

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/15/2026
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)		
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide timeliness diagnostic services to meet the needs for two of three sampled residents (Resident 7 and Resident 8) by failing to: 1. Ensure Resident 7 received a PET scan (Positron Emission Tomography imaging scans- use a radioactive tracer to check for signs of cancer, heart disease and brain disorders) as ordered on 5/21/2026.2. Ensure Resident 8 received a CT scan (A Computerized Tomography scan- is a type of imaging that uses X-ray techniques to create detailed images of the body) for abdominal pain as indicated in the physician's order dated 7/12/2026. These deficient practices resulted in delays in diagnoses services for Resident 7 and 8 and had the potential in worsening Resident 7 and 8's anxiety that could cause emotional and psychosocial distress.a. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 5/8/2026 with diagnoses which included atherosclerotic heart disease (plaque building in the blood vessels that carry oxygen and nutrients from the heart to the rest of the body and the vessels become thick and stiff), presence of cardiac pacemaker (small, battery-powered device that prevents the heart from beating too slowly), and presence of coronary angioplasty implant and graft (can open clogged blood vessels that deliver blood to heart muscles).During a review of Resident 7's History and Physical (H&P), dated 5/11/2026, the H&P indicated Resident 7 has the capacity to understand and make decisions.During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 7 had intact cognitive skills (ability to make daily decisions). The MDS indicated Resident 7 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 7 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, upper body dressing and personal hygiene.During a review of Resident 7's Cardiovascular Consultants (CC- a medical doctor who specializes in diagnosing, treating, and managing diseases of the heart and blood vessels), dated 5/21/2026, the CC indicated PET Scan and Echocardiography Ultrasound (ECHO-uses high-frequency sound waves to create moving pictures of heart's structure and pumping function) were ordered on 5/21/2026.During a review of Resident 7's Progress Notes (PN), dated 5/21/2026, the PN indicated that the resident returned from consultation with cardiology with new orders for ECHO and PET scan.During a review of Resident 7's Progress Notes (PN), dated 6/3/2026, the PN indicated that the resident left for outside appointment to have ECHO and PET scan done.During a review of Resident 7's Progress Notes (PN), dated 6/23/2026, the PN indicated that the resident complaint of having chest pain after waking up.During a review of Resident 7's Progress Notes- Social (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055992 If continuation sheet Page 1 of 8

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Services Note (PNSSN), dated 7/6/2026, the PNSSN indicated the resident was unable to complete PET scan due to billing issues. During a review of Resident 7's Progress Notes (PN), dated 7/6/2026, the PN indicated that the resident's PET scan will be re-scheduled due to billing concerns and there is no re-scheduled date. During a review of Resident 7's PNSSN, dated 7/13/2026, the PNSSN indicated the resident's PET scan on 7/14/2026 was cancelled. During a review of Resident 7's Order Summary Report (OSR), dated 7/13/2026, the OSR indicated Resident 7 may have PET Scan (Positron Emission Tomography imaging scans- use a radioactive tracer to check for signs of cancer, heart disease and brain disorders) diagnosis, which was ordered on 6/17/2026. The OSR indicated Resident 7 had a scheduled appointment for PET Scan on 7/14/2026 at 2 PM. During an interview on 7/13/2026 at 10:55 AM with Resident 7, Resident 7 stated that Resident 7 had a PET scan order since 5/21/2026, which was not accomplished until currently. Resident 7 stated that the facility had scheduled Resident 7's PET scan on 6/3/2026, 7/6/2026, and 7/14/2026, and both appointments on 6/3/2026 and 7/6/2026 were cancelled. Resident 7 stated that the facility did not assist Resident 7 to accomplish the PET scan in timely manner, which could cause delayed diagnosis and treatment on Resident 7 health condition and made Resident 7 feel upset and frustrated. During a review of Resident 7's Progress Notes (PN), dated 7/14/2026, the PN indicated that the resident's PET scan will be re-scheduled and there is no re-scheduled date. During a concurrent interview and record review on 7/14/2026 at 1:38 PM with Licensed Vocational Nurse (LVN) 1, Resident 7's current progress notes were reviewed. Resident 7's progress notes indicated Resident 7 turned from consultation with cardiology with new orders for ECHO and PET scan. LVN 1 stated that Resident 7's PET scan ordered since 5/21/2026 had not been completed. The scheduled PET scan on 6/3/2026 and 7/6/2026 were cancelled. LVN 1 stated that the staff should start making a schedule and arrange for the appointment right after getting the order. During a concurrent interview and record review on 7/14/2026 at 2 PM with the Social Service Director (SSD) and Social Service Assistant (SSA), Resident 7's current progress notes and social service notes were reviewed. The SSD and SSA stated that Resident 7's scheduled PET scan on 6/3/2026, 7/6/2026, and 7/14/2026 were cancelled. The SSD and SSA stated the staff should assist scheduling and arranging an appointment right after getting the order. During an interview on 7/15/2026 at 9:38 AM with Resident 7, Resident 7 stated that the scheduled PET scan on 7/14/2026 was cancelled on 7/13/2025 afternoon. Resident 7 stated that Resident 7 had heart problems and the facility delayed the resident's PET scan several times, which could delay Resident 7's treatment. During an interview on 7/15/2026 at 11:58 AM with the administrator (ADM), the ADM stated that the facility is responsible for getting all residents' procedure done even if the procedures need to be done outside the facility. b. During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on 11/16/2024 with diagnoses which included history of malignant neoplasm of large intestine (commonly known as colorectal cancer- is a serious disease where abnormal cells grow out of control in the colon or rectum), anxiety disorder (involve more than occasional worry or fear, repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes) and hypertension (high blood pressure). During a review of Resident 8's History and Physical (H&P), dated 11/24/2025, the H&P indicated Resident 8 does not have the capacity to understand and make medical decisions. During a review of Resident 8's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 8 had severely impaired cognitive skills. The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	themselves).During a review of Resident 8's Order Summary Report (OSR), for the month of July 2026, the OSR indicated Resident 8 may have a CT scan of the abdomen and pelvis without contrast diagnosis for abdominal pain, dated 7/12/2026.During a review of Resident 8's Physician's Orders (PO), dated 7/12/2026, the PO indicated that CT abdomen and pelvis were ordered for diagnosis abdominal pain.During a review of Resident 8's Change in Condition Evaluation (CICE), dated 7/12/2026, the CICE indicated that the resident may have a CT abdomen and pelvis without contrast due to abdominal pain.During a review of Resident 8's Care Plan (CP), initiated 7/12/2026, the CP indicated that the resident complaint of abdominal pain and may have CT Abdomen and pelvis.During a review of Resident 8's Progress Notes (PN), dated 7/12/2026, the PN indicated the resident complaint of abdominal pain and may have CT abdomen and pelvis after the resident was examined by the doctor.During a review of Resident 8's current PN, the PN indicated that there is no documentation regarding scheduling CT abdomen and pelvis found after the CT was ordered on 7/12/2026.During a review of Resident 8's current Progress Notes- Social Services Note (PNSSN), the PNSSN indicated that there is no documentation regarding scheduling CT abdomen and pelvis found after the CT was ordered on 7/12/2026.During an interview on 7/15/2026 at 8:25 AM with Resident 8, Resident 8 stated that the facility had not scheduled some diagnostic procedures for several days after the diagnostic procedures were ordered. Resident 8 stated that Resident 8 wanted to get these procedures done as soon as possible and the facility should have scheduled these appointments when getting the orders.During an interview on 7/15/2026 at 11:58 AM with the administrator (ADM), the ADM stated that the facility is responsible for getting all residents' procedure done even if the procedures need to be done outside the facility.During a concurrent interview and record review on 7/15/2026 at 3:45 PM with LVN 1, Resident 8's current orders, dated 7/12/2026, were reviewed. LVN 1 stated that Resident 8 had a CT scan order, with an active order date of 7/12/2026. LVN 1 stated that the staff should start making a schedule and arrange for the appointment right after getting the order.During a concurrent interview and record review on 7/15/2026 at 4:02 PM with Social Service Assistant (SSA), Resident 8's current orders, dated 7/12/2026, were reviewed. The SSA stated the staff should assist scheduling and arranging appointments as soon as possible after notice of the orders.During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2018, the P&P indicated, 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. The P&P indicated, Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the physician has requested to be notified as soon as a result is received. Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison.The P&P indicated, Physicians or nurses who have concerns about how test results have been handled or reported should communicate such concerns to the DON and/or Medical Director. Such concerns or disagreements should not prevent timely, clinically appropriate management of a current result or clinical situation.During a review of the facility's policy and procedure (P&P) titled, Referrals, Social Services, revised 12/2008, the P&P indicated, Social services personnel shall coordinate most resident referrals with outside agencies. The P&P indicated, 1. Social services shall coordinate most resident referrals. Exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff.2. Referrals for medical services must be based on (continued on next page)		

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician evaluation of resident needs and a related physician order.3. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.4. Social services will document the referral in the resident's medical record.During a review of the facility's policy and procedure (P&P) titled, Social Services, revised 9/2021, the P&P indicated that the social services staff are responsible for making referrals and obtaining needed services from outside entities. The P&P indicated, the facility is responsible for ensuring that all residents are provided these services whether by a staff member or through referrals to an outside agency.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 4) was not given six medications (vitamin D3- a supplement, amlodipine- used to treat high blood pressure and chest pain [angina], atenolol- used to treat high blood pressure, angina and improve survival after a heart attack, levetiracetam- used to control partial-onset seizures, zinc- a supplement, vitamin C- a supplement) which were not ordered for Resident 4. This failure resulted in Resident 4 received normal saline (a saltwater solution) 1 liter (L, a measurement unit) intravenous bolus (IV bolus- the delivery of a concentrated dose of medication or fluid directly into a vein over a short time, typically taking from 1 to 30 minutes) for lower blood pressure of 83/50 mmHg (milliliter mercury- a measurement unit) after the medication error and was transferred to General Acute Care Hospital (GACH) 1 for evaluation on 7/1/2026. This failure also placed Resident 4 at risk for experiencing adverse consequences (causing physical and/or psychological harm from specific action or treatment) from the medications and impairing the resident's well-being. During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was originally admitted to facility on 6/10/2026 and readmitted to the facility on [DATE] with diagnoses including Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination), presence of cardiac pacemaker (small, battery-powered device that prevents the heart from beating too slowly), and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 4's History and Physical (H&P), dated 6/11/2026, the H&P indicated Resident 4 has the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 6/30/2026, the MDS indicated Resident 4 had intact cognitive skills (ability to make daily decisions). The MDS indicated that Resident 4 was dependent (helper does all the effort) on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 4's Change in Condition Evaluation (CICE), dated 7/1/2026, the CICE indicated that wrong medications including vitamin D3 oral tablet, amlodipine oral tablet 5 milligrams (mg- a metric unit of measurement), atenolol oral tablet 25 mg, levetiracetam tablet 500mg, levetiracetam oral tablet 750 mg, zinc oral tablet 50 mg vitamin C oral tablet 500 mg were given to Resident 4 on 7/1/2026. The CICE indicated the resident received normal saline 1L IV bolus for lower blood pressure 83/50 mmHg after the medication error and was transferred to GACH 1 for evaluation on 7/1/2026. During a review of Resident 4's Order Summary Report (OSR) for the month of July 2026, the OSR indicated Resident 4 did not have orders for vitamin D3 oral tablet, amlodipine oral tablet 5 milligrams (mg- a metric unit of measurement), atenolol oral tablet 25 mg, levetiracetam tablet 500mg, levetiracetam oral tablet 750 mg, zinc oral tablet 50 mg vitamin C oral tablet 500 mg. A review of Resident 4's Nursing Progress Note, dated 7/1/2026, the note indicated on 7/1/2021 at 1 pm, basic Life Support (BLS) Ambulance transport arrived and were unable to transfer Resident 4 to GACH 1 due to low BP. The note indicated at 2:04 pm, 911 was called per Physician's order and at approximately 2:10 pm, the paramedics arrived and left the facility at 2:22 pm. Resident 4 was transferring the GACH 1's Emergency Room. During a concurrent interview and record review on 7/10/2026 at 3:10 PM with Registered Nurse (RN) 2, Resident 4's CICE, dated 7/1/2026, was reviewed. RN 2 stated that wrong medications not ordered for Resident 4 were given to Resident 4 on 7/1/2026. During an interview on 7/10/2026 at 3:38 PM with the Director of Nursing (DON), the DON stated that wrong medications were given to Resident 4 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 7/1/2026 due to not verifying the resident accurately. The DON stated it is important to follow the policy to verify the residents accurately to administer the medications and prevent medication administration error. During a review of the facility's policy and procedure (P&P) titled, Administering Medication, revised 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P indicated, The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the residents include: a. checking identification band; b. checking photographs attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. The P&P indicated, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure the medical record for one of three sampled residents (Resident 7) was accurately documented when the nurse documented Resident 7's PET scan (Positron Emission Tomography imaging scans- use a radioactive tracer to check for signs of cancer, heart disease and brain disorders) was done in Resident 7's Progress Notes (PN) on 6/3/2026 instead of not being done in fact. This deficient practice resulted in inaccurate documentation in Resident 7's medical record and had the potential for delaying interventions and services for Resident 7. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 5/8/2026 with diagnoses which included atherosclerotic heart disease (plaque building in the blood vessels that carry oxygen and nutrients from the heart to the rest of the body and the vessels become thick and stiff), presence of cardiac pacemaker (small, battery-powered device that prevents the heart from beating too slowly), and presence of coronary angioplasty implant and graft (can open clogged blood vessels that deliver blood to heart muscles). During a review of Resident 7's History and Physical (H&P), dated 5/11/2026, the H&P indicated Resident 7 has the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 7 had intact cognitive skills (ability to make daily decisions). The MDS indicated Resident 7 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 7 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, upper body dressing and personal hygiene. During a review of Resident 7's Cardiovascular Consultants (CC- a medical doctor who specializes in diagnosing, treating, and managing diseases of the heart and blood vessels), dated 5/21/2026, the CC indicated PET Scan and Echocardiography Ultrasound (ECHO-uses high-frequency sound waves to create moving pictures of heart's structure and pumping function) were ordered on 5/21/2026. During a review of Resident 7's Progress Notes (PN), dated 5/21/2026, the PN indicated that the resident returned from consultation with cardiology with new orders for ECHO and PET scan. During a review of Resident 7's Progress Notes (PN), dated 6/3/2026, the PN indicated that the resident left for outside appointment to have ECHO and PET scan done. The PN indicated that the resident returned back from having ECHO and PET scan done. During an interview on 7/13/2026 at 10:55 AM with Resident 7, Resident 7 stated that Resident 7 had a PET scan order since 5/21/2026, which was not accomplished until currently. Resident 7 stated that the facility had scheduled Resident 7's PET scan on 6/3/2026, 7/6/2026, and 7/14/2026, and both appointments on 6/3/2026 and 7/6/2026 were cancelled. Resident 7 stated that the facility did not assist Resident 7 to accomplish the PET scan in timely manner, which could cause delayed diagnosis and treatment on Resident 7 health condition and made Resident 7 feel upset and frustrated. During an interview on 7/15/2026 at 9:38 AM with Resident 7, Resident 7 stated that the scheduled PET scan on 7/14/2026 was cancelled on 7/13/2025 afternoon. Resident 7 stated that Resident 7 had heart problems and the facility delayed the resident's PET scan several times, which could delay Resident 7's treatment. During a concurrent interview and record review on 7/15/2026 at 3:45 PM with Licensed Vocational Nurse (LVN) 1, Resident 7's current progress notes were reviewed. LVN 1 stated that Resident 7's PET scan ordered since 5/21/2026 had not been completed yet and the scheduled PET (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scan on 6/3/2026, 7/6/2026, and 7/14/2026 were cancelled. LVN 1 stated that LVN 1 documented wrong with the ECHO and PET scan done on 6/3/2026 regardless the fact that the PET scan was cancelled on 6/3/2026. LVN 1 stated that it is important to accurately document the fact to reflect the resident still needs schedule and get the PET scan done as soon as possible. During a concurrent interview and record review on 7/15/2026 at 2:40 PM with the Director of Nursing (DON), Resident 7's current progress notes were reviewed. The DON stated that Resident 7's PET scan was not done on 6/3/2026 and Resident 7's progress notes on 6/3/2026 were inaccurately documented. The DON stated it is important to accurately document to reflect the resident health status and the services provided. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised 3/2019, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's policy and procedure (P&P) titled, Lab and Diagnostic Test Results - Clinical Protocol, revised 11/2018, the P&P indicated, 1. The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. The P&P indicated, Nursing staff will consider the following factors to help identify situations requiring prompt physician notification concerning lab or diagnostic test results: Whether the physician has requested to be notified as soon as a result is received. Whether the result should be conveyed to a physician regardless of other circumstances (that is, the abnormal result is problematic regardless of any other factors). Whether the resident/patient's clinical status is unclear or he/she has signs and symptoms of acute illness or condition change and is not stable or improving, or there are no previous results for comparison.		