

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555649	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER West Covina Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to revise a plan of care for three of three sampled residents (Residents 4, 15 and 22), as indicated in the facility's policy and procedure titled Care Planning by failing to: a. Revise Resident 4's care plan following an unintended and significant 35 lbs. weight loss. b. Revise Resident 15's care plan who had Pneumonia on 11/25/2025. c. Revise Resident 22's care plan who had a weight loss in 10/2025 and 11/2025. These deficient practices had the potential for Residents 4, 15 and 22 to not receive appropriate care treatment and/or services specific to their individual needs. Findings: a. During a review of Resident 4's admission Record (AR), the AR indicated Resident 1 was admitted to the facility 10/21/25 with diagnoses including chronic respiratory failure (lungs cannot adequately oxygenate {supply with oxygen} the blood or remove enough carbon dioxide), chronic obstructive pulmonary disease (lung condition causing breathing difficulties) and heart failure (heart muscle isn't pumping blood effectively). During a review of Resident 4's History & Physical (H&P) dated 10/22/25, the H&P indicated Resident 4 did not have the capacity to make medical decisions. During a review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 11/3/25, the MDS indicated Resident 4's cognition (ability to think and process information) was severely impaired and Resident 4 was dependent for activities of daily of living (ADLs). During a review of Resident 4's Weekly Weights (WW), the WW indicated Resident 4 weighed 229 lbs. on 10/23/25 lbs., 205 lbs. on 11/4/25, and 194 lbs. on 12/8/25. During a record review of Resident 4's Weight Loss Comprehensive Care Plan (WLCP) initiated on 11/9/25, the WLCP indicated Resident 1 had a 24 lbs. weight loss. Resident 4's WLCP did not indicate the WLCP was revised following Resident 4's additional 11 lbs. weight loss on 12/8/25. During a concurrent interview and record review with Licensed Vocational Nurse 2 (LVN 2) of Resident 4's WLCP on 12/16/25 at 3:48 p.m., LVN 2 stated Resident 4's WLCP was updated on 11/9/25 to obtain Resident 4's weekly weights. LVN 2 stated there were no further revisions or updates of Resident 4's WLCP after Resident 4's weight loss on 12/8/25. LVN 2 stated licensed staff were supposed to update/revise the resident's care plan to determine if the care was effective or if licensed staff needed to inform the physician (MD) or the Registered Dietitian (RD) of the current condition of the resident. LVN 2 stated revising the care plan was important to identify if care was effective. (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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/18/25, at 2:25 p.m., with the Infection Preventionist (IPN), the IPN stated it was important to revise the resident's care plan because that was the primary care plan for the resident so that staff would know what to do, what to implement, plan and how to evaluate and provide proper care. b. During a review of Resident 15's admission Record (AR), the AR indicated Resident 15 was admitted to the facility on [DATE], with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), dysphagia (difficulty swallowing), and quadriplegia (paralysis from the neck down, including legs, and arms). During a review of Resident 15's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/12/2025, the MDS indicated Resident 15 had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 15 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During a review of Resident 15's Radiology Report (RR) result date 11/25/2025, the RR indicated Resident 15 had bilateral multifocal (multiple spots in both lungs) pneumonia with a right-sided effusion (buildup of fluid). During a review of Resident 15's Order Summary Report (OSR) dated 11/26/2025, the OSR indicated for licensed staff to administer Azithromycin (antibiotic medication that destroys microorganisms) Oral Tablet 500 milligrams (mg, unit of measurement) one time a day for pneumonia (an infection/inflammation in the lungs) for five days. During a review of Resident 15's Care Plan (CP) for pneumonia initiated on 8/13/2025, the CP did not indicate Resident 15 had pneumonia on 11/25/2025. During an interview and concurrent record review on 12/19/2025 at 3:17 pm with the Licensed Vocational Nurse 2 (LVN 2) of Resident 15's medical records (PointClickCare - PCC, a cloud-based software), LVN 2 stated Resident 15 had pneumonia on 11/25/2025 and the CP for pneumonia initiated on 8/13/2025 was not revised. LVN 2 stated Resident 15's CP for pneumonia needed to be revised to determine if nursing interventions were effective or not. LVN 2 stated it was the Registered Nurse Supervisor who should revise and update the resident's CP. c. During a review of Resident 22's AR, the AR indicated Resident 22 was admitted to the facility on [DATE], with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support) and encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing). During a review of Resident 22's MDS dated [DATE], the MDS indicated Resident 22 had severely impaired cognition. The MDS indicated Resident 22 was dependent on staff for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During a review of Resident 22's CP for weight loss, revised on 2/11/2025, the CP did not indicate Resident 22 had a weight loss in 10/2025 and 11/2025. During a review of Resident 22's Monthly Weight Record (MWR), the MWR indicated Resident 22 weighed 188 pounds (lbs.- unit of measurement) in 10/2025 and 181 lbs. in 11/2025. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review on 12/16/2025 at 2:56 pm, with LVN 2 of Resident 22's PCC, LVN 2 stated Resident 22 had a weight loss of six lbs. in 10/2025 and seven lbs. in 11/2025 and Resident 22's CP for weight loss that was revised on 2/11/2025 was not revised to reflect the weight loss in 10/2025 and 11/2025. LVN 2 stated Resident 22's CP for weight loss needed to be revised to determine if nursing interventions were effective or not on how to manage Resident 22's weight loss. During an interview on 12/18/2025 at 10:46 am, with the facility's Director of Nursing (DON), the DON stated resident's CP should have been revised if there was a change of condition such as recurrent Pneumonia for Resident 15 and weight loss for Resident 22 to determine if nursing interventions provided were effective or not. During a review of the facility's Policy and Procedure (P&P) titled, Care Planning, reviewed 1/13/2025, the P&P indicated care plans shall be reviewed quarterly and revised PRN (as needed).		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow proper food storage handling practices in accordance with its policy and procedure (P&P) by failing to label and discard expired food items stored in one of one resident's refrigerator located inside the supply room at the nurse's station. The facility staff did not label food items with resident's name and current date. The facility staff did not remove expired food items from the resident's refrigerator. These deficient practices had the potential to result in foodborne illness (illness caused by consuming contaminated food or beverages) for the residents. Findings: During initial observation of the resident's refrigerator inside the supply room on 12/16/2025 at 12:11 PM, one box of pastries did not have a resident's name, room number or an expiration date, two blueberry yogurts did not have a resident's name or room number, six Ensure Drinks (nutritional supplement designed as meal replacement or dietary supplement) did not have a resident's name or room number, five assorted flavored gelatin cups inside a white plastic bag was dated 12/08/2025 with Resident 1's name, and one soda bottle dated 10/29 also for Resident 1. During an interview with License Vocational Nurse (LVN 4) on 12/16/2025 at 12:17 PM, LVN 4 stated there were only three residents that their family would leave food for. LVN 4 stated staff would place the food inside the resident's refrigerator. LVN 4 stated all food items inside the resident's refrigerator should include the resident's name, the date when the food item was received and when the item would expire. LVN 4 stated, if a resident ate a food item that has expired/spoiled, the resident could get sick. LVN 4 stated expired food items should be thrown away. LVN 4 stated staff were not supposed to mix expired foods with non-expired foods because expired food could be given to the residents and cause them to get sick. LVN 4 stated, in order to prevent having expired food inside the resident's refrigerator, the food items should be labeled with the resident's name or room number and the open and expired date or use by date. During an interview with the Director of Nursing (DON) on 12/18/2025 at 11:00 AM, the DON stated resident's family and friends could bring food for the residents but the food needed to have the residents name, date received, date of expiration, and if expired the food should be removed from the refrigerator. The DON stated the Dietary Staff and Registered Nurse Supervisor (RNS) should check every shift to ensure there were no expired food inside the resident's refrigerator and if there was, then it should be thrown out. During an interview with the Infection Prevention Nurse (IPN) on 12/18/2025 at 12:02 PM, the IPN stated, if the resident's family brought food, it should be placed inside the resident's refrigerator and labeled with the resident's room number and date of expiration. The IPN stated, if a food item did not have an expiration date, it was not safe to give the food to a resident because it could make them sick and cause stomach problems like nausea, vomiting and/or diarrhea (lose bowel movement). The IPN stated once a food item was placed inside the resident's refrigerator, it was considered to be expired after 72 hours and must be discarded. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition where the lungs gradually become unable to get enough oxygen into the blood), sepsis due to streptococcus pneumonia (a life-threatening condition where the body's extreme response to a bacterial infection damages tissues and organs), major depressive disorder (mood disorder causing persistent sadness, hopelessness, and loss of interest in activities) and paraplegia (paralysis of the legs and lower body). During a review of Resident 1's Order Summary Report (OSR) dated 9/14/2024, the OSR indicated, Regular diet. Pureed (thick liquid suspension) texture, Regular/Thin consistency, puree/thin liquid, 3 meals a day, .1:1 feeder (dedicated caregiver needed to assist with eating) with full aspiration (food enters the airway by accident) precautions. During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 9/16/2025, the MDS indicated Resident 1 had intact (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive skills (ability to process thoughts) and was dependent (helper does all of the effort to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of the facility's P&P titled, Food: Safe Handling for Foods from Visitors, dated 1/2021, the P&P indicated, Patients will be assisted in properly storing and safely consuming food brought into the hospital for patients by visitors. When food items are intended for consumption, the hospital staff responsible will: Label foods with the patient's name and the current date. During a review of the facility's P&P titled, Use and Storage of Food Brought by Family/Visitors, reviewed 4/23/25, the P&P indicated, It is the right of the residents of this facility to have food brought in by family or other visitors, however the food must be handled in a way to ensure the safety of the resident. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. If not consumed within 3 days, food will be thrown away by the facility staff.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote one of one sampled resident (Resident 15) with respect, privacy and dignity in accordance to facility's Policy and Procedure(P&P) titled Promoting/Maintaining Resident Dignity/Quality of Life. This deficient practice had the potential to cause psychosocial (mental and emotional well-being) decline and lowered self-esteem and self-worth. Findings: During a review of Resident 15's admission Record (AR), the AR indicated Resident 15 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing), history of urinary tract infection (infection that affects part of the urinary tract) and quadriplegia (paralysis from the neck down, including legs, and arms). During a review of Resident 15's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/12/2025, the MDS indicated Resident 15 had intact cognition (process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 15 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During an observation on 12/16/2025 at 9:20 am with Registered Nurse 1 (RN 1), in Resident 15's room, Resident 15 was awake, lying in bed. RN 1 pulled up Resident 15's gown, checked Resident 15's foley catheter tubing attachment and did not ask permission from Resident 15. Resident 15 stated Oh, wait wait, you did not ask permission. No! During an interview on 12/16/2025 9:22 AM with RN 1, RN 1 stated, RN1 should have asked permission from Resident 15 and explained the procedure to Resident 1. RN 1 stated Resident 15 had the right to refuse care and treatment. During an interview on 12/18/2025 at 10:41 am with the facility's Director of Nursing (DON), the DON stated staff needed to introduce themselves and explain the procedure before touching the resident. The DON stated staff needed to ask consent from the resident to provide privacy and respect. The DON stated residents have the right to refuse and know the care provided to them. During a review of the facility's P&P titled, Promoting/Maintaining Resident Dignity/Quality of Life dated 1/28/2025, the P&P indicated to explain care or procedures to the resident before initiating the activity.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on interview and record review, the facility failed to complete a comprehensive assessment within 14 days after a change of condition for one of one sampled resident (Resident 4). This deficient practice placed Resident 4 at risk for delayed implementation of clinical interventions. Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 1 was admitted to the facility 10/21/25 with diagnoses including chronic respiratory failure (lungs cannot adequately oxygenate {supply with oxygen} the blood or remove enough carbon dioxide), chronic obstructive pulmonary disease (lung condition causing breathing difficulties) and heart failure (heart muscle isn't pumping blood effectively). During a review of Resident 4's History & Physical (H&P) dated 10/22/25, the H&P indicated Resident 4 did not have the capacity to make medical decisions. During a review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 11/3/25, the MDS indicated Resident 4's cognition (ability to think and process information) was severely impaired and Resident 4 was dependent for activities of daily of living (ADLs). During a review of Resident 4's Order Summary Report (OSR) dated 11/9/25, the OSR indicated weekly weights for four weeks due to (d/t) 24 pounds (lbs.) weight loss. The OSR dated 10/22/25 indicated weekly weight x four (for four times) for gain/loss of 5 lbs. During a review of Resident 4's Weekly Weights (WW), the WW indicated Resident 4 weighed 229 lbs. on 10/23/25 lbs., 205 lbs. on 11/4/25, and 194 lbs. on 12/8/25. During a concurrent interview and record review of Resident 4's clinical record on 12/16/25 at 3:41 p.m., with Licensed Vocational Nurse 2 (LVN 2), there was no Situation, Background, Assessment, Recommendation (SBAR) completed and LVN 2 stated there should be an SBAR completed for Resident 4. LVN 2 stated there should be an SBAR for every change of condition on a resident. LVN 2 stated a resident must have an SBAR, so staff will be aware of the condition of the resident and what interventions needed to be done. During the same record review, there was no change of condition comprehensive assessment MDS completed indicating Resident 4's 24 lbs. weight loss on 11/4/2025 and additional 11 lbs. weight loss on 12/8/25. During an interview, on 12/18/25, at 2:25 p.m., with the Infection Preventionist (IPN), the IPN stated it was important to complete a change of condition assessment as the primary plan of care for the resident so that staff would know what to do, what to implement, plan and how to evaluate and provide necessary care. During a record review of the facility's Policy and Procedure (P&P), titled, Change of Condition-SBAR- ADLs, dated January 2025, the P&P indicated it is the policy of the facility that any changes in a resident's condition be thoroughly assessed and evaluated with physician notification for early clinical management to avoid unnecessary readmissions to acute hospitals. The P&P further indicated the facility may use the SBAR process to assess and evaluate the resident's change of condition.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 28)'s discharge destination was coded accurately in the Minimum Data Set (MDS - a federally mandated resident assessment tool). Resident 28 was discharged to a general acute care hospital but was coded as being discharged to Skilled Nursing Facility (SNF - an inpatient rehabilitation and medical treatment center staffed with medical professionals). This deficient practice resulted in inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and works with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to result in Resident 28 not receiving interventions to address specific care concerns. Findings: During a review of Resident 28's admission Record (AR), the AR indicated Resident 28 was admitted to the facility on [DATE] with diagnoses that included dependence on respiratory ventilator (machine that helps a person breathe), dependence on supplemental oxygen, and encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for medication/nutritional support). During a review of Resident 28's Physician's Order (PO) dated 11/13/2025, the PO indicated for facility staff to call 911 (phone number used to contact emergency services in the event of a medical emergency) due to resident's fever not relieved by Tylenol (medicine that relieves mild to moderate pain and reduces fever) and cooling measures. During a review of Resident 28's Progress Notes (PN) dated 11/13/2025 at 6:09 am, the PN indicated Resident 28 was transferred to an acute hospital at 6:20 am. During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 was discharged to a nursing home/SNF (long term care facility). During a concurrent interview and record review of Resident 28's MDS with MDS Coordinator (MDSC) on 12/17/2025 at 11:39 am, the MDSC stated Resident 28's MDS was coded as discharged to a SNF. The MDSC stated Resident 28 was discharged to an acute care hospital on [DATE] and not to a SNF. The MDSC stated Resident 28's MDS assessment needed to be coded as discharged to an acute hospital. The MDSC stated Resident 28's MDS assessment needed to be coded accurately to provide accurate information to CMS. During an interview with the facility's Director of Nursing (DON) on 12/18/2025 at 10:38 am, the DON stated, MDS assessment needed to be coded accurately to ensure the facility was not sending wrong information to CMS. During a review of the facility's Policy and Procedure (P&P) titled, Minimum Data Set 3.0 Assessment Completion, Transmission and Validation, dated 1/14/2025, the P&P indicated, To develop and modify the resident's plan of care based on the resident's status. The Resident Assessment Instrument (RAI) Coordinator will schedule all OBRA (Omnibus Budget Reconciliation Act) ARD's daily, monthly and as needed. Addendums to the schedule will be provided by the RAI Coordinator to the IDT as needed as it relates to Discharge Assessments and SCSA's (Significant Change in Status Assessments).		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to report a change of condition (COC) for symptoms of a urinary tract infection (UTI) to the physician (MD) for one of three sampled residents (Resident 4) with foley catheter (a flexible tube that passes through the urethra and inserted into the bladder to drain urine). Resident 4's foley catheter tubing had cloudy, white urine sediments (bacteria and white blood cells are shed into the urine). This failure had the potential to result in delay of care and treatment of urinary tract infection (UTI) and unmanaged UTI pain. Findings: During a review of Resident 4's admission Record (AR), the AR indicated Resident 1 was admitted to the facility 10/21/25 with diagnoses including chronic respiratory failure (lungs cannot adequately oxygenate {supply with oxygen} the blood or remove enough carbon dioxide), chronic obstructive pulmonary disease (lung condition causing breathing difficulties) and heart failure (heart muscle isn't pumping blood effectively). During a review of Resident 4's History & Physical (H&P) dated 10/22/25, the H&P indicated Resident 4 did not have the capacity to make medical decisions. During a review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 11/3/25, the MDS indicated Resident 4's cognition (ability to think and process information) was severely impaired and Resident 4 was dependent on activities of daily of living (ADLs). The MDS indicated Resident 4 had an indwelling catheter (foley catheter). During a review of Resident 4's Order Summary Report (OSR) dated 10/22/25, the OSR indicated to monitor foley catheter for hematuria (blood in urine), sediments, foul smelling urine, and color of urine. During a concurrent observation and interview on 12/16/25, at 4:20 p.m., with Licensed Vocational Nurse 2 (LVN 2), white cloudiness was observed in the tubing of Resident 4's indwelling foley catheter. LVN 2 stated the white cloudiness observed in Resident 4's foley catheter tubing could be urine sediments. LVN 2 stated urine sediments could be a sign of infection. LVN 2 stated the tube should be flushed or changed and the physician (MD) notified. LVN 2 stated LVN 2 observed the sediments in the foley catheter tubing this morning but LVN 2 did not report it to the MD as of this interview. LVN 2 stated it was important to report a resident's COC to the MD because the MD would know what interventions to implement to prevent the situation from getting worse. During an interview on 12/17/25 at 9:03 a.m., with the facility's Infection Preventionist (IPN), the IPN stated Resident 4 had a foley catheter due to (d/t) a history of (h/o) Stage 3 pressure ulcer (bedsore involving full-thickness skin loss). The IPN stated nursing staff should have reported the cloudiness observed in Resident 4's foley catheter tubing. The IPN stated the licensed nurse should have flushed or changed the foley catheter tubing. During a subsequent interview with LVN 2 on 12/17/25 at 10:00 a.m., LVN 2 stated LVN 2 observed the cloudiness in Resident 4's Foley tubing around 10:00 a.m. on 12/16/2025. LVN 2 stated LVN 2 did not notify the physician because LVN 2 was all over the place and was asked to complete other tasks. LVN 2 stated the steps LVN 2 should have taken when cloudiness was observed in the foley catheter tubing included notifying the MD, completing a Situation, Background, Assessment, Recommendation (SBAR), initiating a care plan, determining if there was a need for continuing the foley catheter and flushing the foley catheter tubing and changing the bag as needed. During a review of the facility's Policy and Procedure (P&P) titled, Change of Condition- SBAR- ADLs, dated January 2025, the P&P indicated it was the policy of the facility that any changes in a resident's condition be thoroughly assessed and evaluated with physician notification for early clinical management to avoid unnecessary readmissions to acute hospitals. The P&P further indicated the facility may use the SBAR process to assess and evaluate the resident's change of condition.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Registered Dietitian's (RD) recommendation for one of one sampled resident (Resident 22) to start weekly weights on 11/5/2025 was implemented/carried out and communicated to the physician. This deficient practice had the potential to result in adverse consequences for Resident 22. Findings: During a review of Resident 22's admission Record (AR), the AR indicated Resident 22 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for medication/nutritional support), encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing) and anemia (decrease in the total amount of red blood cells in the blood). During a review of Resident 22's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/25/2025, the MDS indicated Resident 22 had severely impaired cognition (mental action or process of acquiring knowledge) for daily decision making. The MDS indicated Resident 22 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During a review of Resident 22's Care Plan (CP) for weight loss revised on 2/11/2025, the CP indicated Resident 22 was at risk for weight loss secondary to chronic medical condition. The CP indicated for nursing staff to monitor Resident 22's weight as ordered, RD consult to adjust diet as needed and to weigh Resident 22 every week as ordered. During a review of Resident 22's Monthly Nutritional Review (MNR) dated 11/5/2025, the MNR indicated weighing Resident 22 weekly to monitor changes. During an observation on 12/16/2025 at 9:13 am while inside Resident 22's room, Resident 22 was asleep lying in bed. During a concurrent record review of the facility's Monthly Nutritional Review dated 11/5/2025 and interview on 12/16/2025 at 2:25 pm with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated the RD recommended to monitor Resident 22's weight every week for the month of November 2025. LVN 2 stated there was no clinical documentation that weekly weights were done for Resident 22. LVN 2 stated Resident 22's primary physician was not notified regarding the RD's recommendation. LVN 2 stated weekly weights needed to be monitored to determine if Resident 22 was losing or gaining weight. LVN 2 stated the RD recommendation needed to be communicated to Resident 22's primary physician to prevent significant weight problems on Resident 22. During a concurrent record review of the facility's Monthly Nutritional Review dated 11/5/2025 and interview on 12/17/2025 at 2:03 pm with the facility's RD, the RD stated Resident 22 had a total weight loss of 13 pounds (lbs.) in two months and the RD's recommendation to monitor Resident 22's weekly weight for November 2025 was not carried out nor communicated to the primary physician. The RD stated the RD expected from the staff to follow through the RD's recommendation every month and to notify the primary physician to monitor the resident's weight. During an interview on 12/18/2025 at 10:46 am with the facility's Director of Nursing (DON), the DON stated, RD recommendation for Resident 22 was not followed and the primary physician was not notified with the RD's recommendation to monitor Resident 22's weight weekly for November 2025. The DON stated Resident 22's nutritional needs would not be met and could lead to weight loss or gain if the RD's recommendation was not acted upon. During a review of the facility's Policy and Procedure (P&P) titled, Medical Nutrition Therapy: Nutrition Screening, Assessment and Care Planning dated 1/2021 the P&P indicated, the Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional's recommendations for changes in the nutrition plan of care will be communicated to the licensed nursing team and dining Services Director via the summary recommendation sheet.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, one of one License Vocational Nurse (LVN 3) did not flush Resident 23's Gastrostomy Tube (GT- a feeding tube placed directly into the stomach through the abdominal wall, used to deliver nutrition, fluids, and medicine) with water before and after giving medication, to prevent the GT from clogging, to ensure the medication passes, and ensure patency of the GT for future use. This deficient practice had the potential to result in negative consequences for Resident 23. Findings: During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (a condition when the lungs cannot get enough oxygen into the blood), encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing), dysphagia (difficulty swallowing food or liquids) and encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for medication/nutritional support). During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/27/2025, the MDS indicated Resident 23 has severely impaired cognition (mental action or process of acquiring knowledge). The MDS indicated Resident 23 was dependent (helper does all of the effort) to staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing, and personal hygiene. During a review of Resident 23's Order Summary Report (OSR) dated 4/17/2025, the OSR indicated Resident 23 was placed on nothing by mouth (NPO) diet and was on enteral feeding (delivering specially formulated liquid nutrition directly into the stomach through the GT). The order indicated licensed staff may give additional 30 milliliters (ml- unit of measurement) of water during medication pass. During a medication administration observation with LVN 3 for Resident 23 on 12/18/2025 at 9:06 AM, LVN 3 administered the morning medications to Resident 23 via GT without flushing the GT with water before and after each medication. During the same medication observation, LVN 3 did not flush Resident 23's GT with water after all medications had been administered. During an interview with LVN 3 on 12/18/2025 at 9:07 AM, LVN 3 stated LVN 3 did not know if Resident 23 was on fluid restriction and that was the reason why LVN 3 did not flush Resident 23's GT with water during medication administration and once the medication administration was completed. During a concurrent interview with LVN 3 on 12/18/2025 at 9:12 AM, LVN 3 stated after giving all of Resident 23's medications, LVN 3 should have given an additional 30 ml. of water to ensure the medications went into the gastric area and did not stay in the GT. LVN 3 stated if there was not enough water flush after medication administration, the medication would stay in the GT and the GT would get clogged. LVN 3 stated LVN 3 did not flush Resident 23's GT with water in between medications because LVN 3 thought it was too much water for Resident 23. During an interview with the facility's Director of Nursing (DON) on 12/18/2025 at 10:21 AM, the DON stated when the licensed nurse administered medications through the GT, the medications were supposed to be flushed with water after each individual medication was given. The DON stated, the licensed nurse needed to flush the GT with no more than 15 to 20 ml of water before administering the medication, then flush the GT again with 5 to 10 ml of water. The DON stated that each medication needed to be given one at a time and the licensed nurse should flush the GT with water. The DON stated the licensed nurse should flush the GT with about 30 ml of additional water to ensure the GT was not clogged and that the medications did not stay in the GT. During an interview with the facility's Infection Prevention Nurse (IPN) on 12/18/2025 at 2:29 PM, the IPN stated licensed nurses were aware that when administering multiple medications through the GT, the licensed nurse should flush the GT with water before and after each medication. The IPN stated licensed staff had to flush the GT in between medication with at least 5 ml. water and even if the medication was mixed with water and had been diluted (weakened by addition of water), the medication still needed to be flushed with water after administration. The IPN (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, if the medication was in a syrup consistency/form, it was not considered as a flushed medication and there should be at least 5m.l of water flushed after administration. The IPN stated if this procedure was not done, it was considered to be a medication administration error. During the same interview with the IPN on 12/18/2025 at 2:32 PM, the IPN stated, the license nurse should flush the GT with 30-60 ml water before and after giving any medication to prevent clogging the GT, to ensure the medicine passed through the GT and to keep the GT clear/patent for future use. The IPN stated, flushing the GT with water in between each separate medication was very important to ensure the intended results of the medications were achieved. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration (Nasogastric, Gastric and Jejunostomy) dated 1/14/2025, the P&P indicated, Flush the tube with approximately 30 ml. of water before and after medication administration. Rinse medication cup and administer rinsing to assure complete dose. Flush in between medication administration 5ml to 10ml of water.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act upon the pharmacist's Medication Regimen Review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) recommendation for one of five sampled residents (Resident 1) to specify the behavior manifestation to be monitored for Resident 1's routine Xanax (a medication used for the short-term treatment of anxiety disorders and panic disorders) 0.5 milligrams (mg- unit of measurement) QHS (every night at bedtime) for anxiety, ordered on 9/13/2025, for the months of October and November 2025. This deficient practice had the potential for Resident 1 to receive unnecessary medications and result in undesirable or non-therapeutic effect of the medication to the resident. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition where the lungs gradually become unable to get enough oxygen into the blood), sepsis due to streptococcus pneumonia (a life-threatening condition where the body's extreme response to a bacterial infection damages tissues and organs), major depressive disorder (mood disorder causing persistent sadness, hopelessness, and loss of interest in activities) and paraplegia (paralysis of the legs and lower body, typically caused by spinal injury or disease). During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 9/16/2025, the MDS indicated Resident 1 had intact cognitive skills (ability to process thoughts) and was dependent (helper does all of the effort to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 1's Order Summary Report (OSR) dated 10/10/2025, the OSR indicated for licensed staff to give Xanax Oral Tablet 0.25 mg by mouth at bedtime for anxiety. During a review of the MRR for the months of October and November 2025, dated 10/24/25 through 10/24/25 and 11/23/2025 through 11/23/2025, the MRR indicated a note written by the pharmacy consultant to the physician regarding Resident 1 as follows: Please specify the behavior manifestation to be monitored for patient's routine Xanax 0.5mg q HS for anxiety ordered on 9/13/25. Monitor this behavior every shift on the Medication Administration Record (MAR- form used to document and tract medications given to residents) and add in the Xanax order. During an interview with the facility's Director of Nursing (DON) on 12/18/2025 at 10:31 AM, the DON stated Resident 1's medications should be verified by the doctor for specific indication to monitor the behaviors as to why the resident was getting Xanax. The DON stated the monitoring for target behavior for all psychotropic medication (medication used to treat mental health conditions) should be done by the primary nurse, and the resident should be monitored every shift. During the same interview with the DON on 12/18/2025 at 10:42 AM, the DON stated licensed staff needed to monitor Resident 1 to determine if Xanax was effective or not. The DON stated the pharmacist's recommendation was important to acknowledge and for the licensed staff to notify the physician of the pharmacist's recommendation. The DON stated it should not take three months to act upon the pharmacist's recommendation for Resident 1. The DON stated, if the physician has not reviewed the pharmacist's recommendations, it can be emailed or faxed over to the physician. The DON stated the House Supervisor or the Infection Prevention Nurse (IPN) were responsible for calling the physician about the pharmacist's recommendations. The DON stated the purpose of the pharmacist's monthly recommendation was to point out the necessity of the medications and to check for unnecessary medication for the residents (in general). During a review of the facility's Policy and Procedure (P&P) titled Medication Regimen Review dated June 2021, the P&P indicated, The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, Licensed Vocational Nurse 5 (LVN 5) failed to ensure medications were kept secure by failing to lock one of one medication cart (MedCart) that was left unattended and outside of LVN 5's view while providing medication to Resident 3. This deficient practice had the potential for the residents' medications to be accessible to others not authorized to have access to drugs (medications) and biologicals (drugs derived from natural sources) and increased the risk for loss and medication diversion (illegally redirecting prescription medications from intended patient for personal use). Findings: During medication pass observation on 12/18/2025 at 8:25 AM with LVN 5 in the hallway outside Resident 3's room, LVN 5 left the MedCart in the hallway unlocked. During an interview with LVN 5 on 12/18/2025 at 8:38 AM, LVN 5 stated, I did not lock my MedCart when I went inside the resident's room (Resident 3) to give medications. I should have locked the MedCart and not left it unlocked for safety. During an interview with LVN 3 on 12/18/2025 at 9:26 AM, LVN 3 stated, We (licensed staff) must lock the MedCart for safety and we don't want anyone passing by get access to patients' medications. Locking the MedCart was also to keep patient confidentiality. It was very important to have the MedCart locked if the license nurse walked away. During an interview with the facility's Director of Nursing (DON) on 12/18/2025 at 10:21 AM, the DON stated the MedCart needed to be locked if it was outside of licensed nurse's view. Per the DON, when a nurse is administering medication the medication cart is supposed to be locked if the nurse walks away to prevent people from taking medication, it's for safety. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including chronic respiratory failure (a long-term condition where the lungs gradually become unable to get enough oxygen into the blood) and sepsis due to staphylococcus (a life-threatening condition where the body's extreme response to a bacterial infection damages tissues and organs). During a review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 10/13/2025, the MDS indicated Resident 3 had severely impaired cognitive skills (ability to process thoughts) and was dependent (helper does all of the effort to complete the activity) for eating, oral hygiene, toileting hygiene, shower/bathing, upper and lower body dressing, and personal hygiene. During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage in the Facility, dated April 2008, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement and follow infection prevention procedures to prevent the transmission of infectious organisms for one of five sampled residents (Resident 24) by failing to wear proper personal protective equipment (PPE, equipment that protects people from injury or illness in hazardous environments) while providing care to Resident 24 who was placed on Enhanced Barrier Precaution (EBP, precautions that involve using a glove and gown during high-contact resident care activity for residents who are colonized or infected with an multidrug-resistant organisms [MDRO, bacteria that is resistant to many types of antibiotics] and those at a higher risk of developing a MDRO, such as, residents with wounds or indwelling medical devices). This deficient practice had the potential to transmit infectious microorganisms and increase the risk of infection for Resident 24 and staff that could result in a widespread infection in the facility. Findings: During a review of Resident 24's admission Record (AR), the AR indicated Resident 24 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (GT, creation of an artificial external opening into the stomach for nutritional support) and encounter for attention to tracheostomy (surgical opening in the throat in which a tube is placed for the resident's breathing). During a review of Resident 24's Order Summary Report (OSR) dated 4/16/2025, the OSR indicated to place Resident 24 on EBP due to presence of tracheostomy. During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/27/2025, the MDS indicated Resident 24 had severely impaired cognition (mental action or process of acquiring knowledge). The MDS indicated Resident 24 was dependent (helper does all of the effort) on staff for eating, oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During a review of Resident 24's undated Care Plan (CP) titled Enhanced Barrier Precautions, the CP indicated Resident 24 had a tracheostomy and gastrostomy. The CP indicated for nursing staff to observe infection prevention and control at all times such as frequent handwashing and the use of proper PPE as necessary. During an observation on 12/16/2025 at 9:33 am, Resident 24 was awake lying in bed in Resident 24's room. During a concurrent observation and interview on 12/16/2025 at 9:34 am, Resident 24 was lying in bed. Registered Nurse 1 (RN 1) did not wear gown and clothes while touching Resident 24's bed and bedding while assessing Resident 24 GT site. RN 1 stated RN 1 did not wear a protective gown while doing assessment with Resident 24. During an interview on 12/16/2025 at 1:43 pm with the Infection Preventionist Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings), the IPN stated staff needed to wear gown, gloves and mask before touching Resident 24 who was on EBP to avoid the spread of infection from staff to other residents. The IPN stated staff needed to wear appropriate PPE because residents (in general) were susceptible to infection and to prevent cross contamination (the process by which bacteria or other microorganisms are transferred from one substance or object to another). During a review of the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated 1/14/2025, the P&P indicated, Refer for the use of gown and gloves for use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (residents with wounds or indwelling medical devices. Initiation of EBP - wounds and/or indwelling medical devices (central lines, hemodialysis, urinary catheters, feeding tubes, tracheostomy/ventilator tubes even if the resident is not known to be infected or colonized with a MDRO.		