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	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Healthcare Center	850 S. Sunkist Ave. West Covina, CA 91790

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 specific and person - centered care plans for two of two sampled residents (Resident 73 and Resident 99). These deficient practices had the potential for Resident 73 and Resident 99 to not receive appropriate care, treatment, and/or services related to their needs.Findings: a. During a review of Resident 73's admission Record (AR), the AR indicated Resident 73 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 73 was readmitted with diagnoses that included Carbapenem-resistant Enterobacterales (a group of bacteria that were resistant to powerful antibiotics called carbapenems, making infections [harmful germs entered and grew in the body] hard to treat) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment and care screening tool), dated 11/14/2025, the MDS indicated Resident 73 had clear speech, had limited ability to make self-understood, and responded adequately to simple and direct communication. The MDS indicated Resident 73 had severe cognitive impairment (confusion or memory loss). The MDS indicated Resident 73 was dependent (helper did all the effort) on staff with oral hygiene, toileting hygiene, personal hygiene, and transferring. The MDS indicated Resident 73 had a feeding tube. During a review on Resident 73's Initial History and Physical (H&P), dated 2/17/2025, the H&P indicated Resident 73 did not have the capacity to understand and make decisions. During a concurrent record review and interview with Licensed Vocational Nurse 3 (LVN 3) on 12/4/2025 at 3:39 PM, Resident 73's care plan titled Risk for infection at gastrostomy-tube (GT) site, initiated on 12/17/2024, was reviewed. LVN 3 stated the care plan goals included having no infection at GT site daily. LVN 3 stated the care plan did not indicate any specific interventions to address infection control. LVN 3 stated the purpose of the care plan was to inform staff about how to provide the appropriate resident care. LVN 3 stated the care plan interventions should be patient-centered and specific because every resident was different. LVN 3 stated staff should provide proper care to residents according to their needs. LVN 3 further stated Resident 73's care plan interventions should include monitoring for signs and symptoms of infection, such as redness, discharge, and pain. LVN 3 stated it was important to have a patient-centered and specific care plan. During an interview with the Director of Nursing (DON) on 12/5/2025 at 8:43 AM, the DON stated the purposes of the care plan were to inform staff about residents' care, identify any issues, set goals, and develop interventions to provide proper care. The DON stated that the care plan should be comprehensive (full, thorough, and all-inclusive), specific, and patient-centered for the residents. The DON stated that a non-specific care plan could lead to unclear interventions and possible delays in necessary care. b. During a review of Resident 99's AR, the AR indicated Resident 99 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis (a narrowing of the spine that could cause pain, numbness, or weakness) and infection on the surgical site. During a review of Resident 99's MDS, dated [DATE], the MDS indicated Resident 99 had clear speech, had the ability to understand and make self-understood. The MDS indicated Resident 99 had intact cognitive skills for (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily decision making (ability to think and reason). The MDS indicated Resident 99 required partial assistance (helper did less than half the effort) with oral hygiene and personal hygiene. The MDS indicated Resident 99 required substantial assistance (helper did more than half the effort) with toilet hygiene, showering, and transferring. During a review of Resident 99's H&P, dated 9/4/2025, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a concurrent record review and interview with Treatment Nurse 1 (TN 1) on 12/4/2025 at 1:40 PM, Resident 99's care plan for surgical site infection, initiated on 9/4/2025, the care plan goals included resolving the surgical site infection. TN 1 stated the care plan intervention indicated the charge nurse should document for sign and symptoms of surgical site infection for four days. TN 1 stated it was important to implement the care plan intervention. TN 1 stated that without documentation, there was no proof of action. TN 1 stated the care plan's purpose was to ensure proper patient care through interventions. During a concurrent record review and interview with TN 1 on 12/4/2025 at 1:40 PM, Resident 99's Medication Administration Record (MAR), dated 9/4/2025 - 9/8/2025, was reviewed. The MAR indicated no documentation on monitoring signs and symptoms of surgical site. TN 1 stated the licensed nurse should have documented on the MAR. During a concurrent record review and interview with TN 1 on 12/4/2025 at 1:40 PM, Resident 99's Treatments Administration Record (TAR), dated 9/4/2025 - 9/8/2025, was reviewed. The TAR indicated no documentation on monitoring signs and symptoms of surgical site. TN 1 stated the licensed nurse should have documented on the TAR. During a concurrent record review and interview with TN 1 on 12/4/2025 at 1:40 PM, Resident 99's Nursing Progress Notes (NPN), dated from 9/4/2025 - 9/8/2025, were reviewed. The NPN indicated no documentation on monitoring signs and symptoms of surgical site. TN 1 stated the licensed nurse should have documented on the NPN. TN 1 stated it delayed the necessary care and increased the risk of infection without the documentation. During an interview with the Minimum Data Set Coordinator (MDS C) on 12/4/2025 at 2:30 PM, the MDS C stated that the care plan's purpose was to help nurses determine the type of care needed for the residents. The MDS C stated it was important to implement the care plan intervention to manage the risk of infection. The MDS C stated all nursing staff providing care to the residents should have reviewed and followed the care plan. During an interview with Infection Preventionist Nurse 1 (IPN 1) on 12/4/2025 at 2:50 PM, IPN 1 stated the licensed nurse should document in the nursing progress note, daily assessment, and treatment notes every shift. IPN 1 stated the licensed nurse should document monitoring for any surgical site redness, swelling, tenderness, and pain. IPN 1 stated that documentation ensured infections didn't worsen. IPN 1 further stated the documentation facilitated communication among staff providing resident care and helped doctors determine necessary care, keeping everyone informed about the resident's condition. IPN 1 stated it was important to document for four days outlined in the care plan to avoid risks and ensure quality care. IPN 1 stated monitoring and documenting for infection signs and symptoms were parts of the nursing care. During a review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the facility should develop and implement a comprehensive, person-centered care plan for each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food storage and handling practices by failing to label and discard expired food items stored in the facility's kitchen and residents' refrigerator. The facility failed to ensure:1.The kitchen staff removed expired food items from the kitchen refrigerator: a total of five [5] individually packaged peanut butter and jelly (PBJ) half sandwiches inside a white plastic container and a pack of flour tortillas.2. The facility staff removed the following expired food items from the residents' refrigerator:- A Jumbo oven roasted chicken,- A container with yellow liquid inside,- A container covered with foil paper,- A brown paper bag with multiple food items inside,- A plastic bag with three (3) ice cream bars,- A fast-food meal container with leftover food,- A bag of corn tortillas,- A bag of grated Parmesan cheese. 3. To label resident's personal food items inside the residents' refrigerator with the resident's name or room number including the date received and the expiration date. This deficient practice has the potential to result in pathogen (germ) exposure to residents and places them at risk for developing foodborne illness (food poisoning), with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever, which can lead to hospitalization.Findings:During initial observation and interview inside the kitchen's refrigerator in the presence of the Dietary Supervisor (DS) on 12/2/2025 at 8:20 AM, observed five (5) individually packaged peanut butter and jelly (PBJ) half sandwiches inside a white plastic container with label indicating use by date of 12/1/2025. DS stated the sandwiches are made by the Cook. The DS stated that if there are any expired food items, the staff should have checked and thrown them away. DS stated, We are not supposed to mix expired foods with non-expired foods. It can be given to the residents by accident and cause them stomach problems and make them sick. During concurrent observation and interview inside the facility's kitchen's refrigerator in the presence of DS on 12/2/2025 at 8:29 AM, observed a pack of flour tortillas with a Date of 11/8/2025 and a use by date of 11/20/2025. DS stated there was no way to know when the pack of tortillas was opened since the Date section did not specify if it was an open date and confirmed if they were dated with a use by date of 11/20/2025, then the tortillas were expired. DS further stated, We can't give these food items to the patients. If it is expired, it can make them sick or cause them vomiting and diarrhea. It is considered a foodborne illness. During an interview with DS in the residents' Activity Room on 12/2/2025 at 8:41 AM, the DS stated that the residents' refrigerator has food items that are used for residents' cooking activities or snacks. DS stated the residents' refrigerator contained food that was brought in for residents by their friends and family. Per DS, all the food received for residents is placed inside the refrigerator by the nurses or certified nursing assistants (CNAs). DS stated the residents' food inside the refrigerator must have a label indicating the residents name, room number, and must be dated with the day it was received or opened and must include a use by or expiration date. During an observation of the residents' refrigerator in the Activity Room in the presence of the DS and Activity Staff (AS1) on 12/2/2025 at 8:44 AM, the following was observed:-A jumbo oven roasted chicken with a date of 11/27/2025, but it did not specify whether that was the open date or the expiration date.- A plastic tumbler container with yellow liquid inside with no date or name of the liquid.- A plastic container was covered with foil and labeled Activity with the date of 11/27/2025, but it did not specify whether the food item inside was opened or expired on that date.- A large brown paper bag containing a variety of food items with the date of 11/30/25.- A plastic bag containing three (3) ice creams with no use by or expiration date.- A plastic bag dated 11/4/2025 with a fast-food Styrofoam container inside.- A bag of corn tortillas indicating Activities and dated 11/16/2025, but it did not specify whether the bag was opened on that day or if it expired on that day.- A bag of grated Parmesan cheese, labeled for Activities and dated 11/16/2025, but it did not specify whether the bag was opened on that day or if it expired on that day. During an interview with AS1 on 12/2/2025 at 8:50 AM, AS1 stated the food items in the residents' refrigerator need to be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checked for an expiration date. Per AS1, if the food items only have one date, the staff will not know if the items are expired. AS1 stated that some of the food items inside the residents' refrigerator (the corn tortillas and the shredded cheese) were used for the residents' cooking class. AS1 further stated that, according to the facility's policy, in order to keep residents' food items inside the refrigerator, the items need to have a date and can not be expired. Per AS1, if the food item is expired, it should be discarded because it could make residents sick, even if stored in the refrigerator. During a concurrent interview with AS1 on 12/2/2025 at 8:56 AM, AS1 stated the DS should check the residents' refrigerator daily to make sure the residents food inside the refrigerator was not expired. Per AS1, in order to prevent having expired food inside the residents' refrigerator, the labels placed on the food items need to have the open date and the expiration date or use by date. During an interview with the Infection Prevention Nurse (IPN) on 12/2/2025 at 9:07 AM, IPN stated that once a food item is placed inside the residents' refrigerator, it is considered to be expired after 72 hours and must be discarded. Per IPN, if any of the residents eat expired food, they can have rotavirus (a highly contagious virus causing severe watery diarrhea and vomiting) which can cause the patients to experience nausea, vomiting, and diarrhea and can make them sick. Per IPN, if the food items do not have a specific date such as a use by or expiration date, it is considered to be expired and cannot be given to the residents because they need to be prevented from getting sick. A review of the facility's Policies and Procedures (P&Ps), titled Food Receiving and Storage, revised 11/2022, the P&P indicated, Foods shall be received and stored in a manner that complies with safe food handling practices. The P&P indicated:All foods stored in the refrigerator or freezer are covered, labeled, and dated (use by date). Refrigerated foods are labeled, dated, and monitored so they are used by their use by date, frozen, or discarded. All foods belonging to residents are labeled with the resident's name, the item and the use by date. Beverages are dated when opened and discarded after twenty-four (24) hours. A review of the facility's P&P, titled Foods Brought by Family/Visitors, revised 3/2022, the P&P indicated, Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety of residents. The P&P indicated, Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. The nursing staff will discard perishable foods on or before the use by date.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection (harmful germs entered and grew in the body) control measures for two of two sampled residents (Residents 73 and Resident 103) by failing to: a. Rinse off the syringe used for administering gastrostomy-tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly into the stomach. It is commonly used for people with swallowing problems) medication for Resident 73. b. Follow Enhanced Barrier Precautions (EBP, a resident-centered and activity-based approach for preventing multidrug resistant organism [MDRO, microorganisms that are resistant to multiple antibiotics, making them difficult to treat and control]) during Resident 103's linen change when the facility staff did not wear the required Personal Protective Equipment (PPE, an equipment worn to minimize exposure to illnesses). These failures had the potential to result in cross contamination (the process by which bacteria were transferred from one surface or object to another). These deficient practices placed Resident 73 and Resident 103 at risk for infection which could increase the morbidity (the amount of disease in a population) and mortality (the state of being subject to death).Findings: a. During a review of Resident 73's admission Record (AR), the AR indicated Resident 73 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The AR indicated Resident 73's diagnoses included Carbapenem-resistant Enterobacterales (CRE, a group of bacteria that were resistant to powerful antibiotics [a substance used to kill bacteria and to treat infections] called carbapenems, making infections hard to treat), respiratory failure (a medical condition in which the lungs cannot get enough oxygen [a gas essential for humans] into the blood or remove enough carbon dioxide [a waste product] from the blood), and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach, commonly used for people with swallowing problems) status. During a review of Resident 73's Minimum Data Set (MDS, a resident assessment tool), dated 11/14/2025, the MDS indicated Resident 73 had clear speech, had limited ability to make self-understood, and responded adequately to simple and direct communication. The MDS indicated Resident 73 had severe cognitive impairment (confusion or memory loss). The MDS indicated Resident 73 was dependent (helper did all the effort) on staff with oral hygiene, toilet hygiene, personal hygiene, and transferring. The MDS indicated Resident 73 had a feeding tube. During a review on Resident 73's Initial History and Physical (H&P), dated 2/17/2025, the H&P indicated Resident 73 did not have the capacity to understand and make decisions. During a review on Resident 73's Care Plan Report for Risk for infection at gastrostomy-tube (G-tube) site, initiated on 12/17/2024, the care plan goals included having no infection (harmful germs entered and grew in the body) at G-tube site daily. The care plan indicated staff to maintain G-tube. During a concurrent medication administration observation and interview with Licensed Vocational Nurse 1 (LVN 1) on 12/4/2025 at 8:52 AM, in Resident 73's room, LVN 1 did not rinse off the syringe after the G-tube medication administration and placed it back into the pole bag (a transparent medical container designed to safely store a G-tube syringe between uses). LVN 1 stated she did not need to do anything to the syringe after flushing water to Resident 73's G-tube following the medication administration. LVN 1 stated she could just put the syringe back in the pole bag. During an interview with Infection Preventionist Nurse 1 (IPN 1) on 12/4/2025 at 10:55 AM, IPN 1 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the licensed nurse who used the G-tube syringe should rinse it off with running water before returning it back to the pole bag because of the infection control protocol. IPN 1 stated that medication buildup in the G-tube could cause bacteria to sit and grow, leading to infection. IPN 1 stated the G-ube was reusable and changed every 24 hours. IPN 1 stated the licensed nurse must follow the infection control protocols, as improper handling could lead to stomach infection with signs and symptoms of nausea, vomiting, fever, or diarrhea among residents. IPN 1 stated it negatively affected the quality of care. During an interview with Director of Nursing (DON) on 12/5/2025 at 8:50 AM, the DON stated that it was the standard of nursing care to rinse off the G-tube syringe with water after each use. The DON stated the purpose of it was to make sure there was no medication or any kind of liquid residue in the G-tube syringe. The DON stated the medication residue in the G-tube syringe might mix with other medications and cause interaction (one medicine changed the way another medicine worked and caused unexpected side effects). The DON stated medication residue might have caused sediment that clogged the G-tube, leading to malfunction. During a review of the facility's Policy and Procedure (P&P), titled Maintaining Patency of a Feeding Tube (Flushing), revised 11/2018, the P&P indicated to clean reusable equipment according to the manufacturer's instructions. During a review of the manufacturer's instruction for the G-tube syringe used by the facility ([Brand Name] Enteral Feeding Syringe), undated, the manufacturer's instruction indicated staff should rinse syringe thoroughly with tap water greater or equal to 37 degrees Celsius (temperature scale) immediately after each use until the original content had been cleared. The manufacturer's instruction indicated that the staff should submerge the tip of syringe in water, draw up water into the barrel (clear tube portion of the syringe used to hold liquid nutrition, water, and medication), then push water through nozzle lumen using the plunger (part of the syringe used to push liquid nutrition or water into a feeding tube). The manufacturer's instruction further indicated staff should rinse the syringe including the inside surface of the barrel, the stopper, the nozzle lumen, and the outside. The manufacturer's instruction indicated that staff should thoroughly dry the syringe with non-shedding cloth prior to placing it into the pole bag. b) During a review of Resident 103's admission Record (AD), the AD indicated Resident 103 was originally admitted to the facility on [DATE] with diagnoses that included but not limited to encounter for attention to gastrostomy, candidal stomatitis (a fungal infection in the mouth), and urinary tract infection (UTI, infection in the urine). During a review of Resident 103's History and Physical Examination (H&P), dated 11/28/2025, the H&P indicated Resident 103 does not have the capacity to understand and make decisions. During a review of Resident 103's MDS, dated [DATE], the MDS indicated Resident 103 had severe cognitive impairment (never/rarely made decisions) and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene. During a review of Resident 103's Order summary Report (OSR) for active orders as of 12/3/2025, the OSR indicated, Enhanced Barrier Precautions due to: G-tube and pressure ulcers (skin and tissue damage from prolonged pressure) with an order date of 11/26/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 103's Care Plan Report (CP), initiated on 11/27/2025, the CP indicated, Resident requires Enhanced Barrier Precautions (EBP) related to gastrostomy tube (G-tube) and coccyx (tailbone) PU2 (pressure injury stage 2, partial thickness skin loss, like a scrape). The CP's Interventions section indicated, Provide gowns and gloves at door entry, use gowns and gloves during high contact resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, changing lines, device care, wound care). During an observation of the facility on 12/02/2025 at 9:52 AM, EBP sign was posted outside Resident 103's room. It was observed that CNA2 was making the bed for Resident 103 while not wearing gown. During an interview with Certified Nursing Assistant (CNA2) inside Resident 103's room on 12/02/2025 at 9:54 AM, CNA2 stated Resident 103 is on EBP because Resident 103 has wounds. CNA2 stated Resident 103 had just been repositioned by CNA2 about 10 minutes ago. CNA2 stated that if there is a sign posted for EBP outside Resident 103's room, CNA2 should wear gown, gloves, and mask if coming into contact with Resident 103, Resident 103's linen, or belongings. CNA2 stated that wearing a gown is for precautions and to prevent infections or germs that can spread to staff and other residents. CNA2 stated, If I come into contact with residents that are on EBP, then I need to wear a gown for safety. If I don't wear a gown, I can spread germs to other residents. During an interview with Licensed Vocational Nurse (LVN2) on 12/02/2025 at 10:10 AM, LVN2 stated that for EBP, staff must wear gowns, and gloves if providing close contact care to residents. Per LVN2, some patients are on EBP due to having wounds or G-tubes. LVN2 stated that if staff don't wear gowns while providing care to patients on EBP, they can get infections, and can also expose other residents to germs and bacteria. LVN2 further stated, We can spread germs to other patients too, it is an infection control. We have been told we need to wear gowns, it also says so on the EBP sign posted outside the patients rooms. During an interview with Housekeeping Staff (HKP1) on 12/02/2025 at 10:20 AM, HKP1 stated that if a patient is on EBP, that means they have an infection. Per HKP1, if staff walk into a room where a resident is on EBP, the staff need to wear the reusable gowns and place them inside the dirty linen bin before they leave the room. HKP1 stated, We hardly ever get in services on infection control, they should provide us with more education to prevent any infection to myself and the patients. The patients are fragile. During an interview with Registered Nurse Supervisor (RN1) on 12/03/2025 at 3:26 PM, RN1 stated for EBP all the staff must wear gown, gloves, and mask if coming into contact with a patient who is on EBP to prevent cross contamination or spread of germs to other residents and staff. During an interview with Infection Prevention Nurse (IPN1) on 12/04/2025 at 10:18 AM, IPN1 stated EBP is just a precaution method for staff when coming into close contact with a resident. Per IPN1, there's no infection going on. IPN1 further stated, This is what I teach the staff during in-services. If staff is caring for a resident that is on EBP, the staff needs to be using the gown and gloves to provide morning care or dressing the patient because they are coming into contact with the patient. If any of the staff go in the resident's room who is on EBP and they are touching anything in the area or proximity to the resident, they must be wearing a gown and gloves. Once they are done providing care, then they can remove the gown and place it inside the bin. During a review of the facility's P&Ps, titled, Enhanced Barrier Precautions, revised 7/2022, the P&P (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. The P&P indicated the examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: e. Changing Linens. The P&P indicated EBPs are indicated (when contact precaution do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain written informed consent for one of five sampled residents (Resident 4) for the use of psychotropic (any medication capable of affecting the mind, emotions, and behavior) medication. This deficient practice had the potential for Resident 4 not to receive adequate or sufficient information regarding psychotropic medications necessary to make an informed health care decision.Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow), depression (a feeling of severe sadness or hopelessness) and anxiety (emotion characterized by an unpleasant state of inner turmoil). During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/21/2025, the MDS indicated Resident 4 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort) to staff for toileting, showering, lower body dressing and putting on/off footwear. The MDS indicated Resident 4 needed maximum assistance (helper does more than half the effort) from staff for upper body dressing and personal hygiene. During a review of Resident 4's Physician's Order (PO) dated 12/1/2025, the PO indicated for licensed staff to administer Lexapro (antidepressant - a medication that change the way the brain uses certain chemicals to regulate mood and behavior) one tablet 10 milligrams (mg-unit of measurement) by mouth one time a day for depression manifested by verbalization of sadness. During an interview on 12/3/2025 at 10:23 am with Resident 4, Resident 4 stated nursing staff have not discussed with him taking Lexapro nor asking the resident for a consent to take Lexapro. During a concurrent interview on 12/3/2025 at 10:25 am with the facility's Assistant Director of Nursing (ADON) and review of Resident 4's medical record (PointClickCare - PCC, a cloud-based software), the ADON stated, Resident 4's Informed Consent Psychoactive Medication form for Lexapro was not signed by Resident 4 and Resident 4's physician. The ADON stated licensed nurses should have verified the medication upon admission with the ordering physician and ensure a consent was obtained from the resident. The ADON stated the risks and benefits of psychotropic medications should be discussed to Resident 4 upon admission to ensure Resident 4 was aware of the adverse effects (harmful effects) of the medication. During a review of the facility's Policy and Procedure (P&P) titled, Psychotherapeutic Medication Use, dated 6/2021, the P&P indicated, It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication. The Facility shall verify informed consent prior to the administration of a psychotropic medication for a resident.

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	055992	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Healthcare Center	850 S. Sunkist Ave. West Covina, CA 91790

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Advance Directive (AD, a written instruction, recognized under State law relating to the provision of health care when the individual is incapacitated [lacking the ability to meet essential requirements for physical health, safety, or self-care]) for one of two sampled residents (Resident 46) was readily accessible in accordance with the facility's Policy and Procedure (P&P) titled Advance Directives. This failure had the potential for facility staff to provide medical treatment and services against the resident's will. Findings: During a review of Resident 46's admission Record (AR) the AR indicated Resident 46 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD- type of obstructive lung disease characterized by long-term poor airflow) and difficulty in walking. During a review of Resident 46's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/26/2025, the MDS indicated Resident 46 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 46 was dependent (helper does all of the effort) from staff for shower, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 46 needed maximum assistance (helper did more than half the effort) to staff for oral hygiene, toileting hygiene, upper body dressing and personal hygiene. During an interview and concurrent record review on 12/2/2025 at 11:08 am, with Registered Nurse 1 (RN 1) of Resident 46's medical records (chart and PointClickCare [PCC, a cloud-based software]), RN 1 stated there was no AD in Resident 46's chart and PCC. RN 1 stated, RN1 could not find the existing AD of Resident 46 in the chart nor PCC. RN 1 stated, Resident 46's AD needed to be accessible in the chart for staff to identify the resident's medical wants and wishes in case of an emergency. During an interview and record review on 12/2/2025 at 11:17 am, with the Social Service Designee (SSD), the SSD stated the facility requested a copy of Resident 46's AD but the SSD was unable to find the copy in Resident 46's chart. The SSD stated, Resident 46's AD should be accessible to determine the resident's wishes in case of an emergency and in situations when the resident would not have the capacity to make decision. During an interview on 12/3/2025 at 9:19 am, with the facility's Assistant Director of Nursing (ADON), the ADON stated, the resident's AD should be uploaded in PCC and readily accessible by the staff. The ADON stated Social Service was responsible for getting a copy of the resident's AD and medical records designee will upload the AD in PCC. During a review of the facility's P&P titled, Advance Directives, dated 9/2022, the P&P indicated prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The P&P indicated the resident, or representative is provided with written information P&P indicated, if the resident or resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any facility staff.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 4's target behavior was monitored for the use Lexapro (antidepressant - antidepressant - a medication that change the way the brain uses certain chemicals to regulate mood and behavior) for one of five sampled residents (Resident 4) as indicated in the facility's Policy and Procedure (P&P) titled Psychotropic Medication Use. This deficient practice had the potential to result in the use of unnecessary psychotropic drug, which may result in significant adverse (harmful) consequences to Resident 4. Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD- type of obstructive lung disease characterized by long-term poor airflow), depression (a feeling of severe sadness or hopelessness) and anxiety (emotion characterized by an unpleasant state of inner turmoil). During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/21/2025, the MDS indicated Resident 4 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort) to staff for toileting, showering, lower body dressing and putting on/off footwear. The MDS indicated Resident 4 needed maximum assistance (helper does more than half the effort) from staff for upper body dressing and personal hygiene. During a review of Resident 4's Physician's Order (PO) dated 12/1/2025, the PO indicated for licensed staff to administer Lexapro one tablet 10 milligrams (mg-unit of measurement) by mouth one time a day for depression manifested by verbalization of sadness. During a concurrent interview and record review on 12/3/2025 at 9:40 am with the facility's Assistant Director of Nursing (ADON) of Resident 4's medical records (PointClickCare - PCC, a cloud-based software), Resident 4's Order Summary Report (OSR) for active orders as of 12/3/2025 did not indicate the specific target behavior for the use of Lexapro. The facility's ADON stated it was important for the licensed nurse to monitor the target behavior of the residents every shift to determine if the medication was effective or not. During a review of the facility's P&P titled, Psychotherapeutic Medication use, dated 6/2021, the P&P indicated, Facility staff should monitor residents' behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for BPSD. Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) was accurately coded for surgical wound for one of one sampled resident (Resident 99). This failure had the potential to place Resident 99 at risk of not receiving necessary care services. Findings: During a review of Resident 99's admission Record (AR), the AR indicated Resident 99 was admitted to the facility on [DATE], with diagnoses that included spinal stenosis (a narrowing of the spine that could cause pain, numbness, or weakness) and infection (harmful germs entered and grew in the body) on the surgical site. During a review of Resident 99's Minimum Data Set (MDS, a resident assessment tool), dated 9/8/2025, the MDS indicated Resident 99 had clear speech, had the ability to understand and make self-understood. The MDS indicated Resident 99 had intact cognitive skills for daily decision making (ability to think and reason). The MDS indicated Resident 99 required partial assistance (helper did less than half the effort) with oral hygiene and personal hygiene. The MDS indicated Resident 99 required substantial assistance (helper did more than half the effort) with toileting hygiene, showering, and transferring. The MDS indicated Resident 99 had no surgical wounds. During a review of Resident 99's History and Physical (H&P), dated 9/4/2025, the H&P indicated Resident 99 had the capacity to understand and make decisions. During a concurrent record review and interview with TN 1 on 12/4/2025 at 1:40 PM, Resident 99's Treatments Administration Record (TAR), dated 9/4-9/8/2025, was reviewed. TN 1 stated the TAR indicated Resident 99 had a surgical wound on mid back from 9/4-9/8/2025. TN 1 stated it was not acceptable to have an inaccurate MDS assessment because it might delay necessary care. During a concurrent record review and interview with the Minimum Data Set Coordinator (MDS C) on 12/4/2025 at 2:30 PM, Resident 99's MDS, dated [DATE], was reviewed. The MDS indicated Resident 99 had no surgical wounds. The MDS C stated that the MDS was signed and verified to have all information correct and accurate. The MDS C stated the MDS was not an accurate assessment because it should have coded Yes for surgical wound. The MDS C stated that it was important to have an accurate MDS assessment to service as a baseline for providing residents' care accordingly. The MDS C further stated it put residents at risk of not receiving proper care and risk for infection. During a review of the facility's Policy and Procedure (P&P) titled Resident Assessment, revised 10/2023, the P&P indicated All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. The P&P further indicated Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sample resident (Resident 4) had a physician's order for the use of oxygen (a medical treatment used to help a person to breathe more easily) at two and a half liters per minute through nasal cannula (a medical device used for oxygen therapy). This failure had the potential to place Resident 4 at risk for complications associated with oxygen therapy. Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD - a type of obstructive lung disease characterized by long-term poor airflow), depression (a feeling of severe sadness or hopelessness), anxiety (emotion characterized by an unpleasant state of inner turmoil), and gastro esophageal reflux disease (GERD, a chronic digestive disorder where stomach acid or contents leak back into the esophagus, causing symptoms like heartburn and regurgitation) without esophagitis irritation or inflammation of the esophagus (tube that carries food from throat to the stomach. During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 1/21/2025, the MDS indicated Resident 4 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort) on staff for toileting, shower, lower body dressing, and putting on/off footwear. The MDS indicated Resident 4 needed maximum assistance (helper does more than half the effort) from staff for upper body dressing and personal hygiene. During a concurrent observation and interview on 12/2/2025 at 9:36 am, observed with Infection Prevention Nurse (IPN), Resident 4 was lying in bed receiving oxygen at 2.5 liters per minute (LPM) via nasal cannula. The IPN 1 stated Resident 4 was receiving continuous oxygen at 2.5 LPM via nasal cannula. During a concurrent interview and record review on 12/3/2025 at 9:33 am with the facility's Assistant Director of Nursing (ADON), Resident 4's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities for resident charting and care management) were reviewed. The ADON stated that there was no physician's (doctors) order for Resident 4's oxygen therapy. The ADON stated there should be a doctors order for oxygen administration for Resident 4 to receive proper oxygen therapy. During a review of the facility's policy and procedure (P&P), titled Oxygen Administration, revised 2/2024, the P&P indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. The P&P indicated: Verify that there is a physician's order for this procedure.Review the physician's orders or facility protocol for oxygen administration.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its protocol for antibiotic (a substance used to kill bacteria and to treat infections) use for one of one sampled resident (Resident 36), who had received and was receiving antibiotics from 12/2/2025. This deficient practice had the potential for Resident 36 to develop antibiotic resistance and to receive antibiotics without justification. Findings: During a review of Resident 36's admission Record (AR), the AR indicated Resident 36 was initially admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a type of obstructive lung disease characterized by long-term poor airflow) and depressive disorder (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities). During a review of Resident 36's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 11/4/2025, the MDS indicated Resident 36 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 36 needed moderate assistance (helper does less than half the effort) from staff for toileting, shower, lower body dressing, and putting on/off footwear. During a review of Resident 36's Order Summary Report (OSR) for the active orders as of 12/4/2025, the OSR indicated to administer Azithromycin Oral Tablet (antibiotic, a substance used to kill bacteria and to treat infections) 250 milligram (mg, a unit of measurement), one tablet by mouth one (1) time a day for cough with phlegm for four days with an order date of 12/2/2025. During a concurrent interview and record review on 12/3/2025 at 10:43 AM with the facility's Assistant Director of Nursing (ADON), Resident 36's medical records (PointClickCare - PCC, a cloud-based software used in long-term and post-acute care facilities for resident charting and care management) were reviewed. ADON stated the antibiotic screening evaluation was not completed for Resident 36, who was on Azithromycin. ADON further stated that antibiotic stewardship (a coordinated program to ensure antibiotics are used correctly and appropriately to keep residents safe and prevent bacteria from becoming resistant) should have been completed prior to administering antibiotics to the resident to determine if they met the criteria for the use of antibiotics. During an interview on 12/3/2025 at 10:59 AM with the facility's Infection Preventionist Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IPN stated Resident 36 did not meet the criteria to receive antibiotics and IPN should have notified the physician whether to continue administering antibiotics or not. The IPN stated antibiotic screening should have been done before initiating antibiotic therapy to ensure antibiotic use was appropriate and to avoid Multidrug Resistant Organisms (MDRO's refer to microorganisms, predominantly bacteria that are resistant to one or more classes of antimicrobial agents). During an interview on 12/3/2025 at 3:17 AM with Registered Nurse 1 (RN 1), RN 1 stated, I thought the Charge Nurse will complete the infection screening form. RN 1 stated that Resident 36 did not meet the criteria to receive antibiotic therapy and the physician should have been notified prior to administering antibiotics. RN 1 stated that the purpose of antibiotic screening was to identify if antibiotic therapy was appropriate and to avoid residents from becoming resistant to antibiotics. During a review of the facility's Policy and Procedure (P&P), titled Antibiotic Stewardship, dated 12/2016, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. When a nurse calls a physician/prescriber to communicate a suspected infection, he or she will have the following information available:a. Signs and symptoms;b. When symptoms were first observed;c. Resident's hydration status;d. Current medication list;e. Allergy information;f. Infection type;g. Any orders for warfarin and results of last INR;h. Last creatinine clearance or serum creatinine, if available; [NAME]. Time of the last antibiotic dose.

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F 0756 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a medication regimen review (MRR) irregularity identified by the facility's Pharmacy Consultant was acted upon for one of five sample resident (Resident 4). This deficient practice had the potential for harm due to the missed opportunity by the physician and the licensed staff to act upon the reported irregularities. Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, a type of obstructive lung disease characterized by long-term poor airflow), depression (a feeling of severe sadness or hopelessness), anxiety (emotion characterized by an unpleasant state of inner turmoil), and gastro esophageal reflux disease (GERD, a chronic digestive disorder where stomach acid or contents leak back into the esophagus, causing symptoms like heartburn and regurgitation) without esophagitis irritation or inflammation of the esophagus (tube that carries food from throat to the stomach. During a review of Resident 4's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 1/21/2025, the MDS indicated Resident 4 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper does all of the effort) on staff for toileting, showering, lower body dressing, and putting on/off footwear. The MDS indicated Resident 4 needed maximum assistance (helper does more than half the effort) from staff for upper body dressing and personal hygiene. During a review of Resident 4's Order Summary Report (OSR), for the active orders as of 12/3/2025, the OSR indicated an order to administer Linzess (a prescription medication that helps to treat chronic constipation and irritable bowel syndrome with constipation [IBS-C] by increasing the amount of fluid in the intestines) 145 microgram (mcg, a unit of measurement), one capsule by mouth one (1) time a day for bowel management. During a review of Medication Administration Record (MAR), dated 12/2025, the MAR indicated Resident 4 received Linzess oral capsule 145 mcg by mouth one (1) time a day for bowel management at 9 am on 12/1/2025, 12/2/2025, and 12/3/2025. During a review of the facility document titled, Consultant Pharmacist's Medication Regimen Review, dated 10/28/2025, completed by the facility's pharmacist consultant, the document indicated, The resident (Resident 4) has order for Linzess one (1) capsule once daily at 9 am. Manufacturer recommends administering the medication at least 30 minutes before the first meal of the day on empty stomach. During an interview on 12/3/2025 at 3:06 pm, with the facility's Assistant Director of Nursing (DON), the ADON stated the MRR was a monthly recommendation that licensed nurses supposed to carry out once received from the pharmacy. The ADON stated there was no other clinical documentation that the monthly recommendation for Resident 4 from the pharmacist, dated 10/28/2025, was carried out. The ADON stated the purpose of MRR was for the pharmacy to review if residents were receiving proper medications and to avoid unnecessary drug use. The ADON stated, I remembered it (referring to the recommendation), I thought I carried out the recommendation. During a review of the facility's Policy and Procedure (P&P), titled Consultant Pharmacist Reports, dated 6/2021, the P&P indicated, The consultant pharmacist reviews the medication regimen (MRR) of each resident at least monthly either on site or remotely. Recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing by the next physician visit. The director of nursing or designated licensed nurse addresses and documents recommendations that do not require a physician intervention, e.g., monitor blood pressure.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., a unit of measurement) per resident area for fourteen (13) out of thirty-eight (38) resident rooms (Rooms 14, 15, 16, 17, 18, 19, 27, 28, 29, 36, 37, 38, and 39). This deficient practice had the potential to impact on the ability to provide safe nursing care and maintain the privacy of the residents.Findings: During an interview with the facility Administrator (ADM) on 12/2/2025 at 10:25 AM, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) this year for Rooms 14, 15, 16, 17, 18, 19, 27, 28, 29, 36, 37, 38, and 39. The ADM stated nothing was changed and the number of bed occupancy in the 13 rooms. During a review of the facility's letter to request for room waiver, dated 12/2/2025, the room waiver request letter indicated there was ample room to accommodate wheelchairs and other medical equipment, as well as space for mobility and movement of ambulatory residents. The letter indicated there was adequate space for nursing care, and the health and safety of residents occupying these rooms are not in jeopardy. The letter further indicated that these rooms were in accordance with the special needs of the residents, and do not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. During a review of the Client Accommodations Analysis form, dated 12/3/2025, the analysis indicated the following: Room Sq. Ft. Beds 14 234.03 315 234.03 316 232.23 3 17 234.40 318 233.19 319 234.89 3 27 233.65 3 28 232.73 329 225.50 336 232.26 337 233.07 3 38 233.93 3 39 233.60 3 During the Health Recertification Survey, from 12/2/2025 to 12/5/2025, Rooms 14, 15, 16, 17, 18, 19, 27, 28, 29, 36, 37, 38, and 39 had adequate space, nursing care, comfort, and privacy was provided to the residents. The residents were observed to have enough space to move freely inside the rooms. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability), walkers (is a device that gives additional support to maintain balance or stability while walking,) and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). Each resident inside the affected rooms had beds and bedside tables with drawers. The room size did not affect the care and services provided by the staff to the residents when staff were observed providing care to the residents. During an observation and interview on 12/2/2025 at 9:23 AM with Resident 44, who was sitting in bed inside Resident 44's room. Resident 44's walker was observed next to the bed. Resident 44 stated, I don't have problem with my room space. I have enough space. I was able to walk to the restroom with my walker, and I don't have problem with it (space). During an observation and interview on 12/2/2025 at 9:41 AM with Resident 11, Resident 11 was observed lying in bed. Resident 11 stated, I have a special bed, and I do not have an issue with the room space. I am ok with the space here. During an observation and interview on 12/2/2025 at 10:06 AM with Resident 45, Resident 45 was observed sitting in her wheelchair inside Resident 45's room and was able to wheel herself from the bathroom to the bed with ease and with space. During an interview on 12/3/2025 at 11:13 AM with Certified Nurse Assistant 1 (CNA 1), the CNA 1 stated that there was enough space in the rooms to provide care to the residents. CNA 1 stated she was able to move wheelchairs and Hoyer lift inside the rooms with no issues. During an interview on 12/3/2025 at 2:14 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there was enough space to provide care and treatment to the residents without issues, and that they were able to move wheelchairs, Hoyer Lifts, and walkers inside the rooms.