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	07/17/2025

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 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. (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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement care plans (CP- a personalized document that outlines a resident's medical and social care needs and the actions required to address them) for four of seven sampled residents (Residents 1, 2, 6, and 7) according to the facility's policy and procedure (P&P) titled, Care Planning, by failing to: 1. Ensure Residents 1 and 6 had CPs developed for the administration of intravenous (IV- soft, flexible tube placed inside a vein to administer fluids and medication directly to the bloodstream) antibiotics (abx- medication that inhibits the growth of or destroys bacteria in the body). 2. Ensure Resident 7 had a CP developed and implemented for the use of peripherally inserted central venous catheter (PICC- a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart). 3. Ensure Resident 2's CP for IV indicated the location of the IV. These failures resulted in Residents 1, 2, 6, and 7 not having an appropriate CP developed or implemented. These failures had the potential for Residents 1, 2, 6, and 7 to not receive the care and services needed for IV services and to treat the residents' medical conditions.Findings: a1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 was readmitted on [DATE] with diagnoses that included urinary tract infection (UTI- infection that happen when bacteria enter the urethra, and infect the urinary tract) acute kidney failure (when the kidneys suddenly stop working due to complication of another serious illness), and unspecified hydronephrosis (a condition where urine backs up into the kidneys, causing them to swell, generally caused by infection or obstruction). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 1 had an active UTI. The MDS indicated Resident 1 was taking an abx. During a review of Resident 1's Order Summary Report (OSR) date range [DATE] to [DATE], the OSR indicated Resident 1 had an order for Cefepime HCl Intravenous Solution (type of abx), two grams (gm- unit of measurement) per 100 milliliters (mL- unit of measurement). The OSR indicated to give Resident 1 one dose daily intravenously every 12 hours for UTI for five days. The OSR indicated to start Cefepime on [DATE]. During a review of Resident 1's untitled Care Plan Report (CPR), the CPR did not indicate Resident 1 had a CP initiated for use of IV abx therapy, Cefepime. a2. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on [DATE] with diagnoses that included candidal sepsis (a severe bloodstream infection caused by Candida [type of fungus], which can lead to organ damage and even death), asthma (chronic lung disease caused by inflammation and muscle tightening around the airways), and 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). During a review of Resident 6's OSR, date range from [DATE] to [DATE], the OSR indicated Resident 6 had an IV order for Caspofungin (an antifungal medication, used to treat serious fungal infections), 50 milligrams (mg- unit of measurement)) IV every 24 hours for 12 days for fungal infection to the upper right chest dialysis (treatment to clean one's blood by removing waste and extra fluid when the kidneys are unable to) catheter (line used for dialysis). The OSR indicated the order date was [DATE]. During a review of Resident 6's untitled CPR, the CPR did not indicate Resident 1 had a CP initiated for use of IV antifungal therapy, Caspofungin. During a review of Resident 6's MDS dated [DATE], the MDS indicated that Resident 6 had intact cognition. The MDS indicated Resident 6 was on IV medication and had IV access. b. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on [DATE] and was readmitted on [DATE] with diagnoses that included unspecified sepsis, bacteremia (bacterial infection in the bloodstream), and unspecified respiratory failure (serious condition that makes it breathe on one's own). During a review of Resident 7's OSR, date range from [DATE] to [DATE], the OSR indicated Resident 7 had an IV medication order for Zosyn (type of abx), four and a half (4.5) gm IV via PICC line, every eight hours for five days for sepsis. The order date was [DATE]. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 had moderately impaired cognition. The MDS indicated Resident 7 had pneumonia (an infection that inflames the air sacs in one or both lungs and may cause a buildup of fluid or pus) and was on abx. During a review of Resident 7's untitled CPR, the CPR did not indicate Resident 7 had a CP initiated for use of PICC. c. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on [DATE] and was readmitted on [DATE] with diagnoses that included sepsis due to Escherichia coli (E. coli- a type of bacteria commonly found in the intestines [gut] and urinary tract), UTI, and bacteremia

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide clear, complete and signed intravenous (IV- soft, flexible tube placed inside a vein to administer fluids and medication directly to the bloodstream) medication orders, and IV flush (to insert normal saline [NS- a sterile solution of water and sodium chloride (table salt)]) orders according to the facility's policies and procedures (P&P) titled, Medication Orders, Peripheral Catheter (IV) Flushing, and, Continuous Infusion of Medications and Solutions, for seven of seven sampled residents (Residents 1, 2, 3, 4, 5, 6, and 7) by failing to: 1. Ensure Resident 1's Physician Order for Infusion (IV) Therapy (POFIT) dated 6/30/2025, and IV medication administration record (MAR- a report that serves as a legal record of the medications administered to a resident) dated 6/2025 to 7/2025 indicated peripheral (away from the heart) IV flush orders and that licensed nurses (LN) Resident 1's IV was being flushed with 10 milliliters (mL- unit of measurement) NS every 12 hours as indicated. 2. Ensure Resident 2's IV MAR dated 6/2025 indicated when to flush Resident 2's IV according to the POFIT, dated 6/19/2025, and that LNs were flushing Resident 2's IV with 10 mL NS every 12 hours as indicated in the POFIT. 3. Ensure Resident 3's LNs were flushing Resident 3's IV with 10 mL NS every 12 hours as indicated in Resident 3's IV MAR dated 7/2025 and ensure Resident 3's POFIT, dated 7/7/2025 was signed by the physician, indicated peripheral IV flush orders, and indicated an accurate dose of IV medication. 4. Ensure Resident 4's POFIT dated 7/7/2025 was signed by Resident 4's physician. 5. Ensure Resident 5's POFIT dated 5/9/2025 indicated the dose, frequency, and diagnosis for use of IV vancomycin (type of antibiotic [abx- medication that inhibits the growth of or destroys bacteria in the body]), and ensure Resident 5's peripherally inserted central venous catheter (PICC- a thin, flexible tube inserted into a vein in the upper arm and threaded into a larger vein near the heart) was flushed every 12 hours as ordered in Resident 5's POFIT. 6. Ensure Resident 6's IV MAR for 7/2025 indicated to flush Resident 6's IV every 12 hours as ordered by Resident 6's physician in the POFIT dated 7/1/2025. 7. Ensure Resident 7's IV MAR dated 7/2025 indicated the frequency, start and stop dates for use of Zosyn (type of abx). As a result of these failures, Residents 1, 2, 3 and 5, 6's IV or PICC were not flushed every 12 hours as ordered. Residents 3 and 4's POFIT were not signed by their physicians. Resident 7's order for Zosyn did not have a start and stop dates. These failures put Residents 1, 2, 3, 4, 5, 6, and 7 at risk for complications with IV use and medication errors.Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated the facility was readmitted Resident 1 on 6/30/2025 with diagnoses that included urinary tract infection (UTI- infection that happen when bacteria enter the urethra, and infect the urinary tract) acute kidney failure (when the kidneys suddenly stop working due to complication of another serious illness), and unspecified hydronephrosis (a condition where urine backs up into the kidneys, causing them to swell, generally caused by infection or obstruction). During a review of Resident 1's IV MAR dated 6/30/2025 to 7/2025, the IV MAR indicated Resident 1 received one maintenance flush per day from 6/30/2025 to 7/5/2025. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 7/5/2025, the MDS indicated Resident 1 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 1 had an active UTI. The MDS indicated Resident 1 was taking an abx. b. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 7/7/2023 and was readmitted on [DATE] with diagnoses that included sepsis (the body's extreme response to infection and a life-threatening medical emergency) due to Escherichia coli (E. coli- a type of bacteria commonly found in the intestines [gut] and urinary tract), UTI, and bacteremia (bacterial infection in the bloodstream). During a review of Resident 2's IV MAR dated 6/2025, the IV MAR indicated Resident 2 received Meropenem (type of abx) from 6/19/2025 to 6/25/2025. The IV MAR indicated Resident 2 received one maintenance (IV) flush between 3 pm and 11 pm between 6/19/2025 and 6/25/2025. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 2 had a UTI in the last 30 days and was on abx. The MDS indicated Resident 2 had an IV present on admission for abx use. c. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 7/7/2025 with diagnoses that included pneumonia (PNA- an infection that inflames the air sacs in one or both lungs and may cause a buildup of fluid or pus) due Mycoplasma pneumoniae (type of bacteria), unspecified respiratory failure (serious condition that makes it breathe on one's own) and chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems). During a review of Resident 3's IV

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide concise and clear documentation for six of seven sampled residents (Residents 2, 3, 4, 5, 6, and 7) according to the facility's policy and procedure (P&P) titled, Documentation- Nursing, by failing to ensure: 1. Ensure Resident 2's intravenous (IV- soft, flexible tube placed inside a vein to administer fluids and medication directly to the bloodstream flush (to insert normal saline [NS- a sterile solution of water and sodium chloride (table salt)]) in the IV Therapy medication administration record (MAR- a report that serves as a legal record of the medications administered to a resident) (IV MAR) were legible (able to clearly read). 2. Ensure Resident 3's medication name and diagnosis in the IVMAR were legible. Ensure Resident 3's medication dose and diagnosis were on the Physician Order for Infusion (IV) Therapy (POFIT) were legible. 3. Ensure Resident 4's allergies, medication dose, and flush times were legible in the IV MAR. 4. Ensure Resident 5's allergies were documented on the IV MAR. 5. Ensure Resident 6's medication name and allergies in the IV MAR were legible. 6. Ensure Resident 7's allergies, IV flush times, and medication order were legible in the IV MAR. As a result of these failures, Residents 2, 3, 4, 5, 6, and 7's medical records were not legible. These failures had the potential for Residents 2, 3, 4, 5, 6, and 7 to receive inaccurate medications and/or doses, experience an allergic reaction to medications, and not receive IV flushes at the appropriate times. Findings: a. During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 7/7/2023 and was readmitted on [DATE] with diagnoses that included sepsis due to Escherichia coli (E. coli- a type of bacteria commonly found in the intestines [gut] and urinary tract), urinary tract infection (UTI- infection that happen when bacteria enter the urethra, and infect the urinary tract), and bacteremia (bacterial infection in the bloodstream). During a review of Resident 2's IV MAR dated 6/2025, the IV MAR indicated Resident 2 received Meropenem (type of antibiotic) from 6/19/2025 to 6/25/2025. The IV MAR indicated Resident 2 received one maintenance (IV) flush (type of IV flush that it given at set times) between 3 pm and 11 pm between 6/19/2025 and 6/25/2025. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment too) dated 6/24/2025, the MDS indicated Resident 2 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 2 had a UTI in the last 30 days and was on antibiotic (abx- medication that inhibits the growth of or destroys bacteria in the body) therapy. The MDS indicated Resident 2 had an IV present on admission for abx use. b. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 7/7/2025 with diagnoses that included pneumonia (PNA- an infection that inflames the air sacs in one or both lungs and may cause a buildup of fluid or pus) due Mycoplasma pneumoniae (type of bacteria), unspecified respiratory failure (serious condition that makes it breathe on one's own) and chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and breathing problems). During a review of Resident 3's IV MAR dated 7/2025, the IV MAR indicated Resident 3 received IV medication from 7/8/2025 to 7/13/2025. c. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 6/26/2025 with diagnoses that included chronic kidney disease (damage to the kidneys so they cannot filter blood the way they should) stage three, and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow imprecise movement). During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 3 had intact cognition. The MDS indicated Resident 4 had active PNA, was on abx therapy, and had an IV present on admission. During a review of Resident 4's POFIT dated 7/7/2025, the POFIT indicated Resident 3 was to receive ceftriaxone (type of abx) for treatment of UTI. During a review of Resident 4's IV MAR dated 7/2025, the IV MAR indicated Resident 4 received IV medication from 7/7/2025 to 7/11/2025. d. During a review of Resident 5's AR, the AR indicated the facility admitted Resident 5 on 5/9/2025 with diagnoses that included acute (sudden onset) osteomyelitis (serious infection of the bone that be either be acute or chronic) of the left ankle and foot, 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 gangrene (dangerous and potentially fatal condition that happens when blood flow to a large area of tissue is cut off, breaks down then dies). During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had moderately impaired cognition. The MDS indicated Resident 5 had acute osteomyelitis of the left ankle and foot, was taking abx and had IV access. During a review of Resident 5's IV MAR dated 6/2025, the IV MAR indicated Resident 5 received IV cefepime (type of abx) from 6/5/2025 to 6/19/2025. e. During a review of Resident 6's AR, the AR indicated