STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555649	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Covina Medical Center D/P Snf	725 S. Orange Avenue 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	Based on interview and record review, the facility failed to ensure Licensed Vocational Nurses accurately documented during each shift on 12/4/25 and 12/22/2025 as per facility's policy and procedures for one of three sampled residents (Resident 1) investigated under quality of care. This deficient practice resulted in Resident 1's medical record containing inaccurate documentation of patient assessment, which had the potential to affect Resident 1's provision of care. During a review of Resident 1's admission Record, dated 9/13/2024, the admission Record indicated Resident 1 had a medical diagnosis of Chronic Respiratory Failure (a serious condition that develops when the lungs cannot get enough oxygen into the blood), Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), with tracheostomy (a surgical procedure creating an opening in the neck into the windpipe to provide a direct airway for breathing, often using a tube, used for blockages, long-term ventilation, or secretion clearance) 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) in place. During an observation and interview on 12/23/25 at 12:20 p.m. with Certified Nurse Assistant 2 (CNA 2), in Resident 1's room, Resident 1 was observed awake resting in her bed and appeared confused. Resident 1 refused to be interviewed. Resident 1 requested Certified Nurse Assistant 2 (CNA 2) to close the window curtains as the sun was bothering her. CNA 2 was observed closing the window curtains as per Resident 1's request. CNA 2 stated Resident 1 had fluctuating capacity to understand. During an interview on 12/23/2025 at 12:29 p.m. with Licensed Vocational Nurse (LVN) 1, the LVN 1 stated the daily narrative charting for Resident 1 was to be completed only during the night shift (7 p.m.-7 a.m.) by the assigned LVN as per facility document titled, Daily Narrative Charting Schedule, which indicated Resident 1's room to have the daily narrative charting completed during night shift 7pm-7 am. LVN 1 verified there was no narrative charting for Resident 1 on 12/4/25 and 12/22/25 for night shift and day shift completed by the assigned LVNs. LVN 1 stated that a daily narrative charting was important to keep an accurate record of the resident assessments. During an interview on 12/23/2025 at 12:44 p.m. with LVN 2, LVN 2 stated there was a daily narrative charting schedule titled, Daily Narrative Charting Schedule, which indicated the list of room numbers assigned to the LVNs in day shift (7 a.m.-7 p.m.) and the list of room numbers assigned to the LVNs in night shift (7p.m.-7 a.m.). LVN 2 stated that it was important to document a daily narrative charting to have a record of what happens to the patient, their status, if there were any changes or no changes and to communicate with the Registered Nurse and other nurses. During an interview on 12/23/2025 at 1:57 p.m. with the Charge Nurse (CN), the CN verified Resident 1 was missing narrative charting for the dates of 12/4/25 and 12/22/25. CN stated a daily narrative charting was important during each shift to have an accurate documentation record for the residents. During a review of the facility's policy and procedure (P&P) titled, Charting, reviewed on 1/28/2025, the P&P indicated, Charting is a concise legal record of the patient's stay in the hospital. Purpose: to keep a detailed record of the patient's progress and care including admission, medication, treatment and discharge.During each shift, documentation should include, but not be limited: 1. Patient assessment with specific references to the problems and potential problems. 2. Status of IV lines, N/G tube, chest tubes, indwelling catheter and any other line/tubes that may be present.