

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555832	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/30/2024
NAME OF PROVIDER OR SUPPLIER Clara Baldwin Stocker Home for Women		STREET ADDRESS, CITY, STATE, ZIP CODE 527 S Valinda 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>34273</p> <p>Based on observation, interview, and record review, the facility failed to ensure unauthorized person/s did not enter the facility undetected when:</p> <ol style="list-style-type: none"> 1. The facility back door remained unlocked to the outside of the facility after dark. 2. Licensed Vocational Nurses (LVNs) 1, 2, 3, and 4 did not know how to lock the facility doors. <p>These failures had the potential to compromise the safety of 37 of 37 residents in the facility and placed the residents at risk for accident hazards and harm.</p> <p>Findings:</p> <p>During an observation on 9/30/24 at 4:25 am, the facility's gate to the staff parking area located in the back of the facility was wide open and allowed entry to the staff parking area and access to the facility back door. There was no one in the staff parking area and the area was not well-lighted. The small gate located just before the facility back door was wide open and allowed easy access to the facility back door which was unlocked. The facility back door easily pulled open and allowed entry to the facility.</p> <p>During an interview on 9/30/24 at 4:31 am with LVN 1, LVN 1 stated the facility back door had been unlocked to the outside every night since LVN 1 started working the 11 pm to 7 am shift 3 weeks ago. LVN 1 stated the gate to the staff parking area was supposed to be locked and opened with a passcode, but it had been left opened and unlocked. LVN 1 stated LVN 1 did not know how to lock the facility back door and did not know how to lock the small gate located just before the back door.</p> <p>During an interview on 9/30/24 at 4:35 am with LVN 2, LVN 2 stated the facility back door had always been unlocked to the outside since LVN 2 started working the 11 pm to 7 am shift 2 months ago. LVN 2 stated the facility front door had always been locked to the outside of the facility and people had to ring the bell for an employee to open the door and allow entry to the facility.</p> <p>During an interview on 9/30/24 at 4:50 am with LVN 2, LVN 2 stated LVN 2 did not know how to lock the facility back door.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/30/24 at 5:50 am with the Director of Nursing (DON), the DON stated the chain to the gate of the staff parking area in the back of the facility broke in September 2024, but the DON did not know the exact date when it broke. The DON stated the gate to the staff parking area in the back was supposed to be locked with a passcode. The DON stated the facility doors must be locked so unauthorized people from the outside did not enter the facility. The DON stated it was important to lock the facility doors for the safety of the property, the residents, and the employees. The DON stated all Certified Nursing Assistants (CNAs) and Licensed Nurses (LNs) needed to know how to lock the facility doors.</p> <p>During an interview on 9/30/24 at 6:25 am with CNA 1, CNA 1 stated the gate to the staff parking area in the back of the facility broke a month ago. CNA 1 stated the small gate located just before the back door and the facility back door had always been unlocked to the outside since CNA 1 started working the 11 pm to 7 am shift 2 1/2 months ago. CNA 1 stated it was important to lock the facility doors especially at night for the safety of the residents and the employees.</p> <p>During an interview on 9/30/24 at 6:40 pm with LVN 1, LVN 1 stated LVN 1 heard from LVN 5 someone who was not an employee, a resident, or a resident's family entered the facility through the back door once before, but LVN 1 was unable to provide details of the incident. LVN 1 stated LVN 1 was never shown how to lock facility gates and doors when LVN 1 started working in the facility.</p> <p>During an interview on 9/30/24 at 6:56 am with CNA 2, CNA 2 stated CNA 2 had been working in the facility since 2020. CNA 2 stated facility doors must be locked at night. CNA 2 stated the CNAs did not have access to the key to lock facility doors but the LNs did.</p> <p>During an interview on 9/30/24 at 7:12 am with LVN 2, LVN 2 stated LVN 2 was never shown how to lock facility doors when LVN 2 started working in the facility. LVN 2 stated it was important to lock the doors for employees' and residents' safety, and so outsiders did not go inside the facility.</p> <p>During an interview on 9/30/24 at 8:15 am with LVN 3, LVN 3 stated the facility front doors were always locked and people had to ring the bell for an employee to let them in to the facility. LVN 3 stated the facility doors did not have to be locked during the day shift (7 am to 3:30 pm) because there was always a receptionist. LVN 3 stated it was important to lock the facility doors for the safety of the residents and staff, and to monitor who came in and out of the facility. LVN 3 stated LVN 3 did not know how to lock the facility back door.</p> <p>During an interview on 9/30/24 at 8:52 am with CNA 3, CNA 3 stated facility doors must be locked at night because there were a lot of homeless people who wandered outside the facility. CNA 3 stated it was important to lock facility doors for safety reason.</p> <p>During a concurrent observation and interview on 9/30/24 at 1:11 pm with the Maintenance Assistant (MA), the MA stated licensed nurses were responsible for locking the facility doors at night. The MA stated the key to lock and unlock the facility doors was on a purple lanyard (a cord worn around the neck) key ring kept inside the medication cart in Station 1. LVN 4 handed the purple lanyard key ring to the MA and the MA unlocked and locked the facility front door with one of the keys on the purple lanyard key ring. The MA stated the key to lock/unlock the facility front door was the same key to lock/unlock the facility back door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/30/24 at 1:20 pm with LVN 3, LVN 3 stated LVN 3 did not know that the key to lock/unlock the facility front door was the same key to lock/unlock the facility back door.</p> <p>During an interview on 9/30/24 at 1:24 pm with LVN 4, LVN 4 stated LVN 4 did not know that one of the keys attached to the purple lanyard key ring was the key to lock/unlock facility doors. LVN 4 stated LVN 4 had seen homeless people around the facility front door before, but the front door was always locked.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, dated 7/2017, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Our facility-oriented approach to safety addresses risks for groups of residents. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (quality assurance and performance improvement) reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. When accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review the facility failed to implement its policy and procedure (P&P) titled, Isolation (separation of residents with an infection from residents without an infection) - Categories of Transmission-Based Precautions, when two of two residents (Residents 5 and 6) diagnosed with clostridium difficile (C. diff- a highly contagious bacteria that causes severe diarrhea) infection did not have their own package of incontinent wipes (disposable washcloths or wipes used to cleanse the skin and manage urine and/or stool) inside the isolation room during the night shift (11 pm to 7 am) on 9/30/24.</p> <p>This failure had the potential to spread infection to residents and staff.</p> <p>Findings:</p> <p>1. During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE], with diagnoses which included C. diff infection.</p> <p>During a review of Resident 5's Clinical Physician Orders (PO), dated 9/27/24, the PO indicated an order to place Resident 5 on contact isolation (intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment) for C. diff infection.</p> <p>2. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE], with diagnoses which included C. diff infection.</p> <p>During a review of Resident 6's PO, dated 9/18/24, the PO indicated to place Resident 6 on contact isolation for C. diff isolation.</p> <p>During an interview on 9/30/24 at 6:25 am with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 and CNA 2 were provided one package of incontinent wipes each to use for the entire night shift. CNA 1 stated CNA 1 did not find any extra incontinent wipes inside Resident 5's and Resident 6's room. CNA 1 stated Resident 5 and Resident 6 were on isolation for C. diff infection. CNA 1 stated CNA 1 did not have enough incontinent wipes to use for the entire shift.</p> <p>During an interview on 9/30/24 at 6:40 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated CNA 1 and CNA 2 told LVN 1 they did not have enough wipes to use for the entire shift. LVN 1 stated LVN 1 did not know where and how to get more incontinent wipes during the 11 pm to 7 am shift.</p> <p>During an interview on 9/30/24 at 6:56 am with CNA 2, CNA 2 stated CNAs in the facility were provided with only one package of incontinent wipes each to use for their shift. CNA 2 stated most of the time there were no incontinent wipes inside isolation rooms during the 11 pm to 7 am shift. CNA 2 stated CNA 2 did not know if licensed nurses on the 11 pm to 7 am shift were able to get more incontinent wipes.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>During an interview on 9/30/24 at 7:12 am with LVN 2, LVN 2 stated LVN 2 heard CNA 1 and CNA 2 did not have enough incontinent wipes to use during the 11 pm to 7 am shift. LVN 2 stated LVN 2 did not know where and how to get more incontinent wipes during the 11 pm to 7 am shift.</p> <p>During an interview on 9/30/24 at 8:52 am with CNA 3, CNA 3 stated CNAs in the facility were provided with only one package of 50 incontinent wipes each to use for their shift. CNA 3 stated the housekeeper would leave one package of incontinent wipes in each isolation room first thing in the morning during the day shift (7 am to 3 pm). CNA 3 stated CNAs on the day shift could ask the housekeeper for more incontinent wipes when the CNAs ran out of incontinent wipes.</p> <p>During an interview on 9/30/24 at 11:40 am with the Director of Nursing (DON), the DON stated residents who were on contact isolation for C. diff infection needed to have their own package of incontinent wipes in their rooms.</p> <p>During an interview on 9/30/24 at 12:24 pm with the Infection Prevention Nurse (IPN), the IPN stated residents who were on contact isolation for C. diff infection needed their own package of incontinent wipes in their rooms to avoid spreading infection to other residents in the facility.</p> <p>During an interview on 9/30/24 at 1:33 pm with the Housekeeper (HSK), the HSK stated the HSK put one package of 50 incontinent wipes in each isolation room every morning and provided one package of incontinent wipes to each CNA every shift. The HSK stated when CNAs ran out of incontinent wipes the CNAs could get more from the HSK. The HSK stated in case the HSK was not in the facility, licensed nurses had a key to the storage room where incontinent wipes were kept and could give more incontinent wipes to the CNAs.</p> <p>During a review of the facility's P&P titled, Isolation - Categories of Transmission-Based Precautions, dated 10/2018, the P&P indicated, when residents are placed on transmission-based precautions, non-critical resident-care equipment items will be dedicated to a single resident when possible.</p>		