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	07/01/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an injury of unknown origin (the source of the injury was not witnessed by any person and the source of the injury could not be explained by the resident and the injury is suspicious because of its extent, location, the number of injuries at a time, or the number of injuries over time) to the California Department of Public Health (CDPH), Adult Protective Services (APS, the county agency responsible for investigating reports of abuse, neglect, or exploitation of elders and dependent adults), and the Ombudsman (an impartial advocate who investigates and helps resolve complaints between patients and healthcare organizations) within 24 hours for one of three sampled residents (Resident 1) in accordance with state law and the facility's policy and procedure (P&P) titled Unusual Occurrence Reporting.This deficient practice resulted in the delay of regulatory oversight and investigation of suspected abuse, resulting in the continued risk of harm to current and future residents. Findings: During a review of Resident 1's face sheet (FS, summary document summarizing a patient's essential information, acting as the cover sheet for their medical record), dated 6/22/2026 , the FS indicated that Resident 1 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure with dependence of a ventilator (a long-term inability of the lungs to adequately exchange oxygen and carbon dioxide that often requires ongoing oxygen therapy or support of a breathing machine).During a review of Resident 1's History & Physical (H&P, a formal and complete assessment of the patient and the problem), dated 11/15/2025, the H&P indicated Resident 1 was admitted due to chronic respiratory failure, tracheostomy (a surgical procedure creating an opening in the neck into the trachea to facilitate breathing, bypassing the mouth and nose to breathe), epilepsy (a brain condition causing seizures), cerebral palsy (a group of conditions that affect movement, balance and posture), sepsis (a life-threatening reaction to an infection that causes your immune system harming healthy tissues and organs), and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). The H&P also indicated that Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 2/7/2026, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to think, remember, and reason) for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on staff for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on and removing footwear, personal hygiene, and rolling left and right. The MDS also indicated Resident 1's ability to move from sitting to lying and lying to sitting at the side of bed, sit-to-stand, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer, and walk ten feet were not assessed as Resident 1 did not perform this activity prior to the current illness, exacerbation, or injury.During a review of Resident 1's Reportable Incidents Note, dated 6/20/2026, the Note indicated that Resident 1's primary Certified Nurse Assistant (CNA) and Licensed Vocational Nurse (LVN) noticed that Resident 1's left leg from the hip to below the knee was swollen. The Note further (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 1 showed no signs of facial grimacing but noticeable tensing, with an increased heart rate; the charge Registered Nurse (RN) was notified along with the Medical Doctor (MD) who gave orders for an X-ray.During a review of Resident 1's Report Details, dated 6/21/2026, the Report Details indicated Resident 1's x-ray showed Resident 1 had a comminuted fracture (a type of bone break where the bone is shattered into three or more pieces) of the mid femur (thigh bone) and a nondisplaced fracture (a bone break where the bone cracks or snaps without shifting out of alignment) of the superior left acetabulum (the upper portion of the left hip socket).During an interview on 7/1/2026 at 11:40 a.m. with the Interim Acting Director Of Nursing (IDON), the IDON stated that according to Resident 1's Reportable Incidents Note, Resident 1's swollen leg was discovered by the CNA and LVN on 6/20/2026, MD was notified and Resident 1 was transferred to an outside hospital after X-ray confirmed a broken fracture of the left leg. The IDON also stated the facility conducted an in-house investigation into the fracture and determined the fracture was related to severe contractures. The IDON confirmed that the injury was not reported by the facility to any agency. The IDON further stated that a consequence of not reporting this incident to CDPH could be that if it was abuse, it could continue.During a review of the facility's policy and procedure (P&P) titled, Unusual Occurrence Reporting, dated 6/2021, the P&P indicated, Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) Hours of reporting the event or as required by federal and state regulations.During a review of the facility's policy and procedure (P&P) titled, Abuse, Elder and Dependent Adult dated 11/2024, the P&P indicated, Reports of an elder or dependent adult abuse are to be made immediately or as soon as possible by telephone and follow up written reports on a SOC form 341, and must be sent within two (2) working days. When an incident of abuse or neglect is alleged or suspected to have occurred in a long-term care facility, the report is made to the Long- Term Care Ombudsman Program and to the local law enforcement agency. The Department of Health is also to be notified.