe made to relieve an obstruction to breathing) and dialysis (a treatment that removes waste fluid and excess fluid from the blood when the kidneys are no longer functioning properly) residents need to be placed on ESP because they were susceptible to infection. b. During a review of Resident 39's AR, the AR indicated, Resident 39 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI, an illness in any part of the urinary tract) and fracture of the right femur (broken thighbone). During a review of Resident 39's CP, dated 2/28/2024, the CP indicated Resident 39 had a FC and was at risk for complications from catheter use and recurrent UTI. The CP goal indicated to minimize risk of complications from catheter use and risk of recurrent UTI through appropriate interventions. During a review of Resident 39's MDS dated [DATE], the MDS indicated Resident 39 had intact cognition. The MDS indicated Resident 39 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) with toileting and shower. During a review of Resident 39's untitled CP dated 5/7/2024, the CP indicated Resident 39 was placed on ESP due to high risk of infection with FC. The care plan goal was to reduce infection and the CP interventions included hand hygiene during any direct contact. During a concurrent observation and interview inside Resident 39's room with the IPN on 5/7/2024 at 9:44 am, Resident 39 had a FC. Resident 39's room did not have ESP signage posted outside the room and no cart for PPE was provided. The IPN stated Resident 39 should be on ESP because the resident had a FC and was susceptible to infection. During an interview on 5/9/2024 at 12:02 pm with the Director of Nursing (DON), the DON stated, residents (in general) with GT and FC needed to be placed on ESP to prevent the spread of infection. c. During a review of Resident 38's AR, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses that included gastrostomy and tracheostomy. During a review of Resident 32's AR, the AR indicated Resident 32 was admitted to the facility on [DATE] with diagnoses that included gastrostomy and tracheostomy. During a review of Resident 30's AR, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses that included gastrostomy and tracheostomy. (continued on next page)

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	05/10/2024

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Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 70's AR, the AR indicated Resident 70 was admitted to the facility on [DATE] with diagnoses that included gastrostomy and tracheostomy. During an observation on 5/7/2024 at 9:53 am with the IPN, Residents 38, 32, 30, and 70 occupied the same room; the room was on ESP. IPN did not change gloves and did not perform hand hygiene after touching the GT sites of Residents 38, 32, 30, and 70. During an interview on 5/9/2024 at 10:03 am with the IPN, the IPN stated, gowns and gloves were needed in the ESP rooms. IPN stated staff needed to change gloves and perform hand hygiene for every resident encounter such as touching the resident and the surroundings to prevent cross contamination. During an interview on 5/9/2024 at 12:02 pm with the DON, the DON stated, all staff needed to change PPE for every resident especially when staff anticipated splashes or touching of bodily fluids. The DON stated staff needed to perform hand hygiene to prevent the spread of infection. During a review of the facility's undated P&P titled, Enhanced Standard Precaution, the P&P indicated, All residents will be assessed for the need of Enhanced Standard precaution upon admission, quarterly and as needed with any of the following: active infection (non-MDRO infection, colonization with an MDRO, any open wound, and indwelling medical devices. Perform hand hygiene, wear gowns and gloves while performing the following tasks associated with residents who require Enhanced Barrier precaution: morning and evening care, device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter, any car activity where close contact with the resident is expected to occur such as bathing, per-care, assisting with toileting, changing incontinence briefs , transferring, respiratory care, any car activity involving contact with environmental surfaces likely contaminated by the resident and in multi-bed rooms, consider each bed space as a separate room and change gowns and gloves and perform hand hygiene when moving from contact with one resident to contact with another resident. 42781 d. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 12/1/2010 with diagnoses that included dysphagia (difficulty in swallowing) and encounter for attention to gastrostomy (GT - creation of an artificial external opening into the stomach for medication and nutritional support) status. During a review of Resident 8's untitled care plan initiated on 11/19/2019, the care plan indicated Resident 8 was at risk for infection secondary to enteral (gastrostomy) feeding. The care plan interventions included for staff to perform hand hygiene during care and provide standard precaution (infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status, included hand hygiene) at all times. During a review of Resident 8's untitled care plan initiated on 8/8/2022, the care plan indicated Resident 8 was at high risk for infection due to indwelling (FC) medical device. The care plan interventions included for staff to perform hand hygiene, wear gowns and gloves while performing high contact activities and provide enhanced barrier precaution. (continued on next page)

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	05/10/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's untitled care plan initiated on 1/11/2024, the care plan indicated Resident 8 was placed on Enhanced Standard Precaution (ESP) due to high risk for infection. The care plan interventions included for staff to perform hand hygiene during any direct contact. During a review of Resident 8's MDS dated [DATE], the MDS indicated, Resident 8's cognition for daily decision making was severely impaired. The MDS indicated Resident 8 required total dependence (totally dependent with staff for assistance of activities of daily living) with oral hygiene, toileting hygiene, shower, lower body dressing, putting on or taking off footwear and personal hygiene. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 2/11/2022 and readmitted on [DATE] with diagnoses that included dysphagia and gastrostomy status. During a review of Resident 2's untitled care plan initiated on 7/8/2022, the care plan indicated Resident 2 was at high risk for infection The care plan interventions included for staff to perform hand hygiene during care. During a review of Resident 2's untitled care plan initiated on 1/11/2024, the care plan indicated Resident 2 was placed on Enhanced Standard Precaution due to high risk for infection. The care plan interventions included for staff to perform hand hygiene during any direct contact. During a review of Resident 2's MDS dated [DATE], the MDS indicated, Resident 2's cognition for daily decision making was intact. The MDS indicated Resident 2 required total dependence with oral hygiene, toileting hygiene, shower, lower body dressing, putting on or taking off footwear and personal hygiene. During a concurrent observation and interview on 5/7/2024 at 8:57 am with LVN 1, Resident 8 was awake in bed. LVN 1 touched Resident 8's GT site dressing with gloved hands. LVN 1 did not change gloves and did not perform hand hygiene before touching Resident 2 (Resident 8's roommate). LVN 1 stated she touched Resident 2's GT site without changing gloves and did not perform hand hygiene. LVN 1 stated she needed to change gloves and perform hand washing in between resident contact to prevent the spread of infection and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an interview on 5/9/2024 at 11:50 am with facility's Director of Nursing (DON), the DON stated staff needed to perform hand hygiene before and after Resident 8 and Resident 2's care to prevent cross contamination and spread of infection. During a record review of the facility's undated P&P titled, Infection Control, the P&P indicated to perform hand hygiene before and after assisting a resident with personal care, such as oral care, bathing, etc.