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	01/02/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate neurological assessment (a check of how well the brain, nerves, and muscles work often performed after a suspected head injury) for two of eight sampled residents (Residents 1 and 2) after a resident-to-resident physical altercation (a fight or struggle where people used physical force, contact, or aggression against each other) that involved allegations of unwitnessed head injuries on 12/20/2025. These failures had the potential to compromise Residents 1's and Resident 2's health and safety.Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), and metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the body). During a review of Resident 1's History and Physical (H&P), dated 7/12/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/10/2025, the MDS indicated Resident 1 had severe cognitive impairment (confusion or memory loss). The MDS indicated Resident 1 required setup assistance from staff with oral hygiene. The MDS indicated Resident 1 required supervision from staff with eating, toileting hygiene, personal hygiene, bed-to-chair transferring, and using the wheelchair. The MDS indicated Resident 1 required moderate assistance (helper did less than half the effort) from staff with showering. During a review of Resident 1's Change in Condition (COC), dated 12/20/2025, the COC indicated in the morning of 12/20/2025, Certified Nurse Assistant (CNA) 1 observed Resident 1 crying and covering left eye with hand. The COC indicated Resident 1 was holding a sandal with the other hand to demonstrate that Resident 2 hit Resident 1. The COC indicated Resident 1 sustained left eye redness. The COC further indicated that the neurological assessment was not done because it was not clinically applicable to the COC. During a review of Resident 1's Post-Event Review (PER), dated 12/20/2025, the PER indicated on 12/20/2025 at 12:15 PM, Resident 1 reported that Resident 2 hit Resident 1 on the face with a sandal. During an interview with Registered Nurse (RN) 1 on 1/2/2026 at 10:49 AM, RN 1 stated a neurological assessment must be performed on a resident with an unwitnessed head injury to check alertness, cognition, pupil response, responsiveness, and reflexes to make sure the resident was cognitive stable. RN 1 stated the licensed nurse assigned to care for the resident must check vital signs (measurements of temperature, heart rate, breathing rate, blood pressure), pain level, oxygen saturation (amount of oxygen in the blood), and blood sugar if resident was diabetic. RN 1 stated neurological assessments must be started right away if the suspected head injury was unwitnessed or if there was facial redness. RN 1 stated the neurological assessment should be done every 15 minutes for the first hour, every 30 minutes for the next hour, followed by hourly, every two hours, every four hours, and then every shift for total of 72 hours. RN 1 stated all findings should be documented on the neurological assessment form in the resident's medical record. RN 1 stated that the professional standard was not met when the staff failed to initiate a neurological assessment for the residents with an unwitnessed face injury, as this could have resulted in missing any potential changes or injuries. During a concurrent record review and interview with RN 1 on 1/2/2026 at 10:49 AM, Resident 1's Vital Summary (VS) dated 12/20/2025 to 12/23/2025 was reviewed. RN 1 stated the VS indicated no neurological assessment was done for Resident 1 after the resident-to-resident physical altercation on 12/20/2025. RN 1 stated the cause of Resident 1's left eye redness was unwitnessed and the licensed nurse should have initiated the neurological assessment on 12/20/2025. During a concurrent record review and interview with RN 1 on 1/2/2026 at 10:49 AM, Resident 1's medical record, including the Nursing Progress Notes (NPN), dated 12/20/2025 to 12/23/2025 was reviewed. RN 1 stated there were no neurological assessments documented on Resident 1's medical record after the unwitnessed resident-to-resident physical altercation on 12/20/2025. b. During a review of Resident 2's AR, the AR indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia and encephalopathy. During a review of Resident 2's H&P, dated 12/11/2024, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had moderate cognitive (ability to understand) impairment. The MDS indicated Resident 2 required supervision from staff with eating. The MDS indicated Resident 2 required moderate assistance from staff with oral hygiene and personal hygiene