

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  06/07/2024
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure call lights were within reach for two of three sampled residents (Residents 2 and 3).</p> <p>This deficient practice had the potential to result in the delay of care for Residents 2 and 3 when Residents 2 and 3 were unable to reach their call lights to call staff for assistance.</p> <p>Findings:</p> <p>a. During a review of Resident 2's Admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 10/3/2023, and most recently admitted the resident on 12/19/2023, with diagnoses of fracture of right femur (a break in the thighbone), muscle weakness, and dysphagia (difficulty swallowing).</p> <p>During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/19/2024, the MDS indicated Resident 2 was usually understood by others and had the ability to usually understand others. The MDS indicated Resident 2 was dependent (helper did all the effort) on staff for toileting hygiene, lower body dressing, putting on and taking off footwear, and personal hygiene.</p> <p>During a concurrent observation and interview on 6/6/2024 at 12:30 pm with Resident 2, Resident 2 was lying in bed and stated, I am hungry. Resident 2's call light was clipped to the bed and was hanging off the bed. Resident 2 could not reach Resident 2's call light. Licensed Vocational Nurse (LVN) 1 walked over to Resident 2's bed and adjusted the call light to be within reach of Resident 2. LVN 1 stated Resident 2 usually used the call light for assistance.</p> <p>b. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 5/21/2024, with diagnoses of cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), epilepsy (a brain condition that causes repeated seizures [a sudden, uncontrolled burst of electrical activity in the brain]), and dysphagia.</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was sometimes understood by others and had the ability to usually understand others. The MDS indicated Resident 3 was dependent on staff for toileting hygiene and showering/bathing self.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/6/2024 at 12:37 pm with Resident 3, Resident 3 stated staff did not check to see if Resident 3's call light was nearby. Resident 3 stated on 6/6/2024, Resident 3's call light was on the floor and Resident 3 could not call for staff to assist. Resident 3 stated Resident 3 tried to shout out for assistance instead. Resident 3 stated sometimes the call light would be clipped to the bed but on the floor, not reachable to Resident 3.</p> <p>During an interview on 6/7/2024 at 3:38 pm with the Administrator (ADM), the ADM stated it was important for call lights to be within reach of the residents so the residents could call for assistance when needed.</p> <p>During a review of the facility's undated policy and procedure (P&amp;P) titled, Call System, Residents, the P&amp;P indicated residents were provided with a means to call for assistance through a communication system that directly calls a staff member or a centralized work station. Each resident was provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.</p> <p>During a review of the facility's undated P&amp;P titled, Answering the Call Light, the P&amp;P indicated the facility ensured that the call light was accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p>		