STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555832	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clara Baldwin Stocker Home for Women	527 S Valinda Avenue West Covina, CA 91790

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain and maintain copies of advance directives (AD, a legal document explaining a resident's health care wishes when residents cannot speak for themselves) for four of six sampled residents (Residents 3, 6, 43, and 44).This failure had the potential to result in conflict regarding Residents' 3, 6, 43, and 44 health care choices. Findings: a. During review of Resident 3's face sheet. The face sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including but not limited to: arthritis (pain. swelling and stiffness of the joints) right knee infection, muscle weakness, and morbid obesity. During review of the Minimum Data Set (MDS- standardized assessment screening tool) dated 12/11 2025, the MDS indicated Resident 3's cognition was intact. During review of Resident 3's clinical records, the clinical records did not include the resident had an AD. During a concurrent interview and record review on 1/29/2026 at 3:36 PM with the Social Service Director (SSD), Resident 3's clinical records were reviewed. The clinical records indicated Resident 3 had an AD according to the Advance Health Care Directive Acknowledgement Form (AHCD). The SSD stated the AHCD form indicated Resident 3 has an AD, but it is not in their clinical records. The SSD stated it was important to have a copy of the AD in the Residents 3's chart to ensure their choices were honored. During review of the facility's policy and procedure (P&P) titled, Advance Directives dated December 2016, the P&P indicated the facility will comply with state and federal law regarding AD. Upon admission the resident will be provided with written information regarding acceptance or refusal of medical or surgical treatment. If there is an AD it will be placed in the resident's medical record. b. During a review of Resident 43's admission Record (AR), the AR indicated Resident 43 was admitted to the facility on [DATE] with multiple diagnoses including fibromyalgia (long term condition that causes widespread pain, extreme fatigue, and tenderness in muscles and joints throughout the body) and dementia (a gradual decline in mental ability usually caused by a brain disease). During a review of Resident 43's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 1/8/2026, the MDS indicated Resident 43 had impaired cognition (ability to understand and process information) and was dependent on staff for bathing and toileting. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 1/27/2026 at 3:50 PM with Licensed Vocational Nurse (LVN) 5, Resident 43's Advance Healthcare Directive Acknowledgement Form (AHDA), dated 10/24/2024 was reviewed. LVN 5 stated Resident 43's AHDA indicated Resident 43 had a current advanced healthcare directive but there was no copy found in Resident 43's medical chart. The AHDA further indicated if a client has an Advance Health Care Directive, insert a copy into the client's Clinical [medical] Record. c. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including metabolic encephalopathy (broad term for temporary or permanent brain dysfunction caused by an underlying condition) and heart failure (the inability of the heart to pump blood effectively). During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had intact cognition and required partial or moderate assistance (helper does less than half of the effort) for toileting and bathing. During a concurrent interview and record review on 1/28/2026 at 2:15 PM with LVN 3, Resident 6's AHDA, dated 12 /3/2025, was reviewed. LVN 3 stated Resident 6's AHDA indicated Resident 6 had a current advance health care directive. LVN 3 stated the form did not indicate whether the facility had a copy of Resident 6's advance health care directive and the copy was not in Resident 6's medical chart. The AHDA further indicated if a client has an Advance Health Care Directive, insert a copy into the client's Clinical Record. During an interview on 1/29/2026 at 4:18 PM with the Social Services Director (SSD), the SSD stated the facility did not have a copy of Resident 6 or Resident 43's advanced health care directives. The SSD stated it was important to have a copy of the advanced health care directives to be able to follow the residents' (in general) wishes for treatment. During a review of the facility's policy and procedure (P&P), titled Advance Directives, dated 12/2016 the P&P indicated advance directives will be respected in accordance with state law and facility policy. d. During a review of Resident 44's AR, the AR indicated the facility admitted Resident 44 on 12/19/2025 with diagnoses including displaced fracture of the upper end of right humerus (a break in the top of the right arm bone), subsequent encounter for fracture with routine healing (a follow up visit after the initial, active treatment of a broken bone) and a history of falling. During a review of Resident 44's H&P dated 12/20/2025, the H&P indicated Resident 44 had decision making capabilities. During a review of Resident 44's MDS dated [DATE], the MDS indicated Resident 44's cognitive skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 44 was dependent on transfers, toileting, showering, and lower body dressing, substantial assist with upper body dressing, required moderate assistance with oral hygiene, and supervision with eating. During a review of Resident 44's AHDA dated 12/19/2025, the AHDA indicated Resident 44 had an AD in place. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/28/2026 at 10:16 AM with Resident 44, Resident 44 stated Resident 44 had an AD and no one at the facility had asked for a copy of Resident 44's AD. During an interview on 1/29/2026 at 3:36 PM with the Social Service Director (SSD), the SSD stated Resident 44's AHDA dated 12/19/2025 indicated Resident 44 had an AD. The SSD stated the facility did not have a copy of Resident 44's AD. The SSD stated either the SSD or the admitting nurse (in general) were responsible for reaching out to Resident 44 or Resident 44's representative to obtain copies of the AD. The SSD stated it was important to have a copy of the AD in the residents' chart to ensure Resident 44's choices were honored. During a review of the facility's Policy and Procedure (P&P) titled, Advance Directives, revised December 2016, the P&P's policy statement indicated, Advance directives will be respected in accordance with state law and facility policy. The P&P's policy interpretation and implementation indicated, Prior to or upon admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure adequate indications for psychotropic medication (medication used to treat mental health disorders [conditions that affect thinking, feeling, mood, and behavior]) use and failed to ensure specific psychotropic medication behavior monitoring (tracking expressions or indications of distress) was completed for two of five sampled residents (Residents 7 and 64).These failures had the potential to result in unmet medical, physical, mental, and psychosocial needs (the emotional and social requirements that individuals must have to feel safe, supported, and capable of functioning well in their environment) to Residents 7 and 64 and had the potential to result in Residents 7 and 64 receiving unnecessary medications.Findings: a.During a review of Resident 7's admission Record (AR), the AR indicated the facility originally admitted Resident 7 on 1/3/2026 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities) and unspecified psychosis (a severe mental health condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition (the body's natural, healthy operating state). During a review of Resident 7's History and Physical (H&P), dated 1/4/2026, the H&P indicated Resident 7 did not have decision making capacities. During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool), dated 1/15/2026, the MDS indicated Resident 7's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (makes poor decisions requiring cues or supervision). The MDS indicated Resident 7 required substantial assistance with lower body dressing, toileting, showering, sitting to lying, and lying to sitting on the side of bed, partial assist with upper body dressing and oral hygiene, supervision assistance with eating, and was dependent with chair and toilet transfers. During a review of Resident 7's Order Summary Report (OSR), dated active as of 1/29/2026, the OSR indicated the following physician orders: 1.Quetiapine fumarate (medication used to treat mental health disorders) 25 milligrams (mg- a unit of measurement) for psychosis manifested by agitation (a feeling of irritability, mental distress, or severe restlessness) with a start date of 1/16/2026 2.Monitor behavior for psychosis manifested by agitation and tally by hashmark (marking vertical lines for each item on the medication administration record) for quetiapine use with a start date of 1/15/2026. During an interview on 1/29/2026 at 11:57 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated agitation could be manifested by many different behaviors. LVN 4 stated it was important to monitor specific behaviors [e.g., could include: pacing, fidgeting, irritability, restlessness, muscle tension, shouting, or hostility] for Resident 7 to ensure Resident 7 received the correct amount of medication and if Resident 7 did not exhibit the specific behaviors, the facility could lower the medication's dose. During an interview on 1/30/2026 at 9:21 AM with the Director of Nursing (DON), the DON stated for psychotropic medications, behavior manifestation had to be specific for the resident (in general). The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON stated [manifested by agitation as indicated in the OSR] was not a specific indication for [psychotropic] medication use for Resident 7. The DON stated it was important to address the Resident's specific medical needs to ensure Resident 7 received the proper medical care. During a review of the facility's undated Policy and Procedure (P&P) titled, Antipsychotic Medication [medications used to manage symptoms of psychosis] Use, the P&P's policy statement indicated, Antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The P&P's policy interpretation and implementation indicated, Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician will identify, evaluate, and document with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications. b. During a review of Resident 64's AR, the AR indicated Resident 64 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a condition that occurs later in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion). During a review of Resident 64's MDS dated [DATE], the MDS indicated Resident 64's cognition was severely impaired, and Resident 64 was dependent (helper does all the effort) on staff for activities of daily living. During a review of Resident 64's OSR, dated active as of 1/30/2026, the OSR indicated Resident 64 had a physician order for Olanzapine (medication used to treat schizophrenia [a long term severe mental disorder affecting how a person thinks, feels, and behaves, often causing them to lose touch with reality] or bipolar disorder [a long term mental condition characterized by extreme, often disabling, shifts in mood, energy, and activity levels]) give 1 tablet by mouth one time a day for bipolar disorder manifested by manic episodes (periods of abnormally, persistently elevated, or irritable mood and extremely high energy, lasting at least a week or requiring hospitalization) with start date 1/19/2026. During a concurrent interview and record review on 1/30/2026 at 12:15 PM with LVN 3, Resident 64's physician order for Olanzapine was reviewed. LVN 3 stated manic episodes could mean screaming, striking, and acting out of control. LVN 3 stated the order did not indicate a specific behavior presented by Resident 64 and another staff member could have a different idea of how manic episodes were presented. LVN 3 stated the behavior listed in the physician order should be specific to make it clear to all staff what Resident 64 was doing [specific behaviors] and to ensure accurate [behavior] tracking. During an interview on 1/30/2026 at 2:22 PM with the DON, the DON stated Resident 64's order for Olanzapine did not indicate a specific behavior [or indication for use] to monitor. The DON stated it was important to indicate specific behavior [and indication for medication use] for staff to know what to monitor and to help ensure Resident 64 was on the correct medication. During a review of the facility's P&P titled, Antipsychotic Medication Use, undated, the P&P indicated residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medication condition, specific symptoms, and risks to the resident and others.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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:(A) follow-up with the MD for the pharmacist drug regimen review recommendation to have the MD assess for Diclofenac gel (a non-greasy, topical medicine used to relieve joint pain caused by arthritis) and Tizanidine's (a medication used to treat muscle spasms, tightness, and cramping caused by spinal cord injuries or diseases like multiple sclerosis) effectiveness and evaluation if dose reduction or adjustment is warranted for one of one sample resident, (Resident 5)(B) indicate the physician's rationale for not following the pharmacist's recommendation in the resident's medication regime review (MMR) for one of one sampled resident (Resident 2).These deficient practices placed the resident at risk for receiving unnecessary medications that can lead to adverse side effects.Findings: (A) During a review of Resident 5's admission Record (AR) indicated the resident was originally admitted to the facility on [DATE] with diagnoses that included encounter for palliative care (a specialized medical care for people living with a serious illness, focused on relieving symptoms, pain, and stress to improve quality of life for both the patient and their families), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), malaise (a general, vague feeling of being unwell, uncomfortable, or off, often described as a lack of energy or the blahs) and neuromuscular dysfunction of the bladder (a condition where damage to the brain, spinal cord, or nerves disrupts the signals required for proper bladder function) among other diagnoses. During a review of Resident 5's History and Physical (H&P), dated 3/25/2025, indicated the resident had the capabilities for decision making. During a review of Resident 5's Minimum Data Set (MDS – a standardized assessment and care screening tool), dated 11/28/2025, indicated the resident was severely impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills the daily decision making. The MDS also indicated the resident was totally dependent on staff for transfers, and toilet use and required extensive assistance with bed mobility, dressing and hygiene. During a review of Resident 5's Medication Regimen Review for the month of December 2025, dated 12/9/2025 indicated the pharmacist recommendation: Resident has been on Diclofenac gel 1% apply 4 grams to affected joints BID for pain management, Tizanidine 2mg BIDF for muscle spasms. Please ensure MD assessment for effectiveness and evaluates if dose reduction or adjustment is warranted. Follow-through: ok. During a review of Resident 5's Medication Administration Record for the month of January 2026 indicated, Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to Affected joints topically two times a day for pain management. Apply 4 GM. Non-pharmacological intervention 1. Music 2. Relaxation Techniques 3. Repositioning 4. Cold Compress 5. Respiratory/deep breathing exercises 6. Massage 7. Diet 8. Prayer 9. Exercise 10. Calming Voice. Start date 7/9/2025 at 1700. During a review of Resident 5's Medication Administration Record for the month of January 2026 indicated, tizanidine HCL oral tablet 2 mg (Tizanidine HCL) Give 1 tablet by mouth two times a day for muscle spasms. Start date 7/4/2025 at 0900 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Progress Notes, dated 12/18/2025 indicated, MD was made aware of the pharmacist's medication regimen for Resident 5. The resident has been receiving diclofenac gel 1% (apply 4 grams BID) for pain management and tizanidine 2 mg BID for muscle spasms. MD will be assessing the resident for effectiveness of therapy and will evaluate whether does reduction or adjustments are warranted. NNO as of now. Will continue to monitor. During a concurrent observation and interview on 1/29/2026 at 1:55 PM, with the Director of Nursing (DON), the DON stated she was unable to find the MD assessment for effectiveness and evaluation if the dose reduction or adjustment is warranted as per the MRR pharmacist recommendations. This surveyor observed the DON look through the hospice binder, physical chart and medical records. During an interview on 1/29/2026 at 2:37 PM, with the DON, the DON stated that the importance of the MRR is to know if the medication we are giving is still suitable for the patient and if she is getting the right medication and dose based on the recommendation of the pharmacist. Moving forward we will ask the MD when we should be following up with them or if the recommendation is still no new order. (B). During a review of Resident 2's face sheet, the face sheet indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis including but not limited to dementia (decline in brain function), psychosis (mental health symptom where a person can lose touch with reality), and depression, During a review of Resident 2's History and Physical (H&P), dated 1/10/2026, the H&P indicated Resident 2 is not competent and not able to enter into contract. During a review of Resident 2's MRR, dated 1/10/2026, the MRR indicated the facility's pharmacist recommended the physician review the risk and benefits of keeping Resident 2 on Aricept 5 mg (a medication to treat dementia) and Seroquel 100 mg (a medication to treat mood disorders), due to the risk of mortality in the elderly population. The physician disagreed with the recommendation but did not indicate a rationale. During an interview on 1/29/2026 at 1:20 PM with Director of Nursing (DON), DON stated that the response to the pharmacist's recommendation should have included the physician rationale for not following it. During a record review of the facility's policy and procedure (P&P) titled, Drug Regimen Review not dated, the P&P indicated Physicians will be notified of Pharmacists recommendations and the Physicians response is documented in resident's chart. Per State Operations Manual (SOM) a physician's rationale must be provided as part of Physician's response. During a review of the facility's policy and procedure titled, Drug Regimen Review that is undated, indicated that the Physician's response is documented on the Consultant Pharmacist's review record or elsewhere in the resident's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate and complete documentation in the medical records for two of two residents (Residents 5 and 64) by:Failing to include Resident 5's diagnosis for diabetes on Resident 5's admission Record (AR).Indicating a diagnosis of bipolar disorder (BPD, an illness in which the patient goes back and forth between opposite extremes such as high and low levels of mood) for Resident 64 on the AR and the Minimum Data Set (MDS - a federally mandated resident assessment tool) without verification from Resident 64's medical record or confirmation with Resident 64's Medical Doctor (MD).These deficient practices resulted in incomplete/inaccurate medical records for Residents 5 and 64, and had the potential for Resident 5 and 64 to receive inappropriate nursing care and services due to the missing and inaccurate diagnoses on the residents' medical records. Findings: A. During a review of Resident 5's admission Record (AR), the AR indicated the resident was originally admitted to the facility on [DATE] with diagnoses that included encounter for palliative care (a specialized medical care for people living with a serious illness, focused on relieving symptoms, pain, and stress to improve quality of life for both the patient and their families), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), malaise (a general, vague feeling of being unwell, uncomfortable, or off, often described as a lack of energy or the blahs) and neuromuscular dysfunction of the bladder (a condition where damage to the brain, spinal cord, or nerves disrupts the signals required for proper bladder function) among other diagnoses. During a review of Resident 5's History and Physical (H&P), dated 3/25/2025, the H&P indicated Resident 5 had a diagnosis of diabetes mellitus. During a review of Resident 5's Minimum Data Set (MDS – a standardized assessment and care screening tool), dated 11/28/2025, the MDS indicated the resident was severely impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills the daily decision making. The MDS also indicated the resident was totally dependent on staff for transfers, and toilet use and required extensive assistance with bed mobility, dressing and hygiene. During an interview on 1/28/2026 at 10:35 AM with Licensed Vocation Nurse (LVN) 3, LVN 3 stated Resident 5 is receiving insulin with a sliding scale for Humalog Lispro (a fast-acting, man-made insulin used to control high blood sugar in adults and children with diabetes) for diabetes. LVN 3 was not able to see a diagnosis for diabetes for Resident 5 on Resident 5's facesheet. During a concurrent interview and record review on 1/28/2026 at 10:41 AM with the DON, the DON stated, Resident 5 is receiving Humalog Lispro for a diagnosis of diabetes since Resident 5 was admitted to the facility. The DON reviewed Resident 5's facesheet and did not see a diagnosis for diabetes on Resident 5's facesheet. The DON reviewed Resident 5's most recent H&P dated 3/25/2025 and the H&P indicated the resident had a diagnosis of type 2 diabetes. The DON stated it is importance to have the diagnosis of diabetes on Resident 5's facesheet for staff to see the condition of the resident and that the diagnosis could correlate with the medication that the resident is taking. During a concurrent interview and record review on 1/28/2026 at 10:56 AM with the MDS Coordinator (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(MDSC), the H&P dated 3/25/2025 was reviewed. The MDSC stated Resident 5's H&P listed the diagnosis of diabetes but the MDSC could not recall what happened a year ago and why the diagnosis on diabetes was not on Resident 1's facesheet. The MDSC stated the diagnosis is part of Resident 5's medical record and the nursing team needed to make sure the diagnosis is being addressed as well as managed the plan of care. B. During a review of Resident 64's AR, the AR indicated Resident 64 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a condition that occurs later in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion) and bipolar disorder (BPD, an illness in which the patient goes back and forth between opposite extremes such as high and low levels of mood.) During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all the effort) on staff for activities of daily living. The MDS also indicated a diagnosis of BPD. During a review of Resident 64's History and Physical (H&P) dated 1/17/2026 and signed by Resident 64's Medical Doctor (MD), the H&P did not indicate a diagnosis for BPD. During a review of Resident 64's Order Summary Report (OSR), dated active as of 1/30/2026, the OSR indicated Resident 64 had a physician order for Olanzapine (medication used to treat schizophrenia or bipolar disorder) give 1 tablet by mouth one time a day for BPD manifested by manic episodes with start date 1/19/2026. During an interview on 1/30/2026 at 2:11 PM with Resident 64's Medical Doctor (MD), the MD stated Resident 64 did not have a diagnosis of BPD and the inclusion of the BPD diagnosis was likely entered by the admitting nurse as a mistake. During an interview on 1/30/2026 at 2:26 PM with the MDSC, the MDSC stated Resident 64's BPD diagnosis was included in the MDS and AR based on Resident 64's active medication for olanzapine. The MDSC stated the MDSC was acting in good faith that Resident 64's MD had reviewed the medications and agreed with the indicated diagnoses. The MDSC stated it was important to ensure a resident's diagnoses are correct for the facility to be able to provide for the resident's needs. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, dated 7/2017 the P&P indicated documentation in the medical record will be objective (not opinionated or speculative), complete and accurate.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inform one of one sampled resident's (Resident 64) physician (Medical Doctor [MD] 1) of Resident 64's change of condition (CoC, an alteration in a resident's physical health that differs from their previous baseline) when Resident 64 was observed with redness on Resident 64's left eye on 1/27/2026. This failure had the potential for Resident 64 not to receive adequate treatment for a potential infection in Resident 64's left eye.Findings: During a review of Resident 64's admission Record (AR), the AR indicated Resident 64 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a condition that occurs later in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion).During a review of Resident 64's Minimum Data Set (MDS- a resident assessment tool) dated 1/23/2026, the MDS indicated Resident 64's cognition (ability to understand and process information) was severely impaired and Resident 64 was dependent (helper does all the effort) on staff for activities of daily living.During a concurrent observation and interview on 1/27/2026 at 1:10 PM with Family Member (FM) 1, Resident 64's left eye was observed. FM 1 stated Resident 64's left eye appeared more red on this day than ever before. FM 1 stated Resident 64's left eye had been pink and/or red a few months ago when Resident 64 had shingles (painful, blistering skin rash caused by the chicken pox virus) on the left side of Resident 64's face.During a concurrent observation and interview on 1/28/2026 at 12:52 PM with FM 1, in Resident 64's room, Resident 64's left eye was observed with redness in the sclera (white outer coating of the eye that surrounds the cornea). FM 1 stated Resident 64's left eye looked red for a couple days and FM 1 informed Resident 64's nurse on 1/27/2026 of the redness. FM 1 stated Resident 64's nurse told FM 1 it would be taken care of, but FM 1 had not received any updates and did not know if there was planned treatment for the redness in Resident 64's left eye.During an observation on 1/29/2026 at 9:23 AM, Resident 64 had redness on Resident 64's left eye and the eye had white discharge (a combination of mucus, oil, skin cells, and debris that accumulate in the eye) on the lower lid.During an interview on 1/29/2026 at 2:37 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated FM 1 mentioned Resident 64's eye redness to CNA 1 on 1/28/2026. CNA 1 stated CNA 1 offered to report Resident 64's eye redness to the Licensed Vocational Nurse (LVN) 6 on behalf of FM 1 but FM 1 declined because FM 1 spoke to the LVN 6 directly on 1/28/2026.During an interview on 1/29/2026 at 2:48 PM with LVN 3, LVN 3 stated LVN 3 had not received any report [from previous shifts] about Resident 64's eye redness and LVN 3 was not sure when the redness started. LVN 3 stated LVN 3 did not see Resident 64's eyes earlier in the shift. LVN 3 stated MD 1 had not been notified of Resident 64's eye redness. LVN 3 stated the nurse [LVN 6] who received the initial report from FM 1 should have notified Resident 64's doctor to rule out a potential infection.During a review of Resident 64's Progress Notes (PN), dated 1/27/2026 to 1/28/2026, there was no documented evidence indicating MD 1 was informed of Resident 64's eye redness.During a review of Resident 64's Situation Background Assessment Recommendation [SBAR] Communication Form and progress note (SBAR), dated 1/29/2026, timed at 2:30 PM, the SBAR indicated Resident 64 had redness and white discharge on the left eye.During a review of the facility's undated policy and procedure (P&P) titled, Change in a Resident's Condition or Status, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/ mental condition and/or status. The P&P indicated a significant change of condition, is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not self-limiting.) Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/ mental condition or status.

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	555832	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clara Baldwin Stocker Home for Women	527 S Valinda Avenue West Covina, CA 91790

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive care plan (CP) for one of one sampled resident (Resident 57), who was on hospice care (care designed to give supportive care to people in the final phase of a terminal illness with a focus on comfort and quality of life, rather than a cure).This deficient practice had the potential to result in unmet individualized needs for Resident 57 and the potential to affect the resident's physical and psychosocial well-being.Findings:During a review of Resident 57's admission Record (AR) indicated Resident 57 was admitted to the facility on [DATE] with diagnoses including chronic kidney disease (a long-term condition where the kidneys become damaged and gradually lose their ability to filter waste and extra fluid from the blood, leading to a buildup of toxins), atrial fibrillation (a rapid chaotic, and irregular heartbeat), muscle weakness, hypertension (HTN - high blood pressure), and thrombophilia (a tendency for the blood to clot easily due to an imbalance in clotting proteins).During a review of Resident 57's History and Physical (H&P), dated 11/29/2025, the H&P indicated Resident 57 did not have decision making capacities. During a review of Resident 57's CP, initiated 12/1/2025, the CP indicated Resident 57 had the potential for nutritional problems related to hospice care.During a review of Resident 57's Minimum Data Set (MDS- a resident assessment tool), dated 12/2/2025, the MDS indicated Resident 57's cognitive (the ability to think and process information) was severely impaired. The MDS indicated the Resident 57 was totally dependent on staff for transfers and toilet use, and required extensive assistance with bed mobility, dressing, and hygiene.During a review of Resident 57's Order Summary Report (OSR), dated active as of 12/13/2025, the OSR indicated a physician's order, dated 12/13/2025, for Resident 57 to be admitted to hospice under MD (Medical Doctor) care on routine level of care with primary diagnosis of hypertensive heart disease (various heart conditions caused by long term high blood pressure).During a concurrent interview and record review on 1/30/2026 at 11:58 AM, with the MDS Coordinator (MDSC), the MDSC stated the MDSC could not find a hospice CP for Resident 57 that included the most recent hospice plan of care. The MDSC stated [developing] a hospice CP was important because the CP showed how to care for Resident 57 and [helped with] communication with the staff [to follow the] plan of care for the resident.During a review of the facility's revised policy and procedure (P&P) titled, Hospice Program revised July 2017, the P&P indicated coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to revise the Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) related to gastrostomy tube (G-tube, a small flexible tube placed through the skin of the abdomen directly into the stomach) and nutrition for one of one sampled resident (Resident 6) after Resident 6's g-tube was removed.This failure had the potential for Resident 6 not to receive necessary care or services related to the removal of the g-tube. Findings: Based on interview and record review, the facility failed to revise Resident 6's CP related to G-tube and nutrition after Resident 6's g-tube was removed.During a review of Resident 6's admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with multiple diagnoses including dysphagia, oropharyngeal phase (a swallowing disorder affecting the mouth and throat) and heart failure (the inability of the heart to pump blood effectively.)During a review of Resident 6's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated [DATE], the MDS indicated Resident 6 had intact cognition (ability to understand and process information) and required partial or moderate assistance (helper does less than half of the effort) for toileting and bathing. The MDS indicated Resident 6 had a feeding tube on admission and received 26-50% of total calories through the feeding tube.During a review of Resident 6's Care Plan Report (CPR) initiated [DATE], the CPR indicated Resident 6 had a nutritional problem or potential nutritional problem related to g-tube feeding and other co-morbidities (two or more illnesses or health conditions existing in the same person at the same time.) The CPR interventions included for staff to explain and reinforce to the resident the importance of maintaining the diet ordered.During a review of Resident 6's Care Plan Report (CPR) dated [DATE], the CPR indicated Resident 6 was admitted to the facility with G-tube site on abdomen. The goal on the CPR indicated the facility will maintain without complications until next review date, [DATE].During a review of Resident 6's Order Summary Report (OSR), dated active as of [DATE] the OSR indicated a physician order for regular diet, soft and bite sized texture, regular consistency, and double protein with start date [DATE]. The OSR also indicated a physician order to have skilled wound care remove gastrostomy tube with order date [DATE].During an interview on [DATE] at 12:03 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LVN 3 could not find a revision for Resident 6's CP related to g-tube. LVN 3 stated Resident 6's CP related to g-tube should have been revised when the g-tube was removed to ensure the g-tube site was monitored for healing and signs of infection. LVN 3 also stated Resident 6's CP related to nutrition should have been revised when Resident 6's g-tube was removed because Resident 6's diet had changed.During an interview on [DATE] at 1:30 PM with the Director of Nursing (DON), the DON stated Resident 6's CPs should have been revised when the g-tube was removed to indicate Resident 6's current nutritional status and help direct Resident 6's treatment.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, undated the P&P indicated the interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's condition.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to justify a diagnosis of bipolar disorder (BPD, an illness in which the patient goes back and forth between opposite extremes such as high and low levels of mood) for one of one sampled Resident (Resident 64) based on a comprehensive assessment Resident 64 as indicated in the facility's policy and procedure (P&P) titled, Antipsychotic [a class of psychiatric medications primarily used to manage psychosis symptoms] Medication Use.This failure had the potential for Resident 64 to receive unnecessary treatment and/or services and the potential to result in a physical decline to Resident 64.Findings:During a review of Resident 64's admission Record (AR), the AR indicated Resident 64 was admitted to the facility on [DATE] with multiple diagnoses including Alzheimer's disease (a condition that occurs later in life and worsens with time in which brain cells degenerate; it is accompanied by memory loss, physical decline, and confusion), dementia (a gradual decline in mental ability usually caused by a brain disease, such as Alzheimer's), and BPD.During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool), dated 1/23/2026, the MDS indicated Resident 64's cognition (ability to understand and process information) was severely impaired and Resident 64 was dependent (helper does all the effort) on staff for activities of daily living. The MDS indicated a diagnosis of BPD.During a review of Resident 64's History and Physical (H&P), dated 1/17/2026, and signed by Resident 64's Medical Doctor (MD) 1, the H&P indicated Resident 64 had dementia/ Alzheimer's with worsening behavioral issues.During a review of Resident 64's Order Summary Report (OSR), dated active as of 1/30/2026, the OSR indicated Resident 64 had a physician order for olanzapine, give 1 tablet by mouth one time a day for BPD manifested by manic episodes (a period of abnormally high energy, elevated or irritable mood, and increased activity, lasting at least a week, that significantly disrupt daily life and functioning) with start date 1/19/2026.During an interview on 1/30/2026 at 12:15 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated upon admission, Resident 64 presented with agitation: screaming, yelling out, and striking at staff. LVN 3 stated Resident 64 was also resistant to care like showering. LVN 3 stated Resident 64 was taking olanzapine for BPD manifested by manic episodes which LVN 3 described as screaming, striking, and acting out of control. LVN 3 stated Resident 64 also had an active urinary tract infection (UTI, common infection in the urine caused by bacteria entering the urinary system) on admission and that could have been a possible cause of Resident 64's behavior. LVN 3 stated Resident 64 is calmer and more cooperative now compared to behavior noted on admission.During an interview on 1/30/2026 at 2:11 PM with Resident 64's physician (Medical Doctor [MD]) 1, MD 1 stated Resident 64 did not have a diagnosis of BPD the facility might have added the diagnosis of BPD by mistake. MD 1 stated Resident 64 was taking olanzapine at home and MD 1 continued the medication at the facility due to Resident 64's history of Alzheimer's with psychosis. MD 1 stated MD 1 planned to discontinue the medication because Resident 64 was doing well at the facility.During an interview on 1/30/2026 at 2:22 PM with the Director of Nursing (DON), the DON stated the medications a resident presented with on admission did not always list the indication for medication use. The DON stated, upon admission, the admitting nurse (in general) tried to find a diagnosis to correlate to the medication if the diagnosis was not already indicated [in the admission records]. The DON stated the admitting nurse (unidentified) made a mistake writing bipolar disorder as the indication for Resident 64's olanzapine medication [in Resident 64's OSR].During a review of the facility's undated P&P titled, Antipsychotic Medication Use, the P&P indicated antipsychotic medications may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral symptoms have been identified and addressed. The P&P indicated diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's low air loss (LAL - composed of multiple inflatable air tubes that alternately inflate and deflate, mimicking the movement of a patient shifting in bed or being rotated by a caregiver, never leaving the patient in one position for any extended length of time) mattress was set to the correct setting for one of one sample resident (Resident 5).This deficient practice placed Resident 5 at risk for discomfort and the potential for developing pressure ulcers.During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was originally admitted to the facility on [DATE] with diagnoses that included encounter for palliative care (a specialized medical care for people living with a serious illness, focused on relieving symptoms, pain, and stress to improve quality of life for both the patient and their families), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), malaise (a general, vague feeling of being unwell, uncomfortable, or off, often described as a lack of energy or the blahs) and neuromuscular dysfunction of the bladder (a condition where damage to the brain, spinal cord, or nerves disrupts the signals required for proper bladder function) among other diagnoses.During a review of Resident 5's History and Physical (H&P), dated 3/25/2025, the H&P indicated Resident 5 had a diagnosis of diabetes mellitus.During a review of Resident 5's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/28/2025, the MDS indicated the resident was severely impaired in cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) skills. The MDS also indicated the resident was totally dependent on staff for transfers, toilet use and required extensive assistance with bed mobility, dressing and hygiene.During a review of Resident 5's Order Summary Report (OSR) dated 1/27/2026, the OSR indicated Resident 5 had a physician's order, dated 7/3/2025, for Resident 5's low air loss mattress to be monitored every shift for proper functioning and for offloading and pressure relief.During an observation on 1/27/2026 at 9:24 AM, in Resident 5's room, Resident 5 was asleep in bed. Resident 5's LAL mattress was on and the setting was at 450 pounds (lbs. unit used to measure weight and mass).During a concurrent interview and record review on 1/27/2026 at 9:30 AM, with License Vocational Nurse (LVN) 2, LVN 2 stated that Resident 5 had a physician's order for LAL mattress and for staff to check the LAL for pressure relief and monitoring for proper functioning every shift. LVN 2 stated he had not checked the Resident 5's LAL mattress and he is on his way to check the LAL mattress. LVN 2 checked the LAL mattress and stated it was set for 450 lbs. and locked. LVN 2 stated the red sticker on top of the machine indicates 150 lbs. as the corrected setting. LVN 2 changed the LAL mattress's setting to the weight of 150 lbs. LVN 2 stated that at the setting of 450 lbs., the mattress is too firm for Resident 5 and the firmness can cause pressure injuries and redness to Resident 5's skin. During a review of the facility's Policy and Procedure (P&P) titled, Prevention of Pressure Injuries, revised on April 2020, the P&P indicated to select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice.

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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 the facility failed to administer a zinc ointment (a medication that helps protect and heal the skin) per the physician's order for a pressure ulcer (PU - injury to the skin and underlying tissue caused by constant long term pressure) to the sacral area (the bottom of the back right above the tail bone) for one of three sample residents (Resident 3). This failure has the potential to effect the healing of Resident 3's pressure ulcer. Findings: During review of Resident 3's face sheet, the face sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including but not limited to: arthritis (pain, swelling and stiffness of the joints), right knee infection, muscle weakness, and morbid obesity. A review of Resident 3's Minimum Data Assessment (MDS-standardized assessment screening tool), dated 12/11/2025, the MDS indicated Resident 3 required partial assistance from the nursing staff with bathing, dressing, and using the toilet. During an interview on 1/29/2026 at 9:06 AM with Resident 3, Resident 3 stated medication was not applied to their sacral area yesterday (1/28/2026).During a concurrent interview and record review on 1/29/2026 at 9:41 AM, with Licensed Vocational Nurse/Treatment Nurse (LVN 2), Resident 3's Medication Administration Record (MAR) dated 1/28/2026, was reviewed. The MAR indicated LVN 2 administered the zinc ointment to Resident 3's sacral area. LVN 2 stated they checked off the medication as given, even though it was not given. LVN 2 stated they are not supposed to do that. LVN 2 stated checking off medications that are not given can cause harm to a resident, by delaying care, delaying wound healing, or potentially developing another wound.

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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, the facility failed to ensure the resident did not store medications in their room for one of three residents (Resident 3). This failure had the potential to place Resident 3 at risk for unsafe self-administration of medication, which could result in skin irritation, systemic absorption (the process by which medication is absorbed into the bloodstream) and contamination. Findings: During review of Resident 3's face sheet, the face sheet indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including but not limited to: arthritis (pain, swelling and stiffness of the joints), right knee infection, muscle weakness, and morbid obesity. During a review of Resident 3's Minimum Data Assessment (MDS-standardized assessment screening tool), dated 12/11/2025, the MDS indicated Resident 3 required partial assistance from the nursing staff with bathing, dressing, and using the toilet. During a concurrent observation and interview on 1/28/2026 at 12:15 PM with Resident 3, in Resident 3's room, there were several medication ointments found in the resident's closet: bacitracin zinc (used to prevent infection in skin wounds), Activon (promotes faster healing of the skin), and clotrimazole cream (used to treat fungus infection of the skin). Resident 3 stated the medications were provided by facility and are kept in their closet. During an interview on 1/29/2026 at 9:42 AM with Licensed Vocational Nurse/Treatment Nurse (LVN 2), LVN 2 stated the medications left in the resident's room are not supposed to be there. LVN 2 stated they are unsure why the medications are there and does not know who provided them to Resident 3. During review of the facility's policy and procedure (P&P) titled, Storage of medications, dated November 2020, the P&P indicated drugs and biologicals used at the facility are to be stored in locked compartments. Only authorized staff may have access to locked medications.