STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 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 ensure food was stored under sanitary conditions by storing four one-gallon (liquid measurement) cartons of heavy cream in one of two walk-in refrigerators (Refrigerator 1) beyond the manufacturer's use-by date (the final date recommended by the maker for a consumer to use a product while it remains at peak quality, flavor, and texture) and as indicated in the facility's policy and procedure (P&P) titled, Food Supply and Storage Procedures.This deficient practice had the potential to result in foodborne illnesses (refers to illness caused by the ingestion of contaminated food or beverages) to the residents consuming the food prepared with heavy cream. Findings:During an initial kitchen tour observation on 5/26/2026 at 8:30 AM, Refrigerator 1 contained four one-gallon cartons of heavy cream labeled with a manufacturer's best-by date of 5/24/2026.During an interview on 5/28/2026 at 1:37 PM with the Executive Chef (EC), the EC stated food items stored beyond the manufacturer's use-by date should not be kept in the walk-in refrigerators because they could be inadvertently served to the residents (in general). The EC stated consuming food stored beyond the manufacturer's recommended date increased the risk of food quality deterioration and [created the] potential for foodborne illness.During a review of the facility's P&P titled, Food Supply and Storage Procedures revised 9/2022, the P&P indicated all food, non-food items and supplies used in food preparation shall be stored in such manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P's procedure indicated the use-by date is the last date that a food can be consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. The P&P indicated foods past the use-by date should be discarded.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure room temperatures were between 71 degrees Fahrenheit (F - temperature scale) to 81 F for two of two sampled residents (Resident 7 and Resident 30).This deficient practice resulted in Resident 30 feeling cold and the potential for discomfort to Resident 7 and Resident 30 due to the room's temperature.Findings:During a review of Resident 7's Inpatient Facesheet (IF, admission record), the IF indicated the facility admitted Resident 7 on 5/8/2026.During a review of Resident 7's History and Physical (H&P), date of admission 5/8/2026, the H&P indicated Resident 7 had diagnoses that included adult failure to thrive (condition characterized by poor appetite, loss of weight, increased fatigue and a progressive functional decline) with generalized weakness with poor oral intake, anemia (decrease in the total amount of red blood cells).During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool) dated 5/8/2026, the MDS indicated Resident 7 had severe deficit in cognition (ability to think and make decisions) and required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort with bed mobility such as rolling left and right, sit to lying) with activities of daily living (ADL).During a review of Resident 30's IF, the IF indicated the facility admitted Resident 30 on 5/19/2026.During a review of Resident 30's H&P, date of admission 5/19/2026, signed 5/21/2026, the H&P indicated Resident 30 had diagnoses including chronic obstructive pulmonary disease (COPD is a type of obstructive lung disease characterized by long-term poor airˆow), end stage renal disease (ESRD, a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life). The H&P indicated Resident 30 was oriented to person, place, and time.During an interview on 5/27/2026 at 3:45 PM, with Resident 7's responsible party (RP 1) and with Registered Nurse 1 (RN 1) in Resident 7's room, RP 1 stated Resident 7's room felt cold. RN 1 stated the facility submitted a work order for issues with air-conditioning; RN 1 stated the room temperature would not go up even if the setting was at 75 F.During an observation on 5/27/2026 at 3:46 PM, there were two residents inside Room A, Resident 7 and Resident 30.During a concurrent observation and interview on 5/28/2026 at 9:22 AM, Resident 7 and Resident 30's room felt cold. Room A's thermostat reading was 64.4 F. RP 1 stated the room felt cold. RN 1 checked the thermostat; the thermostat's setting was 75 F but the thermostat's temperature read 64.4 F.During an interview on 5/28/2026 at 9:25 AM, with the Director of Nursing (DON), the DON stated the facility submitted a work order yesterday (5/27/2026) to fix the air-conditioning system because Room A was cold.During a concurrent observation and interview on 5/28/2026 at 9:37 AM with the Director of Engineering (DE), the DE checked Room A's temperature by pointing the thermometer sensor at the middle of the room close to Resident 7's bed and Resident 30's bed, the thermometer sensor read 64 F. The DE stated Room A's temperature was cold. The DE stated the DE did not receive a work order yesterday (5/27/2026). The DE stated nursing staff needed to communicate any repair issues needed to the engineering department by using the online work order request or by calling the engineering department.During an interview on 5/28/2026 at 9:45 AM, with Resident 30 and the DON, in Room A, Resident 30 was lying in bed and stated, I am very cold, it was cold during the night. The DON checked Resident 30's blankets, there were 5 blankets on top of Resident 30 covering Resident 30 from the chest down to the legs. Resident 30 stated the blankets felt very heavy.During a concurrent observation and interview on 5/28/2026 at 9:48 AM with RP 1, Resident 7 was asleep in bed, RP 1 stated Resident 7 was covered with a lot of blankets.During an interview on 5/28/2026 at 10:10 AM with the Unit Secretary (US), the US stated the US submitted a work order request for Room A yesterday (5/27/2026) around 9:30 AM.During a concurrent record review and interview on 5/28/2026 at 10:11 AM, with the US, the facility's work order list was printed the reviewed. The work order list (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not indicate a work order submitted on 5/27/2026. The US stated the US completed the work order, but the US forgot to file [submit] the work order request. The US stated the US had to leave early yesterday (5/27/2026) when asked if the US followed up on the work order request (the US thought the US submitted).During a review of the of the facility's work order list - Email Level 2, the list indicated the last work order request was dated 5/15/2026. The list did not indicate a request dated 5/27/2026.During a review of the facility's Policy and Procedure (P&P) titled Quality of Life approved date October 2025, the P&P indicated comfortable and safe temperature levels [the facility] must maintain a temperature range of 71-81 F.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure a dialysis emergency kit (a bag used to store emergency supplies) was kept at the bedside for one of one sampled resident (Resident 30), who was on dialysis (general term, a life-sustaining medical treatment that performs the essential functions of failing kidneys by filtering waste, toxins, and excess fluid from the blood) and as indicated in the facility's Policy and Procedure (P&P) titled Care of the Patient with an Arteriovenous Access.This deficient practice had the potential to result in delayed emergency services and excessive bleeding to Resident 30 during an accidental pull out of the arteriovenous access catheter (a soft, flexible tube inserted into a large vein in the neck, chest, or groin serving as a temporary lifeline to draw and return blood during hemodialysis).Findings:During a review of Resident 30's Inpatient Facesheet (IF, admission record), the IF indicated the facility admitted Resident 30 on 5/19/2026.During a review of Resident 30's History and Physical (H&P), date of admission 5/19/2026, signed 5/21/2026, the H&P indicated Resident 30 had diagnoses including end stage renal disease (ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). The H&P indicated Resident had recently started hemodialysis (specific type of dialysis that uses a machine and an artificial filter to clean the blood outside of the body). The H&P indicated Resident 30 was oriented to person, place and time.During a review of Resident 30's active orders, dated 5/23/2026, the order indicated routine hemodialysis with a duration of three hours.During a concurrent interview and observation on 5/26/2026 at 2:07 PM, with Registered Nurse 5 (RN 5) in Resident 30's room, Resident 30 was lying in bed and had an arteriovenous access located on the right side of Resident 30's neck. RN 5 checked Resident 30's drawers and bedside table and RN 5 was unable to find a dialysis emergency kit in Resident 30's room. RN 5 exited the room, walked to the nursing station, and walked back to Resident 30's room with an emergency kit. RN 5 stated it took approximately one minute to walk to the nursing station and another minute to walk back to Resident 30's room [with the emergency kit obtained from the nursing station]. RN 5 stated if there was [an emergency] bleeding from Resident 30's dialysis site, Resident 30 could bleed a lot. RN 5 stated the dialysis emergency kit needed to be at Resident 30's bedside to immediately stop the bleeding from the dialysis site. RN 5 stated the dialysis emergency kit contained gauze, a hemostat (a specialized metal or plastic clamp used to safely pinch and seal off flexible medical tubing) used to stop bleeding, and tape.During a review of the facility's P&P titled Care of the Patient with an Arteriovenous Access effective November 2025, the P&P indicated for patients on dialysis, a dialysis emergency kit will be maintained at [the resident's] bedside to assist with managing unanticipated bleeding from the dialysis access site. The kit will include the following tape, gauze, and absorbable hemostat.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure their medication error rate was not 5 percent or greater. Two medication errors were identified out of 25 opportunities resulting in a medication error rate of eight percent. The facility failed to ensure medications were administered in accordance with physician orders for two of seven sampled residents (Resident 17 and Resident 26) by failing to:A. Ensure Novolog (Insulin Aspart - a rapid-acting type of insulin [one of many hormones that helps the body turn food into energy]) was administered with meals in accordance with the physician's order to Resident 17. B. Ensure Coreg (Carvedilol - a medication used to lower blood pressure) was administered with meals in accordance with the physician's order to Resident 26. This deficient practice had the potential to result in ineffective treatment, adverse medication reactions (injuries resulting from medication use including physical and mental harm, or loss of function), fluctuations in blood glucose (a simple sugar and the body's primary source of energy), worsening of underlying medical conditions, and the potential for physical declines to Resident 17 and Resident 26.Findings: A. During a review of Resident 17's Inpatient Facesheet (IF, admission record), the IF indicated the facility admitted Resident 17 on 4/20/2026.During a review of Resident 17's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026, the MDS indicated Resident 17 had intact cognition (ability to think and make decisions). The MDS indicated Resident 17 was independent with eating and required moderate assistance (helper lifts, holds or supports trunk or limbs but provides less than half the effort) with bed mobility such as rolling left and right, sitting to lying, lying to sitting while on the bed.During a review of Resident 17's History and Physical (H&P), dated 4/23/2026, the H&P indicated Resident 17 had diagnoses that included diabetes mellitus type 2 (a chronic [persistent or long-lasting] disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production) and right transmetatarsal amputation (surgery to remove all or part of your forefoot).During a review of Resident 17's Active [physician] Orders (PO), the POs indicated two orders for Insulin Aspart (Novolog): 1. Novolog, dated 4/23/2026, timed at 8:00 AM, the PO indicated see protocol, subcutaneous, (administered under the skin, Sub-Q) with meals at bedtime (HS). 2. Novolog, dated 4/23/2026, timed at 12 PM, 3 units (the volume of a single unit of insulin) Sub-Q three times a day (TID) with meals.During an observation on 5/27/2026 at 9:02 AM, in Resident 17's room, Registered Nurse (RN 4) prepared (drew) Novolog 3 units in a syringe and administered 3 units of Novolog on Resident 17's left arm by injection.During an interview on 5/27/2026 at 9:08 AM, Resident 17 stated Resident 17 had already had breakfast around 8:00 AM that morning.During an interview on 5/27/2026 9:09 AM, RN 4 stated Novolog was a short acting insulin and RN 4 needed to administer Novolog before meals or with meals to prevent Resident 17's blood sugar from fluctuating too high during meals. RN 4 stated RN 4 was late in administering Resident 17's insulin because there were two orders for Novolog, one order indicated to administer Novolog with meals based on a sliding scale and the second order indicated to administer a routine dose of Novolog 3 units with meals. RN 4 stated RN 4 missed the second order. B. During a review of Resident 26's IF, the IF indicated the facility admitted Resident 26 on 5/19/2026.During a review of Resident 26's PO, start date 5/19/2026, the PO indicated Carvedilol 3.125 mg (1 tablet) given with food or milk for hypertension.During a review of Resident 26's H&P, dated 5/26/2026, the H&P indicated Resident 26 had a past medical history including Hypertension (high blood pressure), Atrial Fibrillation (irregular heartbeat) post pacemaker (a small, battery-powered device that prevents the heart from beating too slowly) placement.During an observation on 5/27/2026 at 8:40 AM, RN 4 prepared Resident 26's medications including Carvedilol one tablet of 3.125 milligrams (mg, unit of measurement). RN 4 placed the medications in a medication cup and placed the cup inside the medication cart drawer. During an observation on 5/27/2026 at 9:27 AM, RN 4 entered Resident 26's room and checked Resident 26's blood pressure (BP). RN 4 administered one tablet of Carvedilol without food or milk. RN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4 did not instruct Resident 26 to eat or asked Resident 26 if Resident 26 had eaten.During a concurrent review of Resident 26's POs and interview on 5/27/2026 at 3:55 PM, with RN 4, RN 4 stated RN 4 did not administer Carvedilol with food or milk. RN 4 stated the reason why Carvedilol needed to be administered with food was to help with absorption and to prevent stomach upset. RN 4 stated RN 4 needed to follow administration of medications according to the physician's orders. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration approved date February 2025. The P&P indicated medications must be administered as ordered [by the physician].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to:a. Ensure staff followed Enhanced Barrier Precautions (EBP - extra measures, such as donning [putting on] a gown and gloves during high-contact care activities with residents who are at higher risk [have wounds] of having or spreading germs that are hard to treat) with Resident 27 during occupational therapy (OT - therapies used to increase independent function, and regain or build skills to perform every day activities).b. Ensure facility staff performed hand hygiene (HH) after patient care and prior to touching the curtains and blinds for Resident 30. These deficient practices had the potential to result in the spread of microorganisms and cross contamination (the process by which microorganisms [microscopic living organisms that are too small to be seen with the human eye] are unintentionally transferred from one area/object to another with a harmful effect) possibly leading to nosocomial infections (an infection a resident acquires while receiving medical treatment in a healthcare facility) to Resident 27 and Resident 30 and other residents residing at the facility . Findings: a. During a review of Resident 27's Inpatient Facesheet (IF, admission record), the IF indicated Resident 27 was admitted to the facility, on 5/24/2026 with the reason for visit being right femur facture (break in the topmost portion of the right thigh bone) status post right hip hemiarthroplasty (surgical procedure for partial hip replacement). During a review of Resident 27's Current Orders (CO), dated 5/24/2026, the CO indicated Resident 27 had a physician's order for EBP for Transitional Care Unit (TCU) only. During a review of Resident 27's History and Physical (H&P) dated 5/25/2026, the H&P indicated Resident 27 had a past medical history of multiple sclerosis (a disease in which the protective coverings of nerve fibers in the brain are gradually destroyed; symptoms vary from numbness to paralysis and loss of control of bodily function) and hypertension (abnormally high blood pressure, even at rest.) The H&P indicated Resident 27 was awake and alert. During a review of Resident 27's Care Plan (CP), dated 5/25/2026, the CP indicated Resident 27 was at risk for infection. The CP indicated Resident 27 was on EBP related to Resident 27's surgical site on the right hip. During an observation on 5/26/2026 at 10:30 AM, the signage posted in front of Resident 27's room was viewed, the signage was titled, Enhanced Barrier Precautions (EBP), and indicated Personal Protective Equipment (PPE, protective clothing or equipment, designed to protect the wearer from injury or the spread of infection or illness) was required for Resident 27 during high-contact resident care activities that included donning gown and gloves. During an observation on 5/27/2026 at 11:30 AM in Resident 27's room, Occupational Therapist Assistant (OTA) was performing occupational therapies with Resident 27 without PPE. During a concurrent interview and record review on 5/27/2026 at 11:35 AM with the OTA, Resident 27's EBP signage was reviewed. The OTA stated Resident 27 was on EBP and these precautions applied to all medical staff. The OTA stated the purpose of donning a gown and gloves was to protect staff from transferring anything on to the body during patient care because the resident (in general) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 - Few	could potentially be infectious. During an interview on 5/28/2026 at 1:03 PM with the Director of Nursing (DON), the DON stated EBP applied to all staff during [resident] high contact care activities, including occupational therapy. During a review of the facility's policy and procedure (P&P) titled, TCU – Enhanced Barrier Precautions, dated 6/2025, the P&P indicated EBP refers to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and glove use during high contact resident care activities. The P&P indicated high-contact resident care activities included: when anticipating close physical contact while assisting with transfers/ mobility, i.e. during therapy. b. During a review of Resident 30's IF, the IF indicated the facility admitted Resident 30 on 5/19/2026. During a review of Resident 30's H&P, date of admission 5/19/2026, the H&P indicated Resident 30 had diagnoses including chronic obstructive pulmonary disease (COPD is a type of obstructive lung disease characterized by long-term poor airˆow), end stage renal disease (ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life). The H&P indicated Resident 30 was oriented to person, place and time. During an observation on 5/28/2026 at 9:50 AM, Certified Nursing Personnel (CNP) 1 was inside Resident 30's room with another unidentified CNP, both staff were wearing PPE. CNP 1 stated they would begin changing Resident 30's external urinary catheter (a non-invasive device used to manage urinary incontinence [involuntary loss of bladder [hollow muscular balloon-like organ that stores urine]or bowel control] by collecting urine without being inserted into the urethra [a hollow tubular structure that allows urine to pass from the bladder out of the body] or bladder). After completing the task, CNP 1 opened the curtain, touched the curtain, and touched the string to open up the blinds using the same gloves used to change the external urinary catheter. During an interview on 5/28/2026 at 10:00 AM, CNP 1 stated CNP 1 needed to remove the gloves used for changing the urinary catheter attached to Resident 30 and perform HH before touching the curtain and blinds to prevent cross contamination. During an interview on 5/28/2026 at 10:22 AM, the Director of Infection Control stated staff needed to remove gloves and perform HH after resident contact. During a review of the facility's P&P titled Hand Hygiene date approved November 2025, the P&P indicated the facility strives to reduce the transmission of microorganisms by staff to patients or other staff by performing appropriate hand hygiene. The P&P indicated hand hygiene is the most important measure to avoid the transmission of microorganisms and to prevent healthcare-associated infections. The P&P indicated hand hygiene is to be done: a. Before and after having direct contact with patients b. Before entering patient room/after leaving patient room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555610	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emanate Health Inter-Community Hospital- D/P Snf	210 W. San Bernardino Rd. Covina, CA 91723

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 - Few	c. after the removal of personal protective equipment, including gloves. d. at the end of the shift.