STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055992	A. Building B. Wing	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Healthcare Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Abuse Investigation and Reporting, by failing to report an alleged verbal abuse to the facility's Abuse Coordinator, California Department of Public Health (CDPH), the Ombudsman (an official appointed to investigate individual's complaints and assists in resolution of concerns), and the local law enforcement immediately and within 2 hours on 12/19/2024 for one of five sampled residents (Resident 2) when Resident 2 allegedly called Resident 1 derogatory words. This failure had the potential to subject Resident 1 to potential further abuse from Resident 2. Findings: 1. During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses that included hypertension (HTN, high blood pressure) and hypothyroidism (thyroid gland does not produce enough thyroid hormones in the body). During a review of Resident 1's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 10/28/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Change in Condition (COC) Evaluation Form dated 12/23/2024 at 12:16 PM, the COC indicated on 12/19/2024 untimed, Resident 1 reported a male resident came by the door of Resident 1's room and called Resident 1 names. 2. During a review of Resident 2's AR, the AR indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses that included asthma (chronic lung disease that causes the airways to become narrow), anxiety (feelings of worry or fear), and HTN. During a review of Resident 2's H&P dated 2/22/2024, the H&P indicated Resident 2 can make needs known but cannot make medical decisions. During an interview on 12/27/2024 at 11:13 AM with Resident 1, Resident 1 stated Resident 2 was at the doorway and called Resident 1 derogatory words in Spanish. Resident 1 stated it made Resident 1 feel Real bad . (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/27/2024 at 1:33 PM with Certified Nurse Assistant 3 (CNA 3), CNA 3 stated Resident 1 reported to CNA 3 on 12/19/2024 or 12/20/2024 that Resident 2 called Resident 1 bad words in Spanish. CNA 3 stated CNA 3 immediately reported it to LVN 4 the same day. CNA 3 stated Resident 2 allegedly called Resident 1 Venenosa. CNA 3 stated the word would be considered verbal abuse because it is very disrespectful and implying the person was not good. CNA 3 stated CNA 3 did not report the incident to the Administrator (ADM) because the charge nurse reports the incident to the ADM. CNA 3 stated CNA 3 was unsure if the charge nurse reported the incident. CNA 3 stated the risk of not reporting instances of abuse within two hours to the ADM is that the incident could get worse and could escalate to physical abuse. During an interview 12/27/2024 at 1:57 PM with the ADM, the ADM stated LVN 4 was out of the country on vacation. During an interview on 12/27/2024 at 2 PM with Registered Nurse 1 (RN 1), RN 1 stated if a staff member was made aware that a resident was called a derogatory term, the staff member should have notified the ADM because it was considered verbal abuse, contact the Ombudsman, CDPH, and local law enforcement. RN 1 stated the risk of not reporting incidents of abuse to the ADM was putting the safety of residents at risk. During an interview on 12/27/2024 at 2:30 PM with the Assistant Director of Nursing (ADON), the ADON stated staff should have reported the incident to the ADM because the incident was considered alleged verbal abuse. The ADON stated the risk of not reporting immediately was that the incident might reoccur. The ADON stated the facility must do prevention, monitor, and keep residents separated when instances of alleged abuse occur. During an interview on 12/27/2024 at 2:52 PM with the ADM, the ADM stated the ADM was made aware of the incident on 12/23/2024 by Resident 1's family member. The ADM stated staff are to notify both the ADM and the DON for incidents of alleged abuse. The ADM stated the incident on 12/19/2024 would be considered alleged verbal abuse and stated the risk of not reporting the incident was that the facility might fail to protect the resident and do the necessary interventions. During a review of the facility's P&P titled, Abuse Investigation and Reporting revised 7/2017, the P&P indicated alleged violations of abuse are to be reported immediately but no later than two hours if the alleged violation involves abuse.