STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056228	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Haven Healthcare	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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 46687 Based on interview and record review, the facility failed to ensure licensed vocational nurses (LVNs) and certified nurse assistants (CNAs) had the competency (the capability to apply or use the knowledge, skills, and abilities required to successfully perform tasks in the work setting) to understand different infection types in the healthcare setting by failing to: 1. Ensure the Infection Prevention Nurse (IPN), Director of Staffing Development (DSD), LVN 3, LVN 4, CNA 4, CNA 5 and Restorative Nurse Assistant/CNA (RNA) 1 were aware that Group A Streptococcus (GAS- bacteria that enters the body and causes an illness and affects the skin and throat) were bacteria (organism that enters the body and cause illness) that could cause infections through respiratory droplets (respiratory particles created when coughing, sneezing, or talking) or direct contact. 2. Ensure CNA 4 and RNA 1 were aware the facility had an active outbreak (OB- sudden rise in the incidence of a disease) of GAS. These failures had the potential to result in widespread infection in the facility. Findings: During an interview on 3/14/2025 at 11:29 am, with the IPN, the IPN stated the facility had an active GAS OB since 2/20/2025 and would be in active GAS OB until 4/8/2025. The IPN stated the IPN had done in-services on GAS and infection control. During a telephone interview on 3/14/2025 at 11:38 pm, with the Public Health Nurse (PHN), the PHN stated the facility's GAS OB started on 2/20/2025 when the PHN visited the facility to provide recommendations. The PHN stated the facility was currently in a GAS OB until 4/8/2025. The PHN stated GAS was a type of bacterial infection. During an interview on 3/14/2025 at 1:14 pm, with CNA 4, CNA 4 stated CNA 4 was not aware the facility had a GAS OB at the time of the interview. CNA 4 stated there was no COVID-19 (infectious disease caused by SARS-CoV-2 virus) in the facility. CNA 4 stated CNA 4 did not know what GAS was. During an interview on 3/14/2025 at 1:28 pm, with RNA 1, RNA 1 stated the facility had a GAS OB, but did not currently have a GAS OB at the time of the interview. RNA 1 stated RNA 1 did not know what type of infection GAS was. (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

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 03/14/2025
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)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/14/2025 at 1:40 pm, with CNA 5, CNA 5 stated GAS was a virus. During an interview on 3/14/2025 at 1:52 pm, with LVN 3, LVN 3 stated the facility had an active OB of, Strep A virus, until they were cleared by the PHN. During an interview on 3/14/2025 at 2:06 pm, with LVN 4, LVN 4 stated GAS was a fungal infection. LVN 4 stated LVN 4 was in-serviced on GAS when the OB was announced (on 2/20/2025). During an interview on 3/14/2025 at 2:16 pm, with the DSD, the DSD stated the facility currently had an active GAS OB. The DSD stated GAS was a viral throat infection that should be treated like a respiratory infection. During an interview 3/14/2025 at 4:20 pm, with the IPN, the IPN stated both the IPN and DSD provided in-services to staff regarding GAS when the GAS OB was announced on 2/20/2025. The IPN stated GAS was a viral infection that was treated with antibiotics (medication used to treat bacterial infections). During an interview on 3/14/2025 at 4:27 pm, with Registered Nurse Supervisor (RNS) 1, RNS 1 stated GAS was a bacterial infection that was treated with antibiotics. RNS 1 stated if staff did not know what GAS was, did not know what type of infection GAS was, then staff may end up spreading GAS to other residents, who could get sick and end up hospitalized . RNS 1 stated it was important to be educated on the in-services and know what was going on in the facility so staff could keep the residents safe. During a review of the facility's GAS frequently asked questions (FAQ)/fact sheet, undated, the GAS FAQ/fact sheet indicated GAS were bacteria commonly found in the throat and on the skin. During a review of the Centers of Disease Control and Prevention (CDC) website titled, About Group A Strep Infection, updated on 3/1/2024, the website indicated Group A strep bacteria can cause many different types of infections that range from minor to serious. Group A strep bacteria were contagious. Generally, people spread the bacteria to others through respiratory droplets or direct contact. [https://www.cdc.gov/group-a-strep/about/index.html] During a review of the facility's policy and procedure (P&P) titled, Competency Evaluation, dated 8/2017, the P&P indicated it was the facility's policy to perform competency evaluation for all employees. The P&P indicated the competency checklist would include . staff's skills on assessment, evaluation, planning, and implementation of the resident's plan care of care and resident needs, including infection control.

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 03/14/2025
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)

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 46687

Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and/or diseases in the healthcare setting) were followed in accordance with the facility ' s policies and procedures (P&P) titled, Hand Hygiene (procedures that included the use of alcohol-based hand rubs [containing 60%-95% alcohol] and hand washing with soap and water), and Enhanced Barrier Precautions (EBP- set of infection control measures that use personal protective equipment [PPE- equipment worn to minimize exposure to a variety of hazards] to reduce the spread of multidrug-resistant organisms [MDRO- organism that is resistant to most antibiotics] by wearing a gown and gloves), and Resident Isolation- Categories of Transmission-Based Precautions (TBP- set of infection control measures that use PPE to reduce the spread of different organisms) for four of four sampled residents by failing to:

1. Ensure the facility posted their Group A Strep (GAS- bacteria that enters the body and causes an illness and affects the skin and throat) Outbreak (OB- sudden rise in the incidence of a disease) Notification Letter (letter that indicates to staff, residents, and visitors the facility has an active OB) at the front door of the facility, and the GAS frequently asked questions (FAQ)/fact sheet, as recommended by the Public Health Nurse (PHN- focuses on promoting and protecting the health of populations by utilizing nursing, social, and public health knowledge, working in communities to prevent disease and improve health outcomes).

2. Ensure Certified Nurse Assistant (CNA) 1 donned (put on) a mask properly and perform hand hygiene while caring for Resident 3.

3. Ensure CNA 2 performed hand hygiene before and after entering Resident1's room who was on EBP.

4. Ensure the facility including LVN 4 educated Resident 4's visitors (Family 1 and Family 2), who was on contact precautions (used to prevent the spread of infections transmitted by direct or indirect contact with a patient or their environment by wearing a gown and gloves) to wear the appropriate PPE while in the room.

5. Ensure LVN 2 donned a mask properly while in the facility.

6. Ensure CNA 3 donned proper PPE before entering Resident 2's room who was on EBP.

As a result of these failures, Residents 1, 2, 3 , and 4 were at risk for exposure to infectious agents. These failures had the potential to spread and transmit infectious agents from staff to residents that had the potential to result in widespread infection in the facility.

Findings:

(continued on next page)

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 03/14/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1 ' s Admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/12/2025, with diagnoses that included end stage renal disease (ESRD- Condition in which the kidneys cease functioning on a permanent basis leading to the need for regular course of long-term dialysis or kidney transplant to maintain life) and sepsis (the body ' s extreme response to infection and a life-threatening medical emergency). During a review of Resident 1 ' s untitled, undated care plan (CP), the CP indicated Resident 1 had the presence of wounds and indwelling medical devices and needed to be on EBP. The CP interventions included to follow EBP precautions including to use hand hygiene and follow proper infection control practices as indicated. During a review of Resident 1 ' s Minimum Data Set (MDS- a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, remember, and function). The MDS indicated Resident 1 had septicemia (blood poisoning by bacteria). During a review of Resident 2 ' s AR, the AR indicated the facility initially admitted Resident 2 on 6/3/2021 and was readmitted on [DATE], with diagnoses that included ESRD and dependence on renal dialysis (treatment to clean one ' s blood by removing waste and extra fluid when the kidneys are unable to). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated Resident 2 had moderately impaired cognition. The MDS indicated Resident 2 had a pressure ulcer (an injury that breaks down the skin and underlying tissue when an area of skin is placed under pressure). During a review of Resident 3 ' s AR, the AR indicated the facility admitted Resident 3 on 1/17/2025 with diagnoses that included type II diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel) and chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should). During a review of Resident 3 MDS dated [DATE], the MDS indicated Resident 3 had moderately impaired cognition. During a review of Resident 4 ' s AR, the AR indicated the facility initially admitted Resident 4 2/11/2025 and was readmitted on [DATE], with diagnoses that included ESRD and DM2. During a review of Resident 4 ' s untitled, undated CP, the CP indicated Resident 4 was on contact isolation for methicillin-sensitive Staphylococcus aureus (MSSA- type of bacteria that is sensitive to the antibiotic methicillin). The CP interventions indicated to educate family/visitors regarding isolation precautions. During a review of Resident 4 ' s MDS dated [DATE], the MDS indicated Resident 4 had intact cognition. The MDS indicated Resident 4 had MDRO. a. During an observation on 3/14/2025 at 8:30 am, outside the facility ' s entrance, the facility ' s entrance doors and windows were observed. There was no GAS OB Notification Letter on the facility ' s entrance doors and windows indicating the facility had a GAS OB. (continued on next page)

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 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Haven Healthcare	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 3/14/2025 at 11:38 am, with the PHN, the PHN stated the PHN sent the facility the GAS OB Notification Letter on 1/24/2025. The PHN stated the GAS Notification Letter was to be posted at the entrance of the facility so all residents, visitors, and staff could see the facility had an active OB. The PHN stated the PHN recommended the facility provide information to all staff and to post the GAS FAQ/fact sheet where staff and residents could see it. The PHN stated the point of making the GAS FAQ/fact sheet visible was so that anyone at the facility could read information about GAS and be informed. During a concurrent interview and record review on 3/14/2025 at 11:51 am, with the Infection Prevention Nurse (IPN), the PHN recommendations were reviewed. The IPN stated the IPN did not remember needing to post the GAS OB Notification Letter at the entrance of the facility. The IPN stated the GAS FAQ/fact sheet was posted in the breakroom for staff to read. The IPN stated it was important for the GAS OB Notification Letter to be posted at the entrance so anyone walking into the facility will know what was going on in the facility will know how to protect themselves. The IPN stated if residents could not see the GAS FAQ/fact sheet then they would not be informed and may not know how to protect themselves. b. During an observation on 3/14/2025 at 11:17 am, of CNA 1 with Resident 3 in the lobby area, CNA 1 was observed. CNA 1 was observed to walk up towards Resident 3 ' s wheelchair. CNA1 ' s mask was not covering CNA 1 ' s nose and mouth. CNA 1 touched the handles on Resident 3 ' s wheelchair to turn it, then assisted Resident 3 to put on Resident 3 ' s jacket. Resident 3 did not perform hand hygiene before providing care to Resident 3 or after and did not appropriately wear the mask. During an interview on 3/14/2025 at 11:18 am, with CNA 1, CNA 1 stated CNA 1 was supposed to wear a mask while in the facility because the facility had COVID-19 (infectious disease caused by SARS-CoV-2 virus) and that it was protocol. CNA 1 did not state why hand hygiene was important. c. During a concurrent observation and interview on 3/14/2025 at 12:25 pm, CNA 2 was observed at Resident 1 ' s room entrance. An EBP sign was posted next to the door indicating anyone entering the room and upon exiting the room must perform hand hygiene. CNA 2 entered Resident 1 ' s without performing hand hygiene. CNA 2 checked on Resident 1, then exited the room without performing hand hygiene. CNA 2 stated the sign next to Resident 1 ' s room door indicated to perform hand hygiene before entering and upon exiting the room. CNA 1 stated it was important to perform hand hygiene with EBP rooms/residents to stop the spread of infection. d. During a concurrent observation and interview on 3/14/2025 at 12:28 pm, at Resident 4 ' s room, Resident 4 ' s Family 1 and Family 2 were observed. The signed next to Resident 4 ' s door indicated Resident 4 was on contact precautions. Family 1 stated Family 1 and Family 2 were given masks, but stated staff at the facility did not tell Family 1 and Family 2 they were supposed to wear masks, and were supposed to don gown and gloves while visiting Resident 4. (continued on next page)

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 03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Haven Healthcare	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 3/14/2025 at 12:30 pm, with LVN 1, outside of Resident 4 ' s room, Family 1 and Family 2 were observed. LVN 1 stated Family 1 and Family 2 were touching the side of Resident 4 ' s bed. LVN 1 stated Family 1 and Family 2 were not wearing a mask, gown, or gloves. LVN 1 stated Resident 4 was on contact precautions for MSSA. LVN 1 stated anyone in the room should be wearing a gown and gloves to prevent the spread of infection. LVN 1 stated visitors could get sick or spread germs to others at home. LVN 1 stated Family 1 and Family 2 should be wearing masks to prevent the spread of infection. LVN 1 stated it was all staffs ' responsibility to remind visitors about precautions. e. During a concurrent observation and interview on 3/14/2025 at 12:36 pm, at the nurses ' station, LVN 2 was observed. LVN 2 was at the computer, with a mask that was pulled down below the nose and mouth. LVN 2 stated LVN 2 was supposed to wear properly wear a mask to help prevent the spread of infection because the facility required it. f. During a concurrent observation and interview on 3/14/2025 at 12:45 pm, at Resident 2 ' s room, CNA 3 was observed. A sign next to the door indicating EBP was posted. CNA 3 was at Resident 2 ' s bedside, touching Resident 2 ' s bedding. CNA 3 was not wearing a gown or gloves, and CNA 3 ' s mask was pulled down below the nose and mouth. CNA 3 stated CNA 3 was supposed to wear a gown and gloves because Resident 2 was on HD and needed to stop the spread of infection to keep Resident 2 safe. CNA 3 stated masks were the facility ' s protocol and were supposed to be, worn all the way. During an interview on 3/14/2025 at 4:12, with IPN, the IPN stated hand hygiene was important so staff would not spread germs from resident to resident and other staff. the IPN stated hand hygiene was the number one way to prevent the transmission of germs. The IPN stated staff were supposed to wear masks while in the facility because it was influenza (flu- respiratory infection caused by the influenza virus) season. The IPN stated wearing masks prevented the spread of infection and was for resident safety. The IPN stated staff should be wearing a gown and gloves if touching residents or in EBP rooms because they could come in contact with body fluids and could be spreading infection to others. The IPN stated visitors were supposed to were a gown and gloves in contact precaution rooms so they would not spread germs or catch an infection. The IPN stated it was everyone ' s responsibility to ensure all visitors and vendors were wearing the appropriate PPE while in the facility and to educate them for not following isolation precautions. The IPN stated it was everyone ' s responsibility to keep the resident ' s safe. During a review of the facility ' s P&P titled, Standard and Enhanced Barrier Precautions, dated 4/1/2025, the P&P indicated the facility would ensure the use of appropriate PPE to improve infection control as required in the care of residents. The P&P indicated EBP should be used during dressing, bathing/showering, transferring, personal hygiene, changing linens, changing briefs or assisting with toileting and device care or use. During a review of the facility ' s P&P titled, Hand Hygiene, dated 2/9/2024, the P&P indicated the facility would ensure that all individuals used appropriate hand hygiene while at the facility. The P&P indicated the facility considered hand hygiene the primary means to prevent the spread of infection. The indicated to perform hand hygiene immediately upon entering and immediately upon exiting a resident occupied area. (continued on next page)

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 03/14/2025
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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled, Resident Isolation- Categories of TBP, dated 2/9/2024, the P&P the facility would ensure that TBP precautions were used when caring for residents communicable (contagious) diseases or transmittable (spreadable) infections. The P&P indicated TBP were used accordingly when caring for residents who are documented or are suspected of having communicable diseases or infections that can be transmitted to others. The P&P indicated contact precautions were implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident ' s environment.