

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055992	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER West Covina Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 850 S. Sunkist Ave. West Covina, CA 91790	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</p> <p>Based on interview and record review, the facility failed to ensure all nursing staff had the appropriate skills and competencies (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics an individual needed to perform work roles or occupational functions successfully) necessary to provide nursing care safely to one of three sampled residents (Resident 1) in accordance with the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, and Administering Medication by failing to:</p> <p>Ensure Licensed Vocational Nurse (LVN) 1 had demonstrated the skills and proper techniques necessary to care for Resident 1 with regards to medication management and/or medication administration.</p> <p>This deficient practice resulted in Resident 1 receiving an incorrect medication which caused Resident 1 to experience chest pain, burning sensation of Resident 1's body, and Resident 1 felt like Resident 1 was dying. Resident 1 was transferred to General Acute Care Hospital (GACH) 1 on 3/14/2024 at 7:30 pm for further evaluation and was treated for acute opioid withdrawal (a set of symptoms from the sudden withdrawal or reduction of opioids where previous usage has been heavy and prolonged) induced (caused) by accidental Narcan administration.</p> <p>Cross Reference F760</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses of asthma (chronic lung disease caused by inflammation and muscle tightening around the airways), allergic rhinitis (nose irritation, sneezing, watery eyes, and nasal congestion caused by allergic reaction general to environmental factors), acquired absence of right leg above the knee and phantom limb syndrome with pain (the experience of painful sensations in a limb that did not exist).</p> <p>During a review of Resident 1's Physician Order (PO), dated 8/16/2022, the PO indicated, Resident 1 had an order for fluticasone furoate suspension, 27.5 micrograms (mcg- unit of measurement), spray one (1) spray in both nostrils, (nose) two times a day related to adverse (unwanted and harmful) effect of anti-asthmatics (medications that reduced the swelling and tightening in the airways).</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 2/13/2024, the MDS indicated, Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated, Resident 1 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) with oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 1's PO, dated 2/14/2024, the PO indicated, Resident 1 had an order for Narcan nasal liquid (Naloxone Hydrochloride [HCl]), one (1) spray in nostril as needed for opioid overdose.</p> <p>During a review of Resident 1's Progress Notes (PN), dated 3/14/2024 at 7:38 pm, the PN indicated, at approximately 7:00 pm, LVN 1 administered nasal spray (unidentified) to Resident 1. The PN indicated, LVN 1 retrieved a box containing nasal spray (naloxone HCl nasal spray) labeled with Resident's 1 name. The PN indicated, immediately after administration of the nasal spray, Resident 1 began to shout and complain of chest pain, burning sensation of Resident 1's body, and felt like Resident 1 was dying. The PN indicated, Resident 1 complained that Resident 1's body was on fire and Resident 1's nose was burning. The PN indicated, Resident 1's blood pressure (BP- the pressure of blood pushing against the walls of the arteries) was 142/94 millimeters of mercury (mmHg- unit of measurement) (Normal BP was 120/80). The PN indicated, the facility called paramedics (healthcare professional trained to give emergency medical care to people who were injured or ill, typically in a setting outside of a hospital).</p> <p>During an interview on 3/28/2024 at 12:02 pm with LVN 1, LVN 1 stated when giving medications, LVN 1 did not check the medication label on the nasal spray before administering the medication to Resident 1 (on 3/14/2024 at 7 pm). LVN 1 stated LVN 1 normally checked the resident's name, medication order, and matched the information against the medication label to ensure LVN 1 had the right dose of medication, right time, right patient, right medication, and right route of administering the medication. LVN 1 stated on 3/14/2024 at approximately 7 pm, LVN 1 thought LVN 1 was giving Resident 1 Flonase nasal spray. LVN 1 stated LVN 1 had trouble finding the Flonase in the medication cart. LVN 1 stated LVN 1 found a box of nasal spray with Resident 1's name on it but did not look at the name/label of the medication or the bottle of the medication. LVN 1 stated after giving the nasal spray to Resident 1, LVN 1 left Resident 1's room to get Resident 1's prescribed narcotic (medication used to treat moderate to severe pain). LVN 1 stated Resident 1 then wheeled himself into the hallway screaming, My body is on fire. I'm going to die. My chest, my chest! LVN 1 stated Resident 1 vomited. LVN 1 stated at that time, LVN 1 did not know what was happening to Resident 1. LVN 1 stated the desk nurse called 911 (a phone number used to contact the emergency services). LVN 1 stated when the paramedics arrived, the paramedics asked for the medications administered to Resident 1. LVN 1 stated LVN 1 showed the paramedics the box of nasal spray LVN 1 thought was Flonase and administered to Resident 1. LVN 1 stated the paramedics told LVN 1 that LVN 1 gave Resident 1 the Narcan. LVN 1 stated LVN 1 accidentally gave Resident 1 the Narcan. LVN 1 stated it was important to check medication label and bottle to ensure the medication being given was the correct medication. LVN 1 stated not checking the medication bottle/label before giving the medication to Resident 1 caused Resident 1 harm and could have led to Resident 1's death. LVN 1 stated if LVN 1 checked the bottle/label of nasal spray before administering it to Resident 1, the medication error could have been avoided.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 3/28/2024 at 2:03 pm with the Director of Staffing Development (DSD), LVN 1's Medication Competency Assessments, dated 3/27/2024, were reviewed. The DSD stated medication management included the five rights of medication administration (right patient, right medication, right dosage, right time, and right route), medication storage, and actual administration of medication to residents. The DSD stated newly hired nurses were educated on medication management. The DSD stated experienced nurses who mentored newly hired nurses were supposed to assess and sign off on the newly hired nurse's Medication Competency Assessments. The DSD stated once the newly hired nurse passed the medication competency assessment, the newly hired nurse could pass/administer medications to residents without the need of a mentor. The DSD stated LVN 1 administered medications to Resident 1 without a mentor on 3/14/2024 when LVN 1 administered naloxone (in error) instead of fluticasone to Resident 1. The DSD stated LVN 1 was not given the medication competency assessments until 3/27/2024.</p> <p>During a concurrent interview and record review on 3/28/2024 at 4:04 pm with the DSD, LVN 1's New Employee Checklist (NEC) dated 2/20/2024, and the facility's P&P titled, Staffing, Sufficient and Competent Nursing, were reviewed. The DSD stated the NEC did not indicate the need for medication management competency. The DSD stated a medication competency assessment was how the DSD checked if a newly hired nurse had the skills and techniques necessary for medication management in accordance with the P&P Staffing, Sufficient and Competent Nursing. The DSD stated it was possible that LVN 1 could have avoided making a medication error on 3/14/2024 with Resident 1 had LVN 1 demonstrated the skills and techniques necessary for medication management. The DSD stated the facility did not follow the facility's P&P on competent staffing and medication management.</p> <p>During an interview on 3/28/2024 at 4:44 pm with the Director of Nursing (DON), the DON stated a newly hired nurse competent in medication management meant the nurse was educated by the facility in medication management before passing medication without a mentor. The DON stated according to the facility's P&P titled, Staffing, Sufficient and Competent Nursing, nurses must demonstrate the skills and techniques necessary for medication administration. The DON stated if staff skills had been assessed and staff was able to demonstrate correct techniques and passed the medication competency assessments, the staff was then competent in medication management. The DON stated LVN 1 was not assessed for medication competency until after LVN 1 made a medication error. The DON stated it was possible LVN 1's medication error on 3/14/2024 could have been avoided had LVN 1's medication management competency been assessed before LVN 1 administered medications without a mentor.</p> <p>During a review of the facility's P&P titled, Administering Medications, revised in 4/2019, the P&P indicated new personnel authorized to administer medications were not permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. The P&P indicated, the charge nurse must accompany new nursing personnel on their medications rounds for a minimum of three (3) days to ensure established procedures were followed and proper resident identification methods were learned.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's P&P titled, Staffing, Sufficient and Competent Nursing, revised in 8/2022, the P&P indicated, the facility provided staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The P&P indicated, all nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. The P&P indicated, staff must demonstrate the skills and techniques necessary to care for resident needs including medication management. The P&P indicated, competency requirements and training for nursing staff were established and monitored by nursing leadership with input from the medical director to ensure that programming for staff training resulted in nursing competency, gaps in education were identified and addressed, tracking or other mechanisms were in place to evaluate effectiveness of training, and that training included critical thinking skills and managing care in a complex environment with multiple interruptions.</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) was free from significant medication error (medication error which causes the resident discomfort or jeopardizes the resident health and safety) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Licensed Vocational Nurse (LVN) 1 administered fluticasone furoate suspension (Flonase- nasal [nose] spray medication used to treat nasal congestion, sneezing, and runny nose caused by seasonal allergies [body's reaction to normally harmless substances]) instead of Narcan nasal liquid (nasal spray medication used to rapidly reverse the effects of opioid [class of drugs used to treat moderate to severe pain] overdose) to Resident 1 on 3/14/2024 at 7:00 pm. 2. Ensure LVN 1 checked Resident 1's Narcan nasal liquid medication label three times and verified that it was the right medication, right dosage, and right time before administering the medication to Resident 1 as indicated in the facility's policy and procedure (P&P) titled, Administering Medications. <p>As a result, on 3/17/2024 at 7:00 pm, immediately after Resident 1 received the incorrect medication, Resident 1 experienced chest pain, burning sensation of Resident 1's body, and Resident 1 felt like Resident 1 was dying. Resident 1 was transferred to General Acute Care Hospital (GACH) 1 on 3/14/2024 at 7:30 pm for further evaluation and was treated for acute opioid withdrawal (a set of symptoms from the sudden withdrawal or reduction of opioids where previous usage has been heavy and prolonged) induced (caused) by accidental Narcan administration.</p> <p>Cross Reference F726 and F842</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses of asthma (chronic lung disease caused by inflammation and muscle tightening around the airways), allergic rhinitis (nose irritation, sneezing, watery eyes, and nasal congestion caused by allergic reaction general to environmental factors), acquired absence of right leg above the knee and phantom limb syndrome with pain (the experience of painful sensations in a limb that did not exist).</p> <p>During a review of Resident 1's Physician Order (PO), dated 8/16/2022, the PO indicated, Resident 1 had an order for fluticasone furoate suspension, 27.5 micrograms (mcg- unit of measurement), spray one (1) spray in both nostrils, (nose) two times a day related to adverse (unwanted and harmful) effect of anti-asthmatics (medications that reduced the swelling and tightening in the airways).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 2/13/2024, the MDS indicated, Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated, Resident 1 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) with oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting/taking off footwear, and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's PO, dated 2/20/2024, the PO indicated, Resident 1 had an order for Percocet (a combination medication containing oxycodone [an opioid pain medication] and acetaminophen [medication used to treat mild to moderate pain and fever] oral (by mouth) tablet 5-325 milligrams (mg, unit of measurement), give one (1) tablet by mouth every six (6) hours as needed for moderate to severe pain.</p> <p>During a review of Resident 1's PO, dated 2/14/2024, the PO indicated, Resident 1 had an order for Narcan nasal liquid (Naloxone Hydrochloride [HCl]), one (1) spray in nostril as needed for opioid overdose.</p> <p>During a review of Resident 1's Progress Notes (PN), dated 3/14/2024 at 7:38 pm, the PN indicated, at approximately 7:00 pm, LVN 1 administered nasal spray (unidentified) to Resident 1. The PN indicated, LVN 1 retrieved a box containing nasal spray (naloxone HCl nasal spray) labeled with Resident's 1 name. The PN indicated, immediately after administration of the nasal spray, Resident 1 began to shout and complain of chest pain, burning sensation of Resident 1's body, and felt like Resident 1 was dying. The PN indicated, Resident 1 complained that Resident 1's body was on fire and Resident 1's nose was burning. The PN indicated, Resident 1's blood pressure (BP- the pressure of blood pushing against the walls of the arteries) was 142/94 millimeters of mercury (mmHg- unit of measurement) (Normal BP was 120/80). The PN indicated, the facility called paramedics (healthcare professional trained to give emergency medical care to people who were injured or ill, typically in a setting outside of a hospital).</p> <p>During a review of Resident 1's PO, dated 3/14/2024, the PO indicated an order to transfer Resident 1 to GACH 1 via 911 (emergency medical services) on 3/14/2024 (no time and indication specified).</p> <p>During a review of Resident 1's GACH 1 Emergency Department Exam Narrative (ED Exam), dated 3/14/2024 at 7:47 pm, the ED Exam indicated, Resident 1 was brought in for accidental medication administration of Narcan, eight (8) mg. The ED Exam indicated, Resident 1 was normally on Percocet and occasionally on Morphine (opioid pain medication used to treat moderate to severe pain) for chronic pain. The ED Exam indicated, Resident 1 was very anxious and restless and was in acute withdrawal due to Narcan. The ED Exam indicated, Resident 1's blood pressure was 170/80 mmHg. The ED Exam indicated, Resident 1 was treated with buprenorphine (medication used to treat opioid use disorder), clonidine HCl (medication used to lower blood pressure and heart rate), and intravenous (into a vein) fluids.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/2024 at 9:05 am with Resident 1, Resident 1 stated LVN 1 was Resident 1's medication nurse in the afternoon (on 3/14/2024). Resident 1 stated LVN 1 handed Resident 1 a nasal spray medication that did not look familiar to Resident 1. Resident 1 stated Resident 1 explained to LVN 1 that it was not Resident 1's medication, but LVN 1 insisted it was the correct nasal spray medication for Resident 1. Resident 1 stated Resident 1 explained to LVN 1 that Resident 1 normally took Flonase and not Naloxona. Resident 1 stated LVN 1 told Resident 1 to take the medication because it was prescribed to Resident 1 and was due to be taken. Resident 1 stated LVN 1 made Resident 1 take the Narcan. Resident 1 stated immediately after LVN 1 sprayed the Narcan into Resident 1's nostril, Resident 1's body felt like it was burning. Resident 1 stated Resident 1 wanted to remove all of Resident 1's clothes because Resident 1's body felt like it was on fire. Resident 1 stated Resident 1 felt different in Resident 1's head like Resident 1's head was going to explode. Resident 1 stated Resident 1 urinated and vomited on Resident 1's self. Resident 1 stated Resident 1 started to scream and ask for help because Resident 1 felt like Resident 1 was going to die. Resident 1 stated after Resident 1 returned to the facility from GACH 1, Resident 1 still experienced some chest pain and body tingling. Resident 1 stated Resident 1 had never been more scared in Resident 1's entire life than in that moment when Resident 1 received the wrong medication.</p> <p>During an interview on 3/28/2024 at 12:02 pm with LVN 1, LVN 1 stated when giving medications, LVN 1 did not check the medication label on the nasal spray before administering the medication to Resident 1 (on 3/14/2024 at 7 pm). LVN 1 stated LVN 1 normally checked the resident's name, medication order, and matched the information against the medication label to ensure LVN 1 had the right dose of medication, right time, right patient, right medication, and right route of administering the medication. LVN 1 stated on 3/14/2024 at approximately 7 pm, LVN 1 thought LVN 1 was giving Resident 1 Flonase nasal spray. LVN 1 stated LVN 1 had trouble finding the Flonase in the medication cart. LVN 1 stated LVN 1 found a box of nasal spray with Resident 1's name on it but did not look at the name/label of the medication or the bottle of the medication. LVN 1 stated after giving the nasal spray to Resident 1, LVN 1 left Resident 1's room to get Resident 1's prescribed narcotic (medication used to treat moderate to severe pain). LVN 1 stated Resident 1 then wheeled himself into the hallway screaming, My body is on fire. I'm going to die. My chest, my chest! LVN 1 stated Resident 1 vomited. LVN 1 stated at that time, LVN 1 did not know what was happening to Resident 1. LVN 1 stated the desk nurse called 911 (a phone number used to contact the emergency services). LVN 1 stated when the paramedics arrived, the paramedics asked for the medications administered to Resident 1. LVN 1 stated LVN 1 showed the paramedics the box of nasal spray LVN 1 thought was Flonase and administered to Resident 1. LVN 1 stated the paramedics told LVN 1 that LVN 1 gave Resident 1 the Narcan. LVN 1 stated LVN 1 accidentally gave Resident 1 the Narcan. LVN 1 stated it was important to check medication label and bottle to ensure the medication being given was the correct medication. LVN 1 stated not checking the medication bottle/label before giving the medication to Resident 1 caused Resident 1 harm and could have led to Resident 1's death. LVN 1 stated if LVN 1 checked the bottle/label of nasal spray before administering it to Resident 1, the medication error could have been avoided.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 3/28/2024 at 1:36 pm with Pharmacist Consultant (PC) 1, PC 1 stated Narcan was administered only in the event of a suspected or confirmed opioid overdose situation. PC 1 stated Narcan would be administered if a resident was experiencing respiratory depression (decrease in breathing), lethargy (extreme exhaustion) or unresponsiveness. PC 1 stated Narcan diminished the effects of opioids. PC 1 stated Resident 1 had an adverse response to Narcan because it caused vomiting and hypertension (high blood pressure). PC 1 stated LVN 1 made a medication error because Resident 1 was not experiencing opioid overdose when LVN 1 administered the Narcan to Resident 1. PC 1 stated LVN 1 could have avoided the medication error if LVN 1 followed the five rights of medication administration (right medication, right dose, right time, right route, right patient).</p> <p>During an interview on 3/28/2024 at 4:44 pm with the Director of Nursing (DON), the DON stated the five rights of medication administration needed to be followed during medication pass to ensure mistakes or medication errors were not made. The DON stated if the licensed nurses did not follow the five medication rights, medication errors could be made. The DON stated giving a resident Narcan when not indicated could cause a resident to experience increased heart rate, hypertension, anxiety, agitation, and acute opioid withdrawal. The DON stated LVN 1 did not follow the five rights of medication administration before administering the Narcan to Resident 1. The DON stated the medication error and Resident 1's adverse reaction could have been avoided had LVN 1 followed the five medication rights.</p> <p>During a review of the facility's P&P titled, Administering Medications, revised in 4/2019, the P&P indicated, medications were administered in a safe and timely manner, and as prescribed. The P&P indicated, medications were administered in accordance with prescriber orders, including any required timeframe. The P&P indicated, individuals administering medications checked the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687</p> <p>Based on interview and record review, the facility failed to maintain complete and accurately documented medical record for one of three sampled residents (Resident 1) by failing to:</p> <p>Ensure Licensed Vocational Nurse (LVN) 1 documented the administration of Narcan nasal liquid (Naloxone Hydrochloride [HCl]- nasal [nose] spray medication used to rapidly reverse the effects of opioid [class of drugs used to treat moderate to severe pain] overdose) instead of fluticasone furoate suspension (Flonase-nasal spray medication used to treat nasal congestion, sneezing, and runny nose caused by seasonal allergies [body's reaction to normally harmless substances] to Resident 1 on 3/14/2024 at 7 pm.</p> <p>This failure had the potential for Resident 1 to not receive appropriate care and treatment due to an incomplete/inaccurate medical record and could lead to more medication errors.</p> <p>Cross Reference F760</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses of asthma (chronic lung disease caused by inflammation and muscle tightening around the airways), allergic rhinitis (nose irritation, sneezing, watery eyes, and nasal congestion caused by allergic reaction general to environmental factors), acquired absence of right leg above the knee, and phantom limb syndrome with pain (the experience of painful sensations in a limb that did not exist).</p> <p>During a review of Resident 1's Physician Order (PO), dated 8/16/2022, the PO indicated, Resident 1 had an order for fluticasone furoate suspension, 27.5 micrograms (mcg- unit of measurement), spray one (1) spray in both nostrils (nose), two times a day related to adverse (unwanted and harmful) effect of anti-asthmatics (medications that reduced the swelling and tightening in the airways).</p> <p>During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 2/13/2024, the MDS indicated, Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated, Resident 1 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity) with oral hygiene, toileting hygiene, showering/bathing self, upper and lower body dressing, putting/taking off footwear, and personal hygiene.</p> <p>During a review of Resident 1's PO, dated 2/14/2024, the PO indicated, Resident 1 had an order for Narcan nasal liquid (Naloxone HCl), one (1) spray in nostril as needed for opioid overdose.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055992	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER West Covina Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 850 S. Sunkist Ave. West Covina, CA 91790	

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Notes (PN), dated 3/14/2024 at 7:38 pm, the PN indicated, at approximately 7:00 pm, LVN 1 administered nasal spray (unidentified) to Resident 1. The PN indicated, LVN 1 retrieved a box containing nasal spray (Naloxone HCl nasal spray) labeled with Resident's 1 name. The PN indicated, immediately after administration of the nasal spray, Resident 1 began to shout and complain of chest pain, burning sensation of Resident 1's body, and felt like Resident 1 was dying. The PN indicated, Resident 1 complained that Resident 1's body was on fire and Resident 1's nose was burning. The PN indicated, Resident 1's blood pressure (BP- the pressure of blood pushing against the walls of the arteries) was 142/94 millimeters of mercury (mmHg- unit of measurement) (Normal BP was 120/80). The PN indicated, the facility called paramedics (healthcare professional trained to give emergency medical care to people who were injured or ill, typically in a setting outside of a hospital).</p> <p>During a review of Resident 1's Medication Administration Record (MAR) for March 2024, the MAR indicated LVN 1 administered fluticasone to Resident 1 on 3/14/2024 at 5 pm.</p> <p>During a review of Resident 1's MAR for March 2024, the MAR indicated no documentation that LVN 1 administered the Narcan nasal liquid (Naloxone HCl) to Resident 1 on 3/14/2024 at 7 pm.</p> <p>During a review of Resident 1's PO, dated 3/14/2024, the PO indicated an order to transfer Resident 1 to GACH 1 via 911 (emergency medical services) on 3/14/2024 (no time and indication specified).</p> <p>During a review of Resident 1's GACH 1 Emergency Department Exam Narrative (ED Exam), dated 3/14/2024 at 7:47 pm, the ED Exam indicated, Resident 1 was brought in for accidental medication administration of Narcan, eight (8) mg. The ED Exam indicated, Resident 1 was normally on Percocet (opioid pain medication used to treat moderate to severe pain) and occasionally on Morphine (opioid pain medication used to treat moderate to severe pain) for chronic pain. The ED Exam indicated, Resident 1 was very anxious and restless and was in acute withdrawal due to Narcan. The ED Exam indicated, Resident 1's blood pressure was 170/80 mmHg. The ED Exam indicated, Resident 1 was treated with buprenorphine (medication used to treat opioid use disorder), clonidine HCl (medication used to lower blood pressure and heart rate), and intravenous (into a vein) fluids.</p> <p>During an interview on 3/28/2024 at 9:05 am with Resident 1, Resident 1 stated LVN 1 was Resident 1's medication nurse in the afternoon (on 3/14/2024). Resident 1 stated LVN 1 handed Resident 1 a nasal spray medication that did not look familiar to Resident 1. Resident 1 stated Resident 1 explained to LVN 1 that it was not Resident 1's medication, but LVN 1 insisted it was the correct nasal spray medication for Resident 1. Resident 1 stated Resident 1 explained to LVN 1 that Resident 1 normally took Flonase and not Naloxona. Resident 1 stated LVN 1 told Resident 1 to take the medication because it was prescribed to Resident 1 and was due to be taken. Resident 1 stated LVN 1 made Resident 1 take the Narcan. Resident 1 stated immediately after LVN 1 sprayed the Narcan into Resident 1's nostril, Resident 1's body felt like it was burning. Resident 1 stated Resident 1 wanted to remove all of Resident 1's clothes because Resident 1's body felt like it was on fire. Resident 1 stated Resident 1 felt different in Resident 1's head like Resident 1's head was going to explode. Resident 1 stated Resident 1 urinated and vomited on Resident 1's self. Resident 1 stated Resident 1 started to scream and ask for help because Resident 1 felt like Resident 1 was going to die. Resident 1 stated after Resident 1 returned to the facility from GACH 1, Resident 1 still experienced some chest pain and body tingling. Resident 1 stated Resident 1 had never been more scared in Resident 1's entire life than in that moment when Resident 1 received the wrong medication.</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/28/2024 at 12:02 pm with LVN 1, LVN 1 stated on 3/14/2024 at approximately 7 pm, LVN 1 thought LVN 1 was giving Resident 1 Flonase nasal spray. LVN 1 stated LVN 1 had trouble finding the Flonase in the medication cart. LVN 1 stated LVN 1 found a box of nasal spray with Resident 1's name on it but did not look at the name/label of the medication or the bottle of medication. LVN 1 stated after giving the nasal spray to Resident 1, LVN 1 left Resident 1's room to get Resident 1's prescribed narcotic (medication used to treat moderate to severe pain). LVN 1 stated Resident 1 then wheeled himself into the hallway screaming, My body is on fire. I'm going to die. My chest, my chest! LVN 1 stated Resident 1 vomited. LVN 1 stated at that time, LVN 1 did not know what was happening to Resident 1. LVN 1 stated the desk nurse called 911 (a phone number used to contact the emergency services). LVN 1 stated when the paramedics arrived, the paramedics asked for the medications administered to Resident 1. LVN 1 stated LVN 1 showed the paramedics the box of nasal spray LVN 1 thought was Flonase and administered to Resident 1. LVN 1 stated the paramedics told LVN 1 that LVN 1 gave Resident 1 the Narcan. LVN 1 stated LVN 1 accidentally gave Resident 1 the Narcan. LVN 1 stated if a medication was given, it had to be documented in the MAR, even if the medication was given by accident or in error, for safety and accuracy. LVN 1 stated LVN 1 documented that LVN 1 administered fluticasone and not naloxone because LVN 1 thought LVN 1 gave fluticasone. LVN 1 stated LVN 1 forgot to document that LVN 1 administered naloxone to Resident 1 on 3/14/2024 (at approximately 7:00 pm).</p> <p>During an interview on 3/28/2024 at 4:44 pm with the Director of Nursing (DON), the DON stated if a medication was administered to a resident, the medication administration needed to be documented in the MAR so anyone looking at the MAR could see what medications a resident had received. The DON stated documentation needed to be accurate, so the care team would know what medications were given and when for safety purposes. The DON stated not documenting medication administration accurately could lead to more medication errors that could cause adverse side effects and harm a resident.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised in 7/2017, the P&P indicated, all services provided to a resident should be documented in the resident's medical record. The P&P indicated, the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated, medications administered were to be documented in the resident's medical record. The P&P indicated, documentation in the medical record would be objective, complete, and accurate.</p>		