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	05/07/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a care plan for Resident 1's pain in the left shoulder. This deficient practice had the potential for Resident 1 receiving delayed, inadequate and/or inappropriate care and treatment and to not maintaining Resident 1's highest practicable physical, mental, and psychosocial well-being. During a review of Resident 1's admission Record (AR), dated 5/8/2026, the AR indicated Resident 1 was originally admitted to the facility on [DATE]. The AR indicated Resident 1's diagnoses included morbid obesity (a chronic disease in which a person weighs 100 pounds or more over his/her ideal body weight), chronic pain syndrome (a condition where persistent pain lasts for more than 3 to 6 months), and spinal stenosis (the narrowing of the tunnel in a person's spine that contains the spinal cord and nerves). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 1's cognition (ability to make daily decisions) was intact and Resident 1 was dependent (helper does all the effort to complete the activity) on staff for toileting hygiene, to shower/bathe, for upper body dressing, and lower body dressing. During a review of Resident 1's Change of Condition (COC - a specific documentation that describes when the condition or care needs of a resident has changed), dated 9/29/2025, the COC indicated Resident 1 reported pain on Resident 1's left shoulder after Resident 1 tried to pull Resident 1's blanket over Resident 1's shoulder during the previous evening. The COC indicated Resident 1's doctor was made aware of Resident 1's left shoulder pain. During a review of Resident 1's X-ray (an imaging test that uses radiation to take pictures of the inside of a person's body) report of the left shoulder, dated 10/31/2025, the X-ray report indicated Resident 1's left shoulder had no signs of a fracture (broken bone) or dislocation (when the left upper arm bone pops out of its socket). The X-ray report indicated Resident 1 had moderate degenerative joint disease (a condition where the protective coating that cushions the ends of a person's bones gradually wears away). During an interview on 5/7/2026 at 9:31 AM with Resident 1, Resident 1 stated Resident 1 recalled injuring left shoulder approximately nine months ago while Resident 1 was at the facility but could not recall which staff member Resident 1 reported the injury to. Resident 1 stated Resident 1 received an X-ray of the left shoulder which showed severe arthritis. Resident 1 stated about 1-2 months ago, Resident 1 was hospitalized due to pain in the left shoulder, in which Resident 1 received an ultra-sound (a test where high frequency sound waves are used to take pictures of inside a person's body). During a review of Resident 1's COC, dated 3/6/2026, the COC indicated Resident 1's doctor gave an order to send Resident 1 to the emergency room at a General Acute Care Hospital (GACH) after Resident 1 reported severe left shoulder pain that was not relieved by pain medications. The COC indicated the left shoulder was noted to be swollen. During a review of Resident 1's venous duplex (VD - also known as an ultrasound test) report, dated 3/6/2026, the VD report indicated there was no blood clot found in Resident 1's left upper arm. During a review of Resident 1's Nursing Progress Note, dated 3/6/2026, Resident 1 returned to the facility from GACH 1 via ambulance. The Nursing Progress Note indicated Resident 1's doctor was made aware of Resident 1's return and did not give any new doctor's orders. During a concurrent interview (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and record review on 5/7/2026 at 2:33 PM with Registered Nurse 1 (RN 1), Resident 1's care plan was reviewed. RN 1 stated licensed nurses, including any nurse who was involved when a resident had a change of condition, were responsible for creating or updating a resident's care plan. RN 1 stated the purpose of a care plan was to address a resident's needs. RN 1 stated a care plan was the basis of resident care because it described the interventions (actions) that the nursing staff needed to provide to the resident. RN 1 stated if there was a change in a resident's condition, a resident's care plan must be reviewed to determine if goals and interventions needed to be created or updated. RN 1 stated Resident 1 did not have a care plan specifically addressing Resident 1's left shoulder pain. During a concurrent interview and record review on 5/7/2026 at 3:25 PM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's care plan was reviewed. LVN 1 stated a care plan consisting of issues that were specific to a resident, along with the goals and interventions that addressed each specific issue. LVN 1 stated if there was a change in a resident's condition, the licensed nurses must either update the care plan or create a new care plan that addresses a specific issue. LVN 1 stated care plans were important because they directed the staff on how to provide appropriate care for the residents. LVN 1 stated Resident 1's care plan did not contain any issues, goals, or interventions specifically related to Resident 1's left shoulder pain. During an interview on 5/7/2026 at 3:44 PM with Director of Nursing (DON), DON stated a care plan identifies a specific problem for a resident and contains interventions that are designed to address the specific problem. DON stated care plans are important because they guide the approach that nursing staff take in providing resident care. DON stated care plans are also a way to measure whether a resident is improving or not. DON stated a change in condition is any new issue that affects a resident's overall health. DON stated examples of a change of condition include new pain that is reported by a resident. DON stated if a resident experiences a change in condition, a care plan should be created or updated because the nursing staff needs to be aware of the problem and how to address it. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, the P&P indicated it is the facility's policy that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated that the comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, including.which professional services are responsible for each element of care. The P&P further indicated Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.