| 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 | 04/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview, and record review the facility failed to provide privacy for one of 22 sampled residents (Resident 69) when staff did not close the privacy curtain while checking Resident 69's Gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall) site.<br><br>This deficient practice violated Resident 69's right to bodily privacy and resulted in unnecessary exposure of Resident 69's abdominal area and lower extremities. This deficient practice had the potential to affect Resident 69's psychosocial (mental and emotional) well-being, self-esteem, and self-worth.<br><br>Findings:<br><br>During a review of Resident 69's Admission Record (AR), the AR indicated Resident 69 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and dysphagia (difficulty swallowing).<br><br>During a review of Resident 69's Care Plan (CP) titled, Care Plan Report, revised 1/7/2025, the CP indicated Resident 69 required assistance with activities of daily living (ADL) due to G-tube feeding. The CP interventions indicated for staff to maintain Resident 69's privacy and respect Resident 69's rights.<br><br>During a review of Resident 69's Physician Order (PO) dated 2/25/2025, the PO indicated for staff to administer Jevity 1.2 (liquid formula used for G-tube feeding) at 50 cubic centimeters per hour (cc/hr- unit of measurement) for 20 hours via enteral pump (medical device used to deliver tube feeding) to provide 1,000 cc per 1,220 kilo calories (kcal, unit of energy) per day.<br><br>During a review of Resident 69's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/3/2025, the MDS indicated Resident 69 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 69 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.<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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 4/15/2025 at 10:05 am with the Director of Staff Development (DSD), in Resident 69's room, Resident 69 was awake, lying in bed. The DSD pulled up Resident 69's gown and checked Resident 69's G-tube site. The DSD did not close Resident 69's privacy curtain to provide Resident 69 privacy, exposing Resident 69's abdominal area and lower extremities to Resident 69's roommate and possibly the hallway.<br><br>During an interview on 4/15/2025 at 10:07 am with the DSD, the DSD stated the DSD pulled up Resident 69's gown to check Resident 69's G-tube site and did not close the privacy curtain to provide Resident 69 privacy, exposing Resident 69's abdomen and lower extremities. The DSD stated privacy curtain needed to be closed during ADLs to provide privacy.<br><br>During an interview on 4/16/2025 at 8:36 am with the Director of Nursing (DON), the DON stated Resident 69s' privacy curtain needed to be closed during care and ADLs to maintain Resident 69's dignity and privacy by not exposing Resident 69's body parts.<br><br>During a review of the facility's policy and procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated staff would promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438<br><br>Based on observation, interview, and record review, the facility failed to ensure the pad sensor/call lights were within reach for three of three sampled residents (Residents 9, 14, and 34).<br><br>These failures had the potential for the residents not to receive or receive delayed care that could result in a fall or accident.<br><br>Findings:<br><br>a. During a review of Resident 9's Admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), osteoporosis (weak and brittle bone due to lack of calcium and vitamin D) and traumatic fracture (a bone break caused by a sudden, strong force, like a fall or car accident).<br><br>During a review of Resident 9's untitled Care Plan (CP) dated 6/14/2024, the CP indicated Resident 9 was at risk for falls/injury related to impaired mobility, use of psychotropic medications and unsteady gait. The CP interventions included staff to keep the resident's call light within easy reach and to encourage the resident to use it to get assistance.<br><br>During a review of Resident 9's Fall Risk Assessment (FRA) dated 3/18/2025, the FRA indicated Resident 9 was assessed as high risk for fall.<br><br>During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 3/19/2025, the MDS indicated Resident 9 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 9 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.<br><br>During a concurrent observation inside Resident 9's room and interview on 4/15/2025 at 10:40 am with Certified Nurse Assistant 1 (CNA 1), Resident 9 was lying in bed, on her back with pad sensor hanging on the left siderail of the bed. CNA 1 stated Resident 9 could not reach and pull the pad sensor. CNA 1 stated Resident 9 was stronger on her right side. CNA 1 stated the pad sensor should be placed next to the strong arm and hand of Resident 9 where she could reach it and call when help was needed.<br><br>b. During a review of Resident 14's AR, the AR indicated Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), muscle weakness (decreased strength in the muscles) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) affecting the left dominant side.<br><br>During a review of Resident 14's untitled CP dated 9/14/2022, the CP indicated Resident 14 was at risk for falls/injury related to difficulty walking, generalized weakness and poor body balance control. The CP interventions included placing the call light within easy reach.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 14's FRA dated 3/27/2025, the FRA indicated Resident 14 was assessed as high risk for fall.<br><br>During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 had severely impaired cognition. The MDS indicated Resident 14 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene.<br><br>During a concurrent observation inside Resident 14's room and interview on 4/15/2025 at 10:57 am with Licensed Vocational Nurse 2 (LVN 2), Resident 14 was in bed, on her back with the call light on the floor on the left side of the bed. LVN 2 stated Resident 14 could not move her left arm and hand. LVN 2 stated the call light should be placed next to the strong arm and hand of Resident 14 for Resident 14 to call for assistance and staff could address her needs in a timely manner.<br><br>During an interview on 4/16/2025 at 8:45 am with the Director of Nursing (DON), the DON stated the resident's call light should be placed next and close to the residents' strong arm and hand so the resident could call for help, communicate needs and for staff to assist the resident's needs promptly.<br><br>36924<br><br>c. During a review of Resident 34's AR, the AR indicated Resident 34 was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (disease that affects the function or structure of the brain), Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait) and muscle weakness (decreased strength in muscles).<br><br>During a review of Resident 34's History & Physical (H&P) dated 10/27/2024, the H&P indicated Resident 34 had the capacity to make decisions for activities of daily living (ADLs- basic self-care tasks).<br><br>During a review of Resident 34's Fall Risk CP revised 1/29/2025, the CP indicated to place Resident 34's call light within easy reach.<br><br>During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had severely impaired cognition (ability to understand and process thoughts), and required substantial/maximal assistance with sit to stand, toileting, shower and bathing, personal hygiene and walking 10 feet.<br><br>During a review of Resident 34's FRA dated 3/3/2025, the FRA indicated Resident 34 was assessed as high fall risk.<br><br>During an observation on 4/15/2025 at 10:50 a.m. in Resident 34's room, Resident 34's call light was on the floor and not within Resident 34's reach.<br><br>During an observation and interview on 4/15/2025 at 11:00 a.m. with the Director of Rehabilitation (DOR), the DOR stated the DOR observed Resident 34's call light on the floor.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 4/15/2025 at 11:27 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated the call light should not be on the floor because the floor was dirty and for infection control.<br><br>During an interview on 4/18/2025 at 10:53 a.m. with the facility's DON, the DON stated it was the facility's policy to keep the residents' call light within easy reach. The DON stated the importance of the call light being within easy reach was for the resident to access right away when the resident needed assistance and to prevent falls for residents who were assessed as high risk for fall.<br><br>During an interview on 4/19/2025 at 10:34 a.m. with LVN 11, LVN 11 stated interventions for fall risk residents included low bed, frequent checks, call light within reach and floor mat. LVN 11 stated it was important that the resident's call light was within reach for access and to call for assistance and for the residents not to get up unsupervised.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.<br><br>During a review of the facility's P&P titled, Call System, Residents, dated 9/2022, the P&P indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed. From toileting/bathing facilities and from the floor. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan. |

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| F 0636<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on interview and record review, the facility failed to complete a discharge assessment Minimum Data Set (MDS, a standard resident assessment and care screening tool) per Center of Medicare & Medicaid Service (CMS- a federal agency that provides health coverage and focuses on improving the quality and outcome within the healthcare system) requirement for one of one sampled resident (Resident 82).<br><br>This failure had the potential for inaccurate reporting to CMS and for Resident 82 not to receive necessary care and services.<br><br>Findings:<br><br>During a review of Resident 82's Admission Record (AR), the AR indicated Resident 82 was admitted to the facility on [DATE] with diagnoses including difficulty in walking and hypertension (high blood pressure).<br><br>During a review of Resident 82's Minimum Data Set (MDS, a resident assessment tool) dated 12/11/2024, the MDS indicated Resident 89 had clear speech, had the ability to understand others and make self-understood. Resident 82 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for personal hygiene, lower body dressing, and rolling left and right.<br><br>During a review of Resident 82's Discharge Summary Report (DSR) dated 2/1/2025, the DSR indicated Resident 82 was discharged on [DATE].<br><br>During an interview on 4/16/2025 at 2:40 pm, with the MDS Coordinator (MDS C), the MDS C stated Resident 82 was admitted on [DATE] and discharged home on 2/1/2025. The MDS C stated the MDS C forgot to complete a discharge MDS for Resident 82 and it was due 2/15/2025. The MDS C stated once the resident was discharged home, the facility had seven to 14 days to complete a discharge assessment and transmit to CMS. The MDS C stated it was important to update CMS regarding Resident 82's health condition and whereabout at the time Resident 82 was discharged from the facility and ensure correct billing.<br><br>During a review of the facility provided document titled Submission And Correction of the MDS Assessments, dated 10/2024, the document indicated Completion time frame: for all non-Admission OBRA (regulations that have defined a schedule of assessments that will be performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment) and PPS (Prospective Payment System), MDS completion date must be no later than 14 days after the Assessment Reference Date. For a Quarterly, Significant Correction to prior Quarterly, Discharge assessment, encoding must occur within 7 days after the MDS completion date. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on interview and record review, the facility failed to ensure two of three sampled residents' (Resident 16 and 23's) swallowing/nutritional status was accurately assessed and coded in Resident 16 and 23's Minimum Data Set (MDS- a resident assessment tool).<br><br>This deficient practice resulted in inaccurate reporting to the Centers for Medicare and Medicaid Services (CMS, a federal agency that administers major healthcare programs in the United States) and had the potential for Residents 16 and 23 to not receive interventions to address specific care concerns.<br><br>Findings:<br><br>a. During a review of Resident 23's Admission Record (AR), the AR indicated Resident 23 was admitted to the facility on [DATE], with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement).<br><br>During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23 had severely impaired cognition (ability to think, learn, and remember) for daily decision making. The MDS indicated Resident 23 required partial/moderate assistance (helper does less than half the effort) with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 23 required substantial/maximal assistance with toileting hygiene, showering/bathing self, and upper and lower body dressing. The MDS indicated Resident 23 had a weight loss of five (5) percent (%) or more in the last month or 10% or more in last six (6) months of the assessment. The MDS indicated Resident 23 had no weight gain of 5% or more in the last month or gain weight of 10% or more in last 6 months of the assessment.<br><br>During a review of Resident 23's Weights and Vitals Summary (WVS) from 1/1/2024 to 4/30/2025, the WVS indicated Resident 23 had a weight gain of eight (8) pounds (lbs.- unit of weight) from 79 lbs. on 8/5/2024 to 87 lbs. on 2/5/2025 (period of six month). The WVS indicated Resident 23 had a weight gain of seven (7) lbs. from 80 lbs. on 1/6/2025 to 87 lbs. on 2/5/2025 (period of one month).<br><br>During a concurrent interview and record review on 4/16/2025 at 8:58 am with the MDS Nurse (MDSN), Resident 23's MDS dated [DATE] was reviewed. The MDSN stated Resident 23's MDS needed to be coded with no weight loss and with weight gain. The MDSN stated Resident 23 had a weight gain of 7 lbs. in a month from 1/6/2025 to 2/5/2025 with a significant weight gain of 7.5%. The MDSN stated Resident 23's MDS assessment needed to be coded accurately to give accurate information to CMS.<br><br>During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, dated 11/2019, the P&P indicated any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment. The P&P indicated the information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.<br><br>40037<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. During a review of Resident 16's AR, the AR indicated Resident 16 was readmitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and respiratory failure (lungs are unable to adequately exchange oxygen).<br><br>During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2025, the MDS indicated Resident 16 had unclear speech, did not have the ability to understand others and to make self-understood. The MDS indicated Resident 16 was dependent (helper does all of the effort) for personal hygiene, upper and lower body dressing, and rolling left and right. The MDS indicated Resident 16 had a weight loss of 5% (percent) or more in the last month or weight loss of 10% or more in the last six months.<br><br>During a review of Resident 16's Weight and Vitals Summary (WVS) from 8/1/1024 to 4/30/2025, the WVS indicated Resident 16's weight was 108 lbs. (pound) on 9/24/2024, 110 lbs. on 2/5/2025 and 115 lbs. on 3/5/2025. The WVS indicated Resident 16 had a weight gain of 5 lbs. from 2/5/2025 to 3/5/2025 and a weight gain of 7 lbs. from 9/24/2024 to 3/5/2025.<br><br>During an interview and concurrent record review on 4/16/2025 at 10:05 am, with the MDS Coordinator (MDS C), the MDS C stated, Resident 16's MDS was coded incorrectly in Resident 16' MDS dated [DATE]. MDS C stated Resident 16 actually had a weight gain during the identified period of time. The MDS C stated, Resident 16 had weight gain of 5 lbs. from 2/5/2025 to 3/5/2025, a weight gain of 7 lbs. from 9/24/2024 to 3/5/2025, and there was no weight loss during the last month's review and last six month's review from the MDS dated [DATE]. The MDS C stated the MDS C did not check Resident 16's WVS to ensure the correct weight information before MDS C entered the data in the MDS dated [DATE]. The MDS C stated it was important to ensure accuracy of Resident 16's weight entered in the MDS because it could affect resident's quality of care. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924<br><br>Based on observation, interview, and record review, the facility failed to develop an individualized and comprehensive communication plan of care for one of one sampled resident (Resident 50) with language barrier.<br><br>This failure resulted in Resident 50 not receiving individualized care and did not maintain the resident's highest physical and mental well-being.<br><br>Findings:<br><br>During a review of Resident 50's Admission Record (AR), the AR indicated Resident 50 was readmitted to the facility on [DATE] with diagnoses that included chronic kidney disease (longstanding disease of the kidneys), Type 2 diabetes mellitus (body has trouble controlling and using blood sugar) and essential hypertension (high blood pressure with no known underlying cause).<br><br>During a review of Resident 50's History & Physical (H&P) dated 2/24/25, the H&P indicated Resident 50 did not have the capacity to make medical decisions.<br><br>During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool) dated 2/27/25, the MDS indicated Resident 50 had severely impaired cognition (ability to understand and process thoughts) and the resident's preferred language was Tagalog (language primarily spoken in the Philippines). The MDS indicated Resident 50 required substantial/maximal assistance with sit to stand and shower/bathing self.<br><br>During a review of Resident 50's medical record, there was no Care Plan (CP) developed to address Resident 50's language needs.<br><br>During an observation in Resident 50's room on 4/15/25 at 11:30 a.m., there was no communication board available at Resident 50's bedside.<br><br>During an interview on 4/19/25 at 12:06 p.m. with the facility's Infection Preventionist (IP), the IP stated Resident 50 speaks Tagalog only.<br><br>During an interview on 4/19/25 at 3:23 p.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 50 previously had a communication board with pictures at Resident 50's bedside but CNA 2 hasn't seen the communication board in a while. CNA 2 stated CNA 2 was unsure when and if the communication board was replaced. CNA 2 stated Resident 50 does not understand English, and it would be easier to communicate with Resident 50 with pictures.<br><br>During a concurrent observation and interview on 4/19/25, at 4:25 p.m. with CNA 5, CNA 5 stated Resident 50 does not speak English and Resident 50 did not understand when CNA 5 asked Resident 50 if Resident 50 wanted a shower. CNA 5 stated CNA 5 was going to look for a translator (staff).<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/19/25 at 4:51 p.m. with the Director of Nursing (DON), the DON stated Resident 50 only speaks Tagalog.<br><br>During an interview on 4/19/25 at 4:56 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the importance of developing an individualized and comprehensive care plan was to identify the plan of care for specific for the resident in order to provide the necessary care the resident needed.<br><br>During a review of the facility's undated Policy and Procedure (P&P) titled, Resident Participation-Assessment/Care Plans, the P&P indicated resident assessments are begun on the first day of admission and completed no later than the fourteenth (14th) day after admission. A comprehensive care plan is developed within (7) days of completing the resident assessment. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924<br><br>Based on observation, interview, and record review, the facility failed to maintain the bed alarm in proper working and functional condition for one of three sampled residents (Resident 34) reviewed for accidents and hazards.<br><br>This failure placed Resident 34 at risk for a preventable fall/accident.<br><br>Findings:<br><br>During a review of Resident 34's AR, the AR indicated Resident 34 was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (disease that affects the function or structure of the brain), Parkinson's disease (disease that affects the nerve cells in the brain that produces symptoms that include muscle rigidity, tremors, and changes in speech and gait) and muscle weakness (decreased strength in muscles).<br><br>During a review of Resident 34's History & Physical (H&P) dated 10/27/24, the H&P indicated Resident 34 had the capacity to make decisions for activities of daily living (ADLs- basic self-care tasks).<br><br>During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 1/30/25, the MDS indicated Resident 34 had severely impaired cognition (ability to understand and process thoughts), and required substantial/maximal assistance with sit to stand, toileting, shower and bathing, personal hygiene and walking 10 feet.<br><br>During a review of Resident 34's Fall Risk Assessment (FRA) dated 3/3/25, the FRA indicated Resident 34 was assessed as high fall risk.<br><br>During an observation in Resident 34's room, Resident 34's bed alarm was observed hanging on the side of Resident 34's bed and Resident 34's bed alarm had no batteries.<br><br>During a concurrent observation and interview on 4/15/25 at 11:33 a.m. with Licensed Vocational Nurse (LVN 9), LVN 9 stated Resident 34's bed alarm did not have batteries, and the bed alarm should have batteries. LVN 9 stated Resident 34's bed alarm cannot function properly without batteries. LVN 9 stated it was important for Resident 34's bed alarm to be functional to alert staff when the resident needed help or wanted to get out of bed. LVN 9 stated Resident 34 was on Falling Star Program (residents identified as at risk for falls).<br><br>During an interview on 4/17/25, at 3:40 p.m. with the Director of Nursing (DON), the DON stated bed alarm was used as an intervention to prevent falls. The DON stated Resident 34's bed alarm was not functional without batteries. The DON stated it was important that the bed alarm was functional to help prevent a fall. The DON stated nurses (in general) making rounds every shift and the Maintenance staff needed to check the bed alarms to ensure the residents' bed alarms were functioning.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 4/19/25 at 5:35 p.m. with the Maintenance Supervisor (MS), the MS stated the MS did not know what or how to implement a system to monitor the residents' bed alarms were functioning properly and there was no system in place to monitor the bed alarms. The MS stated the bed alarms were checked once a month.<br><br>During a review of Resident 34's Care Plan (CP) for Impaired Mobility, Impaired Transfers, and Impaired Ambulation, revised 10/31/24, the CP indicated Resident 34 required a Sensor Pad Alarm when in: (Wheelchair, Bed) due to spontaneous act/behavior of trying to get up unassisted. The CP interventions included for staff to monitor the alarm for good working condition and proper placement as needed.<br><br>During review of the facility's Policy and Procedure (P&P), titled, Maintenance Service, revised 12/2009, the P&P indicated the maintenance department was responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on observation, interview, and record review, the facility failed to change the dressing (a clean or sterile covering) every seven (7) days for two of two sampled residents' (Resident 63's and 294's) central line (a flexible tube inserted into a vein in the neck, chest, arm or groin) and midline intravenous (IV- existing or taking place within a vein/s) catheter (a long, thin, flexible tube that is inserted in the upper arm with the tip located just below the axilla [armpit]) in accordance with Resident 63's and Resident 294's care plan and the facility's policies and procedures (P&P) titled, Midline Catheter Dressing Change, and Peripheral and Midline IV Dressing Changes.<br><br>This failure had the potential to result in an infection for Resident 63 and 294 and worsen Resident 63's and 294's health condition.<br><br>Findings:<br><br>a. During a review of Resident 294's Admission Record (AR), the AR indicated Resident 294 was admitted to the facility on [DATE], with diagnoses that included other acute osteomyelitis (infection of the bone) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control) with diabetic polyneuropathy (nerves in various part of the body are damaged by elevated blood sugar levels).<br><br>During a review of Resident 294's Physicians Order (PO) dated 4/3/2025, the PO indicated for staff to change (Resident 294's) central line and midline (catheter) every day shift, every seven (7) days for site care, until 4/28/2025. The PO indicated for staff to change all central line, peripherally inserted central catheter (PICC- a type of central line inserted into a vein in the arm and threaded to a large vein near the heart) and midline transparent dressings per sterile (free from bacteria or living microorganism) technique (upon admission if not dated or site not visible for assessment). The PO indicated for staff to change injection cap to each lumen (passageway inside the catheter) and change securement device.<br><br>During a review of Resident 294's Care Plan (CP) titled Care Plan Report, revised 4/3/2025, the CP indicated Resident 294 required IV therapy related to osteomyelitis and had the potential for infection and/or complications related to IV access and medication administration. The CP interventions included for the nursing staff to change the dressing, needleless access device and securement device every 7 days and as needed (PRN) using a transparent dressing for central line, PICC line, and/or midline.<br><br>During a review of Resident 294's Minimum Data Set (MDS, a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 294 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 294 needed substantial/maximal assistance (helper does more than half the effort) from staff for toileting hygiene, showering/bathing self, lower body dressing, and personal hygiene.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 4/15/2025 at 9:55 a.m. with the Director of Staff Development (DSD), Resident 294 was awake, lying in bed, with a midline IV catheter on Resident 294's right arm. Resident 294's midline IV catheter dressing was observed with a date of 4/1/2025. The DSD stated Resident 294's midline IV catheter dressing was dated 4/1/2025.<br><br>During an interview on 4/16/2025 at 8:48 a.m. with the Director of Nursing (DON), the DON stated the resident's (in general) midline IV transparent dressing and securement device needed to be changed every 7 days to prevent infection on the site.<br><br>During a concurrent interview and record on 4/16/2025 at 9:04 am with Registered Nurse 1 (RN) 1, Resident 294's electronic medical record was reviewed. RN 1 stated RN 1 did not change Resident 294's midline IV catheter transparent dressing based on the PO since 4/1/2025. RN 1 stated Resident 294's midline IV site dressing needed to be changed every 7 days or PRN to prevent infection.<br><br>During a review of the facility's P&P titled, Midline Catheter Dressing Change, revised 3/2023, the P&P indicated, dressing changes using transparent dressings are performed upon admission, at least weekly, and if the integrity of the dressing has been compromised (wet, loose or soiled). The P&P indicated to change catheter securement device every 7 days and as needed. The P&P indicated, to change antimicrobial disc every 7 days and PRN. The P&P indicated to label dressing with date, time, and nurse's initials.<br><br>40438<br><br>b. During a review of Resident 63's AR, the AR indicated, Resident 63 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses that included diabetes mellitus, hemiplegia (complete paralysis [loss of the ability to move] on one side of the body) and hemiparesis (partial weakness on one side of the body).<br><br>During a review of Resident 63's MDS, dated [DATE], the MDS indicated Resident 63 had an intact cognition. The MDS indicated Resident 63 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, required substantial/maximal assistance with upper body dressing, and was dependent (helper does all of the effort) on staff for toileting hygiene, showering/bathing, lower body dressing, and personal hygiene.<br><br>During a review of Resident 63's CP titled, Care Plan Report, dated 4/8/2025, the CP indicated Resident 63 had the potential for infection and/or complications related to IV access and medication administration. The CP interventions included for staff to change the dressing and securement device every 7 days and PRN using a transparent dressing or every 48 hours if using gauze (a very thin fabric with loose open weave) dressing.<br><br>During a concurrent observation and interview on 4/15/2025 at 10:10 am with Licensed Vocational Nurse (LVN) 1, inside Resident 63's room, Resident 63 had a midline IV on Resident 63's right upper arm. LVN 1 stated the midline IV was covered with white gauze dressing. LVN 1 stated the midline IV site dressing was not labeled with the date when it was inserted or changed. LVN 1 stated the midline IV site dressing should be labeled with the date to know when it was started and the last time the dressing was changed to prevent infection to the site.<br><br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/16/2025 at 8:47 am with the DON, the DON stated midline dressing should be changed every 7 days and PRN. The DON stated IV site dressing should be labeled with the date of when it was inserted and the date when the dressing was changed to keep the IV site clean and for infection control.<br><br>During a review of the facility's P&P titled, Peripheral and Midline IV Dressing Changes, revised March 2023, the P&P indicated, Place new dressing (TSM [transparent semi-permeable (allowing for moisture and gas exchange) membrane] or gauze) over insertions site. Label dressing with the date and time of dressing change, and initials. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) to change the face mask (an oxygen delivery device) for breathing treatment every seven days for one of three sampled residents (Resident 35).<br><br>This failure had the potential to result in infection for Resident 35.<br><br>Findings:<br><br>During a review of Resident 35's Admission Record (AR), the AR indicated Resident 35 was readmitted to the facility on [DATE] with diagnoses including End Stage Renal Disease (ESRD, irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and anemia (a condition where the body does not have enough healthy red blood cells).<br><br>During a review of Resident 35's Minimum Data Set (MDS, a resident assessment tool) dated 3/10/2025, the MDS indicated Resident 35 had clear speech, had the ability to understand others and made self-understood. The MDS indicated Resident 35 had intact cognition (the mental process of thinking, learning, remembering, being aware of surroundings, and using judgment). The MDS indicated Resident 35 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for personal hygiene, upper and lower body dressing, and sit to stand.<br><br>During an observation on 4/15/2025 at 10:22 am, Resident 35 was in bed with eyes closed. Resident 35 was receiving oxygen via nasal canula (NC, an oxygen delivery device) at 4 liters per minute. There was a face mask on Resident 35's bedside stand and the face mask was dated 3/10/2025. During a concurrent interview, Licensed Vocational Nurse 3 (LVN 3) stated, Resident 35 received breathing treatment using a face mask, and the face mask should be changed weekly for infection control purposes.<br><br>During a review of Resident 35's Order Summary Report (OSR) dated 4/1/2025, the OSR indicated an order for Ipratropium-Albuterol Solution (medication for relaxing and opening the air passages to the lungs to make breathing easier) inhale orally every 4 hours as needed for SOB (shortness of breath) or wheezing (abnormal lung sound) via nebulizer (a medical device that converts liquid medication into a mist for inhalation, often delivered through a face mask or mouthpiece). The OSR indicated to change NC/mask every seven (7) days.<br><br>During an interview on 4/17/2025 at 9:57 am with the Director of Nursing (DON), the DON stated staff should change the resident's face mask and other respiratory equipment every seven days and as needed for infection control. The DON stated unclean face mask could result in infection.<br><br>During a review of the facility's undated P&P titled Oxygen Administration, the P&P indicated The oxygen tubing should be changed weekly and as needed, including changing the mask, cannula, nebulizer equipment, etc. when not in use, the oxygen tubing should be stored in a clean bag. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438<br><br>Based on observation, interview, and record review, the facility failed to implement its policy and procedure (P&P) titled, Bed Safety and Bed Rails, for one of one sampled resident (Resident 5) when staff did not attempt alternative interventions prior to the use of bed rails and did not obtain informed consent for the use of bed rails for Resident 5.<br><br>These failures placed Resident 5 at risk for entrapment (an event in which resident was caught, trapped, or entangled in a tight space around the bed) and injury from the use of side rails and to be uninformed about the risks and benefits of side rails.<br><br>Findings:<br><br>During a review of Resident 5's Admission Records (AR), the AR indicated Resident 5 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included respiratory failure (occurs when the lungs could not properly exchange gases, causing abnormal levels of carbon dioxide and/or oxygen in the arteries), dementia (a progressive state of decline in mental abilities), and parkinsonism (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). The AR indicated Resident 5's responsible party (RP) was RP 1.<br><br>During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2025, the MDS indicated Resident 5 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 5 was dependent (helper did all the effort, resident did none of the effort) on staff for oral hygiene, toileting, showering/bathing self, upper and lower body dressing, and personal hygiene.<br><br>During a concurrent observation and interview on 4/15/2025 at 10:55 am with Licensed Vocational Nurse (LVN) 1, inside Resident 5's room, Resident 5 was lying in bed, on her back with upper one-half side rails up on both sides of the bed. LVN 1 stated Resident 5 was confused.<br><br>During a concurrent interview and record review on 4/15/2025 at 11:27 am with LVN 5, Resident 5's medical records (chart) and electronic medical record were reviewed. LVN 5 stated there was no documented evidence that appropriate alternative interventions were attempted and did not meet the needs of Resident 5 before the installation of bilateral one-half side rails. LVN 5 stated there was no signed informed consent for the use of the bilateral upper half side rails in Resident 5's chart and electronic medical record. LVN 5 stated staff needed to obtain informed consent from Resident 5 or Resident 5's RP for the use of side rails to make sure that Resident 5 and/or RP 1 understood and were educated on the risks and benefits of using side rails and Resident 5's bed mobility was not restricted.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/16/2025 at 8:41 am with the Director of Nursing (DON), Resident 5's chart and electronic medical record were reviewed. The DON stated appropriate alternative interventions should be attempted and not meet the needs of the resident before the installation of side rails for the safety of Resident 5. The DON stated a signed informed consent should be obtained and a copy retained in the chart before the use and installation of side rails or bed rails or grab bars to make sure the risks and benefits were explained and understood.<br><br>During a review of the facility's P&P titled, Bed Safety and Bed Rails,' revised August 2022, the P&P indicated, The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P indicated, Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>42781<br><br>The facility failed to provide a 24-hour sufficient nursing staffing on one of fourteen Saturdays and one of fourteen Sundays for Quarter 1 of 2024 (10/1/2024 to 12/31/2024) consistent with Payroll Based Journal (PBJ, a system for collecting and reporting staffing information from nursing homes and other long-term care facilities) Staffing Data Report. The facility did not meet the required 2.4 Certified Nursing Assistant (CNA) direct care hours per patient day on 12/1/2024 and 12/14/2024.<br><br>These failures had the potential to affect the quality of care and negatively affect the resident's quality of life in the facility.<br><br>Findings:<br><br>During a review of the facility's PBJ Staffing Data Report for Quarter 1 for 2024, from 10/1/2024 to 12/31/2024, the PBJ staffing Data Report indicated the facility had an excessively low weekend staffing.<br><br>During a concurrent interview and record review on 4/18/2025 at 2:18 pm with the Director of Staff Development (DSD), the Weekend Nursing Staffing Assignment and Sign in Sheet from 10/1/2024 to 12/31/2024, the weekend Direct Care Service Hours Per Patient Day (DHPPD, refers to the actual hours of work performed per patient day by a direct caregiver) from 10/1/2024 to 12/31/2024, and the Staffing Summary report from 10/1/2024 to 12/31/2024, were reviewed. The DSD stated the nursing staffing and sign in sheet and ending census were verified and calculated as actual DHPPD wherein 2.4 hours were actual CNA DHPPD. The DSD stated completed DHPPD form were transmitted to the California Department of Public Health (CDPH). The DSD stated the DHPPD on 12/1/2024 was 2.04 actual CNA hours and on 12/14/2024 was 2.15 actual CNA hours. The DSD stated the facility did not meet the required 2.4 CNA direct care hours per patient day on 12/1/2024 and 2/14/2024.<br><br>During an interview on 4/19/2025 at 4:15 pm with the Director of Nursing (DON), the DON stated the quality of care could be compromised if there were fewer nursing staff working. The DON stated the facility was struggling with the CNA hours last October 2024 to December 2024. The facility DON stated facility should have sufficient staff for every shift to meet the resident's needs.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Nurse/Patient Staffing Policy, undated, the P&P indicated, the facility will employ sufficient nursing staff to ensure that the following nursing staffing hours are met: minimum daily average of 2.4 actual CNA hours per patient day.<br><br>During a review of the facility's P&P titled, Staffing, Sufficient and Competent Nursing, revised 8/2022, the P&P indicated, the staffing numbers and requirements of direct care staff will be in compliance with the 3.5 and 2.4 minimum standards. |

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| F 0730<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>42781<br><br>Based on interview and record review, the facility failed to ensure one of eight sampled employees (Certified Nurse Assistant [CNA] 4) had performance evaluation completed annually.<br><br>This failure had the potential for CNA 4 to not receive feedback on CNA 4's job performance and not be aware of areas that needed improvement in CNA 4's provision of patient care.<br><br>Findings:<br><br>During an interview on 4/19/2025 at 9:58 am with CNA 4, CNA 4 stated CNA 4 did not receive CNA 4's annual performance evaluation last year (2024). CNA 4 stated CNA 4 could not remember the last time the facility completed CNA 4's performance evaluation.<br><br>During a concurrent interview and record review on 4/19/2025 at 2:23 pm with the Director of Staff Development (DSD), CNA 4's employee file was reviewed. The DSD stated CNA 4's annual performance evaluation was not done. The DSD stated the DSD, or the Director of Nursing (DON) needed to complete staff performance evaluation annually.<br><br>During an interview on 4/19/2025 at 3:46 pm with the DON, the DON stated performance evaluation needed to be done annually for all the staff.<br><br>During a review of the facility's policy and procedure (P&P) titled, Performance Evaluations, revised 9/2020, the P&P indicated, The job performance of each employee shall be reviewed and evaluated at least annually. The P&P indicated, A performance evaluation will be completed on each employee at least annually thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review. |

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| Covina Rehabilitation Center | 261 W. Badillo Street<br>Covina, CA 91723 |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Post nurse staffing information every day.<br><br>42781<br><br>Based on observation, interview and record review, the facility failed to post the total number of licensed and unlicensed nursing staff directly responsible for resident care per shift daily in accordance with the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers.<br><br>This deficient practice had the potential to result in residents and/or visitors not knowing the facility's nursing staffing information.<br><br>Findings:<br><br>During a general observation of the facility on 4/15/2025 at 10:57 am, the facility's Staffing Posting (SP) dated 4/15/2025 was observed in Nursing Station 3. The SP did not indicate the total number of licensed and non-licensed nursing staff working for all three posted shifts (7 am to 3:30 pm, 3 pm to 11:30 pm, and 11 pm to 7:30 am) on 4/15/2025.<br><br>During a general observation of the facility on 4/15/2025 at 11:04 am, the facility's Sub-Acute Staffing Posting (SASP) dated 4/15/2025 was observed in Nursing Station 2. The SASP did not indicate the total number of licensed and non-licensed nursing staff working for all three posted shifts on 4/15/2025.<br><br>During a concurrent interview and record review on 4/17/2025 at 3:36 pm with Director of Staff and Development (DSD), the SASP for Station 2 and SP for Station 3 dated 4/14/2025, 4/15/2025, 4/16/205, and 4/17/2024 were reviewed. The DSD stated the staffing postings did not include the total number of licensed and non-licensed staff responsible for resident care on the enumerated dates. The DSD stated the staffing posting needed to indicate the total number of licensed and non-licensed staff responsible for resident care to know how many staff were scheduled to work.<br><br>During an interview on 4/17/2025 at 3:44 pm with the DSD consultant, the DSD consultant stated it was important to post the nursing staffing information with the total number of licensed and non-licensed staff responsible for resident care to know how many staff were scheduled on that day to provide care and treatment to the residents.<br><br>During an interview on 4/19/2025 at 4:15 pm with the Director of Nursing (DON), the DON stated the nurse staffing information posting needed to indicate the total number of licensed and non-licensed staff responsible for resident care per shift so residents and employees would know how many staff were scheduled to work on that day.<br><br>During a review of facility's P&P titled, Posting Direct Care Daily Staffing Numbers, revised 8/2022, the P&P indicated the facility will post on daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The P&P indicated the information recorded on the form shall include the total number of licensed and non-licensed nursing staff working for the posted shift. |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037<br><br>Based on interview and record review, the facility failed to ensure two of three sampled residents (Residents 35 and 89) were not administered Epoetin Alfa-epbx (Epogen, a medication to treat anemia [a condition when the blood does not have enough red blood cells or reduced amount of hemoglobin [Hgb, a protein in red blood cells that carries oxygen throughout the body]) injections as indicated in Residents 35 and 89's physicians orders (PO) to hold Epogen injections when Residents 35 and 89's Hgb level was > (more than) 10 grams per deciliter (g/dl, unit of measurement for Hgb).<br><br>As a result, Resident 35 received 19 unnecessary (extra/not needed) doses of Epogen injections from [DATE] to [DATE] ([DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]) when Resident 35's Hgb level was at 11.5 g/dl. Resident 89 received three unnecessary doses of Epogen injections from [DATE] to [DATE] ([DATE], [DATE] and [DATE]) when Resident 89's Hgb levels were at 12.3 g/dl and 12.9 g/dl.<br><br>These deficient practices placed Residents 35 and 89 at risk to experience adverse side effects (unintended effects that occur when a medication was administered incorrectly) such as polycythemia (a medical condition where there is an abnormally high number of red blood cells in the blood) and hypercoagulability (increased tendency to form blood clot), stroke (a medical condition where blood flow to part of the brain is disrupted, causing brain damage), and heart attack (a serious medical emergency where a section of the heart muscle is damaged or dies due to a lack of blood flow) from receiving excessive doses (toxic amount/ when taking more than the recommended amount) of Epogen injections, and had the potential to result in serious harm, injury or death from these significant medication errors (any preventable event that may cause or lead to inappropriate medication use or patient harm).<br><br>On [DATE] at 12:43 pm, the California Department of Public Health (CDPH, the Department) called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, impairment, or death to a resident) situation, in the presence of the Administrator (ADM), the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The ADM, DON, and ADON were informed of the facility's failure to have a system in place to ensure Residents 35 and 89 were not administered Epogen injections as ordered by Resident 35 and 89's Primary Care Physicians (PCP 1 and PCP 2). The ADM, DON, and ADON were aware that the deficient practices resulted in potential serious harm that threatened the health and safety of Residents 35 and 89, from receiving excessive doses of Epogen injections (significant medication errors).<br><br>On [DATE] at 3:30 pm, the facility provided an acceptable IJ Removal Plan (IJRP, interventions to correct the deficient practice). While onsite at the facility, the survey team verified/confirmed implementation of the IJRP through observation, interview and record review, and determined the IJ situation regarding significant medication errors was no longer present. The survey team removed the IJ on [DATE] at 4:18 pm in the presence of the ADM, DON, ADON and the Clinical Nursing Consultant (CNC).<br><br>The facility provided an acceptable IJRP as follows:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | A1. For Resident 35:<br><br>1. On [DATE], the DON notified the pharmacist regarding Resident 35 received 19 extra doses of Epogen injections from [DATE] to [DATE] when Resident 35's Hgb level was at 11.5 g/dl, which was outside of the prescribed parameter (specific instructions that can be measured), with no further recommendations.<br><br>2. On [DATE], the DON communicated with the Nephrologist (Neph 1, a medical doctor specializing in diagnosing and treating diseases and disorders of the kidneys), who recommended that the dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) center will administer Epogen injections based on Resident 35's lab work (medical test performed in a laboratory to analyze bodily samples, such as blood, urine, or tissue ) during dialysis treatments at the dialysis center.<br><br>3. On [DATE], the ADON followed up with Resident 35's Primary Physician (PCP 1), who agreed with Neph 1's recommendation and clarified the order as: Epogen to be given at the dialysis center.<br><br>4. On [DATE], the DON assessed Resident 35 for overall health condition and status. Resident 35 denied any distress, no pain or other symptoms suggesting adverse reaction.<br><br>A2. For Resident 89:<br><br>1. On [DATE], the DON notified Resident 89's Primary Physician (PCP 2) regarding Resident 89 received three extra doses of Epogen injections on [DATE], [DATE] and [DATE] when Resident 89's Hgb was > 10 g/dl.<br><br>2. On [DATE], PCP 2 ordered to continue the Epogen order with the same parameter (hold Epogen injections when Resident 89's Hgb > 10 mg/dl), pending a complete blood count (CBC, a blood test that measures amounts and sizes of red blood cells, hemoglobin, white blood cells [part of the body's immune system] and platelets [small, colorless fragments in the blood that form clots and stop or prevent bleeding]) results on [DATE].<br><br>3. On [DATE], the DON notified the pharmacist regarding Resident 89 received a total of three Epogen injections administered on [DATE], [DATE] and [DATE] when Resident 89's Hgb was above the prescribed parameter (Hgb > 10 mg/dl), without any further recommendations.<br><br>6. On [DATE], the DON assessed Resident 89 for overall health condition and status. Resident 89 denies any distress, no pain or other symptoms suggesting adverse reaction.<br><br>B. On [DATE] and [DATE], the ADM and DON notified the Medical Director of the IJ outlined in the IJ template (a document issued to the provider/facility when an IJ is called) and the Medical Director assisted in developing the IJ removal plan.<br><br>C. On [DATE], the DON notified the licensed nurses (all Licensed Vocational Nurses [LVNs] and Registered Nurses [RNs]) of the IJ findings outlined in the IJ template and provided in-services regarding the Medication Administration policy and procedure. The training covered the following topics:<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 1. To avoid medication error, the licensed nurse must check or verify the following information, but not limited to: resident name, medication name, dose, route time and special instruction such as parameters (guideline/measurable factor) as ordered by the physician.<br><br>2. Hold or discontinue the medication according to the specific parameter instructions.<br><br>3. Notify the physician if the resident has medication related issues e.g., signs or symptoms of medication reaction.<br><br>D. On [DATE] and [DATE], the ADM and DON notified one RN (RN 1) and three LVNs (LVN 3, 6, 7) who were responsible for the identified findings in the IJ template and provided one-on-one in-services regarding medication administration policy, focusing on Epogen injection administration based on parameters, following disciplinary action.<br><br>E. As of [DATE], There are a total of 48 licensed nurses, and 44 licensed nurses had completed the in-services regarding medication administration policy and procedure. Four licensed nurses could not attend the in-services due to medical and personal leave and these four licensed nurses will complete the in-services upon returning to work, before the start of their schedule shifts.<br><br>F. On [DATE], the ADM and DON initiated a Quality Assurance and Performance Improvement (QAPI, a systematic approach to ensure and enhance the quality of care and services in healthcare settings) plan to address the findings outlined in the IJ template.<br><br>G. On [DATE], the DON and ADON reviewed all current residents with the order of Epogen injections. Except Residents 35 and 89, the facility had one resident (Resident 244) with Epogen order, and no issues were identified with Resident 244.<br><br>H. Effective [DATE], the DON would provide a monthly in-service regarding medication administration policy and procedure for all licensed nurses for three months. The training covered the following topics:<br><br>1. To avoid medication errors, the licensed nurses must check or verify the following information, but not limited to, resident name, medication name, dose, route, time and special instruction, such as parameters as ordered by the physician instructions.<br><br>2. Hold or discontinue the medication according to the specific parameter instructions.<br><br>3. Notify the physician if the resident has medication related issues e.g., signs or symptoms of medication reaction.<br><br>I. Effective [DATE], the DON and/or ADON will review all residents with Epogen injection order, medication administration records, laboratory results (the outcomes of medical tests conducted in a laboratory to analyze samples of blood, urine, or other bodily fluids or tissues), after their admissions, then weekly and as needed to ensure compliance.<br><br>J. On [DATE], the DON created an Epogen injection administration log which included resident name, Epogen injection order, medication administration following parameter and laboratory monitoring.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | K. The DON and/or ADON will review all residents with Epogen injection order, medication administration record, laboratory results, after their admissions then weekly and as needed for three months and document the findings with corrective action on the monitoring log.<br><br>L. Effective [DATE], the facility will review the QAPI program every month for three months then annually thereafter or as needed. The facility will adjust the measures needed to ensure effective and ongoing compliance with the State and Federal regulations.<br><br>Findings:<br><br>1. During a review of Resident 35's Admission Record (AR), the AR indicated the facility admitted Resident 35 on [DATE] and readmitted Resident 35 on [DATE] with diagnoses including End Stage Renal Disease (ESRD, irreversible kidney failure), dependence on renal dialysis and anemia.<br><br>During a review of Resident 35's untitled Care Plan (CP, a comprehensive personalized document outlining a patient's specific healthcare needs, goals, and preferences) revised on [DATE], the CP indicated, for licensed nurses to administer Resident 35's medications as ordered.<br><br>During a review of Resident 35's PO dated [DATE], the PO indicated for licensed nurses to Administer Epogen injection solution, 10000 units per millimeter (unit/ml, unit of measurement), to inject subcutaneously (administered under the skin) in the evening. every Tuesday, Thursday and Saturday for anemia, and hold if Resident 35's Hgb was > 10 g/dl.<br><br>During a review of Resident 35's laboratory report (LR, result from the blood test) dated [DATE], the LR indicated Resident 35's Hgb level was 11.5 g/dl.<br><br>During a concurrent review of Resident 35's Medication Administration Record (MAR, record used to document medications taken by each resident), dated from [DATE] to [DATE], and interview with Licensed Vocational Nurse 6 (LVN 6) on [DATE] at 4:39 pm, the MAR dated from [DATE] to [DATE] indicated to administer Epogen injection solution 10000 unit/ml, inject 10000unit subcutaneously in the evening on Tuesday, Thursday and Saturday for amenia, hold if Hgb above 10 mg/dl. The MAR indicated Resident 35 received a total of 19 doses of Epogen injection ([DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]). The MAR indicated Resident 35's Hgb level was 11.5 g/dl. LVN 6 stated, LVN 6 administered Epogem injection to Resident 35 on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. LVN 6 stated, Resident 35's most recent CBC result was reported on [DATE] and Resident 35's Hgb level was 11.5 g/dl. LVN 6 stated 11.5 g/dl was above the physician's order to give Epogen injection to Resident 35. LVN 6 stated, Resident 35's PO was to hold Epogen injection when Resident 35's Hgb was > 10 g/dL. LVN 6 stated LVN 6 did not check Resident 35's PO before administering Epogen injections to Resident 35. LVN 6 stated, LVN 6 need to follow Resident 35's PO and hold Epogen injections when Resident 35's Hgb was at 11.5 g/dL. LVN 6 stated that administering excessive doses of Epogen injections would increase Resident 35's blood Hgb level that could cause headache, dizziness, elevated blood pressure and polycythemia. LVN 6 stated, before Epogen administration, LVN 6 needed to check the right patient, right medication, right dose, right route, right time and relevant special instructions of the medication.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a telephone interview with the facility's Medical Director on [DATE] at 10:36 am, the MD stated the facility had residents receiving Epogen injections (Residents 35, 89 and 244) with a standing order (a pre-approved, written protocol) to hold Epogen injection if the Residents' (Residents 35, 89 and 244's) Hgb level was more than 10 g/dl. The MD stated the risk for Resident 35 receiving excessive doses of Epogen was elevated blood Hgb level and could result in polycythemia and hypercoagulability.<br><br>During a telephone interview with Neph 1 on [DATE] at 10:50 am, Neph 1 stated, Resident 35 was under Neph 1's care. Neph 1 stated, Resident 35's Epogen injections should be administered at Dialysis Center (DC) 1 during Resident 35's dialysis days instead of at the facility because there was a standing order for DC 1 to check Resident 35's Hgb twice a month. Neph 1 stated licensed nurses needed to stop giving Epogen injection when Resident 35's Hgb level was >10 g/dl. Neph 1 stated, when residents (in general) receive excessive doses of Epogen injections the Hgb level would elevate and could result in stroke and heart attack.<br><br>During a concurrent review of Resident 35's MAR, dated from [DATE] to [DATE] and interview with LVN 7 on [DATE] at 1:24 pm, the MAR dated from [DATE] to [DATE] indicated to administer Epogen injection solution 10000 unit/ml, inject 10000unit subcutaneously in the evening on Tuesday, Thursday and Saturday for amenia, hold if Hgb above 10 mg/dl. The MAR indicated Resident 35 received a total of 19 doses of Epogen injection ([DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] [DATE], and [DATE]). The MAR indicated Resident 35's Hgb level was 11.5 g/dL. LVN 7 stated, LVN 7 administered Epoge injection to Resident 35 on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] when Resident 35's Hgb level was 11.5 g/dl. LVN 7 stated Resident 35's PO was to hold Epogen injection when Resident 35's Hgb level was > 10 g/dl but LVN 7 did not read nor check Resident 35's PO prior to administrating Epogen injections to Resident 35. LVN 7 stated LVN 7 needed to hold Resident 35's Epogen injections when the resident's Hgb level was 11.5 g/dl. LVN 7 stated, these (mistakes) were considered medication errors. LVN 7 stated high Hgb level could cause Resident 35 to have blood clots and possible stroke.<br><br>During a telephone interview with the Clinical Coordinator (CC) from DC 1 on [DATE] at 9:30 am, the CC stated possible risks for high Hgb included blood clot, heart attack and stroke.<br><br>During a review of DC 1's laboratory results for Resident 35 from [DATE] to [DATE], the laboratory results indicated Resident 35's Hgb level was at 10.7 g/dl on [DATE]; 11.5 g/dl on [DATE]; 12.4 g/dl on [DATE], and 12.5 g/dl on [DATE].<br><br>2. During a review of Resident 89's AR, the AR indicated the facility admitted Resident 89 on [DATE] and readmitted Resident 89 on [DATE], with diagnoses including kidney transplant (a surgical procedure where a healthy kidney from a living or deceased donor was placed into a recipient whose kidneys were failing or no longer functioning) and anemia.<br><br>During a review of Resident 89's most current LR dated [DATE], the LR indicated Resident 89's Hgb level was 12.9 g/dl.<br><br>During a review of Resident 89's PO dated [DATE], the PO indicated for licensed nurses to administer Epogen injection solution 10000 unit/ml, inject subcutaneously in the morning, every Monday, Wednesday and Friday for anemia, hold if Hgb > 10 g/dl.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a review of Resident 89's untitled CP dated [DATE], the CP indicated for licensed nurses to administer Resident 89's medications as ordered.<br><br>During a concurrent interview with LVN 3 and review of Resident 89's MAR dated from [DATE] to [DATE], on [DATE] at 1:40 pm, the MAR dated from [DATE] to [DATE], indicated to administer Epogen injection solution 10000 unit/ml, inject 10000unit subcutaneously in the morning on Monday, Wednesday and Friday for amenia, hold if Hgb above 10 mg/dl. The MAR indicated Resident 89 received Epogen injections on [DATE], [DATE] and [DATE]. The MAR indicated Resident 89's Hgb level was 12.3 g/dL. LVN 3 stated, LVN 3 administered Epogen injections to Resident 89 on [DATE] without checking Resident 89's latest Hgb level. LVN 3 stated based on the result of Resident 89's Hgb on [DATE] (12.9 mg/dl), Resident 89 did not need the Epogen injection on [DATE]. LVN 3 stated Resident 89's Epogen injections should have been held. LVN 3 stated, LVN 3 also administered Epogen injection to Resident 89 on [DATE] when Resident 89's Hgb level was at 12.3 g/dl. LVN 3 stated LVN 3 did not read Resident 89's PO accurately before administering Epogen injections to Resident 89. LVN 3 stated, high Hgb level could result in blood clots, heart attack and strokes to Resident 89.<br><br>During an interview on [DATE] at 9:48 am, with the DON, the DON stated, It was a medication error. The DON stated the facility did not follow the physicians' order and administered Epoetin injections to Residents 35 and 89 when Residents 35 and 89's Hgb level were above the prescribed parameter (specific instructions to hold when Hgb >10 mg/dl). The DON stated, licensed nurses needed to check Residents 35 and 89's most recent/current Hgb level before administering Epogen injections to Residents 35 and 89. The DON stated, when administering medication, licenses nurses needed to follow the principle of Five Rights including right patient, right drug, right dose, right route and right time. The DON stated licensed nurses needed to double check any medication ordered with a parameter to prevent medication errors. The DON stated that high levels of Hgb would cause serious side effects including blood clots, heart attack and stroke.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated , d+[DATE], the P&P indicated Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.<br><br>During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, dated ,d+[DATE], the P&P indicated A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional providing services. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781<br><br>Based on interview and record review, the facility failed to ensure complete and accurate documentation for one of one sampled resident (Resident 37) on a Low Air loss Mattress (LAL- a medical mattress designed to prevent and treat pressure wounds) when Resident 37's use and monitoring of LAL was not documented in Resident 37's Treatment Administration Record (TAR).<br><br>This failure resulted in Resident 37's medical record to contain incomplete information and had the potential to affect Resident 37's care.<br><br>Findings:<br><br>During a review of Resident 37's Admission Record (AR), the AR indicated Resident 37 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs).<br><br>During a review of Resident 37's Physician Order (PO), dated 1/8/2025, the PO indicated Resident 37 had an order for LAL for wound care and management every shift.<br><br>During a review of Resident 37's MDS dated [DATE], the MDS indicated Resident 37 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 37 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene.<br><br>During a review of Resident 37's Treatment Administration Record (TAR) for the month of January 2025, the TAR indicated the LAL for wound care and management was not documented/checked/signed off as performed on the following dates and shifts:<br><br>1. 1/15/2025 for 11 pm to 7 am shift.<br><br>2. 1/20/2025 for 11 pm to 7 am shift.<br><br>3. 1/21/2025 for 3 pm to 11 pm and 11 pm to 7 am shift.<br><br>4. 1/24/2025 for 3 pm to 11 pm shift.<br><br>5. 1/26/2025 for 11 pm to 7 am shift.<br><br>6. 1/27/2025 for 11 pm to 7 am shift.<br><br>During an observation on 4/15/2025 at 10:39 am, Resident 37 was asleep lying in a LAL.<br><br>(continued on next page) |

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|---|---|---|---|
| | 055449 | A. Building<br>B. Wing | 04/19/2025 |

| 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.

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/17/2025 at 11:07 am with Treatment Nurse (TN) 1, Resident 37's electronic medical record was reviewed. TN 1 stated Resident 37's TAR had no documentation regarding the use of the LAL on 1/15/2025 for 11 pm to 7 am shift, 1/20/2025 for 11 pm to 7 am shift, 1/21/2025 for 3 pm to 11 pm and 11 pm to 7 am shift, 1/24/2025 for 3 pm to 11 pm shift, 1/26/2025 for 11 pm to 7 am shift, and 1/27/2025 for 11 pm to 7 am shift. TN 1 stated TN 1 did not know why Resident 37's TAR was not checked/signed off by the licensed nurses. TN 1 stated licensed nurses needed to monitor the LAL setting every shift and document it in the TAR.<br><br>During an interview on 4/17/2025 at 12:14 pm with the Director of Nursing (DON), the DON stated resident's (in general) TAR needed to be checked off and licensed staff needed to sign the TAR immediately after performing a treatment to the resident as per physician's order. The DON stated the LAL needed to be monitored if it was working and in the correct setting. The DON stated Resident 37 had a wound and the wound might get worse if the LAL was not monitored every shift.<br><br>During a review of the facility's policy and procedure P&P titled, Pressure-Reducing Mattresses, undated, the P&P indicated to provide mattresses that will prevent and/or minimize pressure on the skin and to provide comfort if resident prefers. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40438<br><br>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 for three of five sampled residents (Residents 5, 24, and 1) by failing to:<br><br>a. Ensure staff implemented the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precaution (EBP, precautions that include the use of a gown and gloves during high contact resident care activities for residents), to prevent the spread of infections for Residents 5 and 24.<br><br>b. Ensure Resident 1's oxygen tubing was not on the floor.<br><br>These failures had the potential to result in transmission of multidrug-resistant organisms (MDRO, bacteria that is resistant to antibiotics (medicine used to stop or kill the growth of bacteria) to other residents in the facility.<br><br>Findings:<br><br>a1. During a review of Resident 5's Admission Records (AR), the AR indicated Resident 5 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included respiratory failure (occurs when the lungs could not suitably exchange gases, causing abnormal levels of carbon dioxide and/or oxygen in the arteries), dementia (a progressive state of decline in mental abilities), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).<br><br>During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2025, the MDS indicated, Resident 5 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 5 was dependent (helper did all the effort, resident did none of the effort) on staff for oral hygiene, toileting, showering/bathing, upper and lower body dressing, and personal hygiene.<br><br>During a review of Resident 5's Physician Order (PO), dated 11/13/2024, the PO indicated, Resident 5 had an order for EBP due to gastrostomy tube (GT, a feeding tube surgically inserted into the stomach through the abdominal wall).<br><br>a2. During a review of Resident 24's AR, the AR indicated, Resident 24 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses that included stage 4 pressure ulcer (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of sacral region (triangular bone at the base of the spine that forms part of the pelvis), obstructive uropathy (a urinary tract disorder that occurs when urine flow is obstructed) and dementia (a progressive state of decline in mental abilities).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 24's MDS, dated [DATE], the MDS indicated, Resident 24 had severely impaired cognition. The MDS indicated Resident 24 required partial/moderate assistance (helper did less than half the effort) with eating, oral hygiene, and was dependent (helper did all the effort, resident did none of the effort to complete the activity) on staff for personal hygiene, showering/bathing, and lower body dressing.<br><br>During a review of Resident 24's PO, dated 11/24/2024, the PO indicated, Resident 24 had an order EBP for sacrococcyx wound (a type of pressure injury that occurs in the sacrum and tailbone).<br><br>During a concurrent observation and interview on 4/15/2025 at 10:54 am with Licensed Vocational Nurse (LVN) 1, inside Resident 5's room, LVN 1 was checking Resident 5's GT for placement and residuals. LVN 1 was wearing a yellow gown and gloves.<br><br>During an observation on 4/15/2025 at 10:58 am with LVN 1, inside Resident 24's room, Resident 24 was in bed on her back with an indwelling Foley Catheter (FC, a flexible tube inserted into the bladder to drain urine). LVN 1 was checking Resident 24's FC tubing for the presence of white sediments in the tubing. LVN 1 did not change LVN 1's gown and gloves LVN 1 used while providing care for Resident 5 before proceeding to Resident 24.<br><br>During an interview on 4/15/2025 at 11 am with LVN 1, LVN 1 stated Residents 5 and 24 were both on EBP precaution. LVN 1 stated LVN 1 needed to change LVN 1's gown and gloves for every encounter with residents on EBP to prevent the spread of infection.<br><br>During an interview on 4/16/2025 at 8:50 am with the Director of Nursing (DON), the DON stated gown and gloves should be donned and changed when in close contact with EBP residents to prevent cross-contamination of infection between residents.<br><br>During a review of the facility's &P titled, Enhanced Barrier Precaution, undated, the P&P indicated, Perform hand hygiene, wear gowns and gloves while performing the following tasks associated with residents who require Enhance Barrier precaution: Morning and evening care, device care, for example, urinary catheter, feeding tube, tracheostomy, vascular catheter, any care activity where close contact with the resident is expected to occur such as bathing, peri-care, assisting with toileting, changing incontinence briefs, transferring, respiratory care . In multi-bedrooms, 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.<br><br>36924<br><br>b. During a review of Resident 1's AR, the AR indicated the facility readmitted the resident on 12/19/24 with diagnoses that included acute respiratory failure (lungs cannot properly exchange gases), schizoaffective disorder (mental illness) and chronic obstructive pulmonary disease (COPD- lung diseases that block airflow).<br><br>During a review of Resident 1's History & Physical (H&P) dated 7/26/24, the H&P indicated Resident 1 had the capacity to make medical decisions.<br><br>During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 was cognitively intact. The MDS indicated Resident 1 was on oxygen therapy.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 4/19/25 at 11:15 a.m., Resident 1's oxygen tubing was on the floor.<br><br>During a concurrent observation and interview on 4/19/25 at 11:17 a.m., with Licensed Vocational Nurse 9 (LVN 9), LVN 9 stated Resident 1's oxygen tubing was not supposed to be on the floor. LVN 9 stated it was important to keep the oxygen tubing off the floor for infection control.<br><br>During an interview on 4/19/25 at 4:00 p.m., with the DON, the DON stated it was important that oxygen tubing was not on the floor to deliver oxygen adequately to the resident and for infection control.<br><br>During an interview on 4/19/25 at 4:07 p.m., with the Infection Preventionist (IP), the IP stated it was important to keep the oxygen tubing off the floor to prevent infection. IP stated oxygen tubing on the floor was a hazard for tripping over causing trauma to the resident/staff.<br><br>During a review of the facility's undated Policy and Procedure (P&P) titled, Oxygen Administration, the P&P indicated oxygen tubing should be used in a manner that prevents it from touching the floor. |