

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER West Haven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1495 West Cameron 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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905</p> <p>Based on observation, interview, and record review, the facility failed to follow the facility's policy and procedures (P&P) on controlled medication storage for one of two sampled Medication Storage (MS) Rooms (MS room [ROOM NUMBER]) when:</p> <ol style="list-style-type: none"> Two licensed nurses were not present when checking the Controlled Substance Two (II) Emergency Kit (CS II E-kit, emergency medications that require authorization if a medication is not in stock in the facility's pharmacy or medication cart. Substance II medications have a high potential for abuse, potentially leading to severe physical dependence) in MS room [ROOM NUMBER] when five tablets' of ,d+[DATE] milligrams (mg, unit of measurement) of Percocet (prescribed controlled medication used to treat moderate to severe pain) and two tablets of ,d+[DATE] mg of Percocet were reported missing from the CS II E-kit on [DATE]. A discrepancy on Cart 1 Controlled Drug Reconciliation (CDR, process of comparing number of controlled medications on paper to the physical number of controlled medications that is available or left to ensure accurate inventory) form was not reported to the Director of Nursing (DON) on [DATE]. <p>These failures had the potential to result in drug diversion (illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) of residents' (in general) controlled medications.</p> <p>Findings:</p> <p>During a review of the facility's Manifest: CRVN [facility's name] CAR 01 (Manifest, document that is required by carriers when drivers arrive or pick up packages), dated [DATE] timed at 12:15 AM, the Manifest indicated CS II E-kit was replaced, delivered, and received by LVN 5 on [DATE] at 12:12 AM.</p> <p>During a review of the facility's Nursing Sign in Sheet (NSIS), dated [DATE], the NSIS indicated Registry LVN 6 worked at the facility from 11:00 PM to 7:30 AM. The NSIS indicated on [DATE]: LVN 2 worked at the facility from 7 AM to 7 PM, LVN 4 worked from 3 PM to 7:30 AM, and LVN 5 worked from 11 PM to 7:30 AM.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER West Haven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1495 West Cameron 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 9:44 AM with the Administrator (Admin), the Admin stated the Admin was made aware by the Registered Nurse Supervisor (RN Sup) 1 of five tablets of ,d+[DATE] mg and two tablets of ,d+[DATE] mg of Percocet were taken from the CS II E-kit on [DATE]. The Admin stated the CS II E-kit's two red tags were cut (cut or broken red tags indicate the E-kit has been opened) behind the tag and put back into the plastic bag to make it look like the CS II E-kit was intact.</p> <p>During an interview on [DATE] at 9:59 AM with RN Sup 1, RN Sup 1 stated RN Sup 1 was made aware of the incident from Licensed Vocational Nurse (LVN) 5 the morning of [DATE]. RN Sup 1 stated LVN 5 stated the plastic covering for CS II E-kit looked as if someone ripped the bottom very carefully. RN Sup 1 stated at every change of shift, licensed nurses were required to count the controlled medications in the medication carts, check if CS II E-kits were opened, and document [the information] in the CDR form. RN Sup 1 stated the whole process should be completed by two licensed nurses. RN Sup 1 stated licensed nurses were to physically check if the CS II E-kit was sealed and stated it should not be one nurse to check the CS II E-kit.</p> <p>During a concurrent observation and interview on [DATE] at 10:15 AM with RN Sup 1 in MS room [ROOM NUMBER], the original red tags and plastic of the CS II E-kit were observed to be cut. RN Sup 1 stated the plastic was cleanly ripped on the perforated edges. RN Sup 1 stated the red tags were cut carefully and cleanly behind the tag so it would not be visible to staff. RN Sup 1 stated LVN 5 found the plastic flap near the perforated line to be slightly up and opened.</p> <p>During an interview on [DATE] at 10:52 AM with LVN 2, LVN 2 stated LVN 2 worked on [DATE] from 7 AM to 7:30 PM in Station 1. LVN 2 stated LVN 2 did a visual check of the CS II E-kits at the beginning of the shift alone in MS room [ROOM NUMBER]. LVN 2 stated LVN 2 did not see any discrepancies on the plastic or tags. LVN 2 stated the CS II E-kit was not opened recently and stated if the CS II E-kit was opened there should be a yellow tag. LVN 2 stated LVN 2 did medication reconciliation for the medication cart in Station 1 and gave hand off report to LVN 4 at 7:30 PM. LVN 2 stated LVN 2 did not check the CS II E-kit with LVN 4 on [DATE], and stated it was usually [usual practice] one licensed nurse checking E-kits in MS room [ROOM NUMBER].</p> <p>During an interview on [DATE] at 11:45 AM with LVN 4, LVN 4 stated LVN 4 worked on [DATE] in Station 1 from 7 PM to 11 PM, and in Station 3 from 11 PM to 7 AM. LVN 4 stated LVN 4 did medication reconciliation of the medication cart in Station 1 with LVN 2 on [DATE] at 7 PM. LVN 4 stated LVN 4 did a visual check on the E-kits alone in MS room [ROOM NUMBER]. LVN 4 stated LVN 5 came to relieve LVN 4 at 11 PM and completed the medication reconciliation of the medication cart in Station 1 with LVN 5. LVN 4 stated at around 11:30 PM, LVN 5 asked LVN 4 if LVN 4 opened the CS II E-kit. LVN 4 stated LVN 4 saw the plastic bag covering the CS II E-kit was opened perfectly at the perforation line, and two red tags were on the CS II E-kit to look like they were intact. LVN 4 stated LVN 4 and LVN 5 proceeded to count each narcotic medication individually and stated two tablets of ,d+[DATE] mg of Percocet and ,d+[DATE] mg of Percocet were missing. LVN 4 stated LVN 4 called the pharmacy to ask when the last time the CS II E-kit was replaced and stated the E-kit was replaced on [DATE] and was received by LVN 5. LVN 4 stated [the incident] was reported to RN Sup 1 the morning on [DATE]. LVN 4 stated it was usually one nurse to check E-kits in MS room [ROOM NUMBER].</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER West Haven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1495 West Cameron 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 12:25 PM with LVN 5, LVN 5 stated LVN 5 worked on [DATE] from 11 PM to 7 PM. LVN 5 stated LVN 5 counted narcotic medications in the medication cart with LVN 4 in Station 1 at 11 PM. LVN 5 stated at around 11:30 PM, LVN 5 checked E-kits alone in MS room [ROOM NUMBER] and saw the plastic of CS II E-kit was opened. LVN 5 stated LVN 5 saw the plastic was carefully ripped from the perforation line and the two red tags were cut from behind. LVN 5 stated LVN 5 called LVN 4 over to witness the CS II E-kit and asked LVN 4 if LVN 4 opened the CS II E-Kit. LVN 5 stated LVN 5 and LVN 4 counted the medications in CS II E-kit and stated an entire box of Percocet ,d+[DATE] mg, and two tablets of ,d+[DATE] mg were missing. LVN 5 stated LVN 5 placed the CS II E-kit back into the locked cabinet and notified RN Sup 1 the morning of [DATE]. LVN 5 stated from [DATE] to [DATE] the CS II E-kit was not opened. LVN 5 stated licensed staff were to check off [document] if the emergency kits were checked on the CDR form for Cart 1. LVN 5 stated licensed nurses checked the red tags on an E-kit because the [unbroken] red tags indicated an E-kit had not been opened. LVN 5 stated if the CDR form was not filled out, this was considered a discrepancy. LVN 5 stated one nurse checked E-kits in MS room [ROOM NUMBER], and it was usually the oncoming nurse. LVN 5 stated not filling out the CDR form indicated staff did not check the E-kit and there was a risk for medications to be taken from the E-kit.</p> <p>During an interview on [DATE] at 1:11 PM with the facility's Pharmacy Consultant (PC), the PC stated the purpose of monitoring CS medications, in particular, Percocet, was due to the medication being an easily addictive medication. The PC stated Percocet was heavily monitored because there was a high risk of misuse which could result in an overdose, decreased respiration rate (rate of breathing), or death.</p> <p>During a concurrent interview and record review on [DATE] at 2:05 PM with RN Sup 1, Cart 1 CDR form dated [DATE] was reviewed. The Cart 1 CDR form indicated a signature for an incoming and outgoing nurse but did not indicate if the emergency box was intact or expired. RN Sup 1 stated it was not filled out and [this situation] was considered a discrepancy. RN Sup 1 stated if there was a discrepancy on the form, the oncoming nurse should check the completeness of the form before signing the form. RN Sup 1 stated staff should have reported the discrepancy to the DON and Admin immediately and stated the risk of not filling out the CDR form [completely was] staff would not know if the E-kit was opened or missing [drugs].</p> <p>During a concurrent interview and record review on [DATE] at 3:06 PM with the DON, the facility's P&P titled, Controlled Medication Storage dated ,d+[DATE] was reviewed. The P&P indicated at each shift change a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses, and is documented on the controlled medication accountability record. The P&P indicated any discrepancy in controlled substances medication counts is reported to the DON immediately. The DON stated staff are not following the P&P if one nurse is checking the CS II E-kit. The DON stated the risk of having one nurse check the CS II E-kit is that there can be a discrepancy or medications can be taken. The DON stated both the outgoing and incoming nurses should be signing the CDR form at the same time. The DON stated if the form was not filled out, it could indicate staff did not monitor the E-kit, and the risk for discrepancies would rise. The DON stated a discrepancy was when the number of medications was not correct, physically or on paper. The DON stated if the right amount was not indicated or documented, then it was considered a discrepancy. The DON stated if the CDR form was not filled out then there was a risk for error, or the E-kit could be opened.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/03/2024
NAME OF PROVIDER OR SUPPLIER West Haven Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1495 West Cameron 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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 3:53 PM with LVN 6, LVN 6 stated LVN 6 worked at the facility on [DATE] from 11 PM to 7 AM. LVN 6 stated LVN 6 did not have any residents with orders for Percocet. LVN 6 stated LVN 6 did not know where the E-kits were placed. LVN 6 stated LVN 6 did not ask where the E-kits were located because everything LVN 6 needed was in the medication cart. LVN 6 stated LVN 6 purposefully left the section of checking the E-kit blank because LVN 6 did not visually see the E-kits. LVN 6 stated LVN 6 did not check the E-kits with both the oncoming and incoming nurses.</p> <p>During a review of the facility's P&P titled, Drug Diversion, dated ,d+[DATE], the P&P indicated the designated staff members will be responsible for maintaining the controlled substance inventory, storage, and disposal. The P&P indicated all records of controlled substances, including receipts, administration, waste, disposal, loss, or possible diversion must be accurate and maintained.</p>		