STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055544	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harvard Creek Post Acute	519 W. Badillo St. Covina, CA 91722

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 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. Based on interview and record review, the facility failed to incorporate Assessments and Care Planning Goals and Objectives in the Care Plans that lead to the residents' highest obtainable level of independence for one of five residents (Resident 1). Resident 1's care plan did not include Resident 1's behavior of crawling on the floor. This failure result in no nursing interventions for Resident 1's behavior of crawling on the floor and placed Resident 1 at risk for not reaching Resident 1's highest obtainable level of independence. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/7/2025 with diagnoses which included cerebral infarction (also called ischemic stroke, occurs as result of disrupted blood flow to the brain) and cognitive communication deficit (impaired attention, memory, perception, organization, language, and lack of coordination, symptoms and signs involving the musculoskeletal system). A review of Resident 1's fall risk care plan (CP), dated 2/7/2025, the CP indicated Resident 1 was at risk for falls secondary to history of falls prior to admission, and due to confusion, gait (a person's way of walking) and balance problems, and antihypertensive medication (medication used to treat high blood pressure with common side effects of dizziness and fatigue) use. The fall risk care plan goal was for Resident 1 to be free from injury through 5/7/2025. The fall risk care plan interventions indicated to provide bilateral floor mats for all fall precautions, to keep the resident call light within easy reach and answer the call lights promptly and within reasonable time, provide resident with a safe and clutter-free environment. During a review of Resident 1's Fall Risk Evaluation, dated 2/9/2025, the Fall Risk Evaluation indicated Resident 1 had confusion, had balance problem while standing and walking, had decreased coordination (ability to use different parts of the body together smoothly and efficiently), and was at risk for falls. During a review of Resident 1's History Physical (H&P) Examination, dated 2/10/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decision. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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	During a review of Resident 1's Minimum Data Set (MDS, a Resident assessment and care planning tool), dated 5/9/2025, the MDS indicated Resident 1 had severely impaired cognitive (ability to think and reason) skills for decision making and required extensive assistance of staff to move around in bed, to move to or from bed, chair, wheelchair, or standing position, to dress, to eat, to use the toilet, and to maintain personal hygiene (includes combing hair, brushing teeth, shaving, washing/drying face and hands). During a concurrent observation and interview 6/10/2025 at 11:35 am, Resident 2 was sitting in bed watching television. Resident 2 stated my roommate Resident 1 crawls down to the floor every day, multiple times a day, and crawls to my side of the room near my bedside table right here. During an interview with Certified Nurse Assistant 1(CNA 1- a healthcare professional who provides support and care for patients under the direction of licensed nurses) on 6/10/2025 at 12:30 pm, CNA 1 stated Resident 1 had periods of confusion, he crawled out of bed, and we transferred him back to his bed or on his wheelchair. CNA 1 stated This occurs several times a day. CNA 1 stated there have been times Resident 1 crawled out of the room to the hallway, and he assisted in picking himself up by grabbing onto the hallway rails and we slide the wheelchair under him and sat down. During an interview with Licensed Vocational Nurse 1 (LVN 1- an entry level health professional who provides basic medical assistance and works under a registered nurse) on 6/10/2025 at 2:17 pm, LVN 1 stated LVN 1 was assigned to care for Resident 1 on 6/5/2025 and 6/6/2025. LVN 1 stated Resident 1 had a wander guard (device worn by individuals at risk of wandering, often residents in assisted living or memory care facilities, to trigger alerts when they move outside of a designated safe zone) on Resident 1's ankle. During an interview with the Director of Nursing (DON) on 6/10/2025 at 3:30 pm, the DON stated the floor mats were placed for fall precautions and the expectation was for staff to assist the resident back to bed once they find the resident crawling on the floor mats. The DON stated Resident 1 crawls in his room, and when staff see him, staff need to monitor and assist Resident 1 back to bed. The DON stated It is not safe for Resident 1 to crawl to Resident 2's bedside because Resident 1 could hold onto objects and hurt himself. The DON stated Resident 1's fall risk care plan should have been updated per the facility's policy and procedure (P&P) to include crawling on the floor as one of Resident 1's behavior. A review of the facility's P&P titled, Goals and Objectives, Care Plans, dated 2001, (Revised April 2009), the P&P indicated, care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. Care plans goals and objectives are derived from information contained in the resident's comprehensive assessment and are behaviorally stated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to implement its Policy and Procedure, titled Falls and Fall Risk, Managing, for one of five sampled residents (Resident 1) when: 1. Resident 1 was not assessed for injury whenever staff (in general) found Resident 1 on floor crawling on the floor mats (a padded cushion placed on the floor next to the bed to help reduce injuries from a fall) as indicated in Resident 1's fall risk care plan. 2. Resident 1's care plan did not include Resident 1's behavior of crawling on the floor. 3. Licensed Vocational Nurse (LVN) 1 did not document Resident 1's wander guard trial in Resident 1's medical record. This failure placed Resident 1 at risk for harm and injury. Cross reference F656, F842 Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/7/2025 with diagnoses which included cerebral infarction (also called ischemic stroke, occurs as result of disrupted blood flow to the brain) and cognitive communication deficit (impaired attention, memory, perception, organization, language, and lack of coordination, symptoms and signs involving the musculoskeletal system). A review of Resident 1's fall risk care plan (CP), dated 2/7/2025, the CP indicated Resident 1 was at risk for falls secondary to history of falls prior to admission, and due to confusion, gait (a person's way of walking) and balance problems, and antihypertensive medication (medication used to treat high blood pressure with common side effects of dizziness and fatigue) use. The fall risk care plan goal was for Resident 1 to be free from injury through 5/7/2025. The fall risk care plan interventions indicated to provide bilateral floor mats for all fall precautions, to keep Resident 1's call light within easy reach and answer the call light promptly and within reasonable time, provide resident with a safe and clutter-free environment. During a review of Resident 1's Fall Risk Evaluation, dated 2/9/2025, The Fall Risk Evaluation indicated Resident 1 had confusion, had balance problem while standing and walking, had decreased coordination (ability to use different parts of the body together smoothly and efficiently), and was at risk for falls. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care planning tool), dated 5/9/2025, the MDS indicated Resident 1 had severely impaired cognitive (ability to think and reason) skills for decision making and required extensive assistance of staff to move around in bed, to move to or from bed, chair, wheelchair, or standing position, to dress, to eat, to use the toilet, and to maintain personal hygiene (includes combing hair, brushing teeth, shaving, washing/drying face and hands). (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview 6/10/2025 at 11:35 am, Resident 2 was sitting in bed, watching television. Resident 2 stated my roommate Resident 1 crawls down to the floor every day multiple times a day, and crawls to my side of the room near my bedside table right here. During an interview with Certified Nurse Assistant 1(CNA 1- a healthcare professional who provides support and care for patients under the direction of licensed nurses) on 6/10/2025 at 12:30 pm, CNA 1 stated Resident 1 had periods of confusion, he crawled out of bed, and we transferred him back to his bed or on his wheelchair. CNA 1 stated This occurs several times a day. CNA 1 stated there have been times Resident 1 crawls out of the room to the hallway, and he assists in picking himself up by grabbing onto the hallway rails and slide the wheelchair under him and sit down. During an interview with LVN 1 on 6/10/2025 at 2:17 pm, LVN 1 stated LVN 1 was assigned to care for Resident 1 on 6/5/2025 and 6/6/2025, Resident 1 had a wander guard (device worn by individuals at risk of wandering, often residents in assisted living or memory care facilities, to trigger alerts when they move outside of a designated safe zone) on Resident 1's ankle and LVN 1 did not document the Wander guard trial in Resident 1's medical record. LVN 1 stated per facility's policy and procedure (P&P) It is my responsibility to document in medical record and I did not follow the policy. During an interview with the Director of Nursing (DON) on 6/10/2025 at 3:30 pm, the DON stated the floor mats were placed for fall precautions and the expectation was for staff to assist Resident 1's back to bed once staff find Resident 1 crawling on the floor mats. The DON stated Resident 1 crawls in his room, and when staff see him, staff need to monitor and assist Resident 1's back to bed. The DON stated, It is not safe for Resident 1 to crawl to Resident 2's bedside because Resident 1 could hold onto objects and hurt himself. The DON stated Resident 1's fall risk care plan should have been updated per the facility's P&P to include crawling behavior. The DON stated a change in condition like a wander guard should have been endorsed from one staff to another, but it was not. The DON stated the assigned LVNs should have endorsed and documented in Resident 1's medical record per the facility's policy, but it was not done. A review of the facility's P&P titled, Fall and Fall Risk, Managing, dated 2001 (Revised March 2018), the P&P indicated Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling According to the MDS, a fall is defined as: Unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an over whelming external force (e.g., a resident pushes another resident) Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to implement its Policy and Procedure titled, Charting and Documentation, for one of five sampled residents (Resident 1) when: Licensed Vocational Nurse 1 (LVN 1) did not document Resident 1's wander guard trial in Resident 1's medical record. This failure result in incomplete documentation for Resident 1 and placed Resident 1's inter disciplinary team at risk for miscommunication regarding the Resident 1's condition and response to care. Cross Reference: F689 and F656 Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/7/2025 with diagnoses which included cerebral infarction (also called ischemic stroke, occurs as result of disrupted blood flow to the brain) and cognitive communication deficit (impaired attention, memory, perception, organization, language, and lack of coordination, symptoms and signs involving the musculoskeletal system). A review of Resident 1's fall risk care plan (CP), dated 2/7/2025, the CP indicated Resident 1 was at risk for falls secondary to history of falls prior to admission, and due to confusion, gait (a person's way of walking) and balance problems, and antihypertensive medication (medication used to treat high blood pressure with common side effects of dizziness and fatigue) use. The fall risk care plan goal was for Resident 1 to be free from injury through 5/7/2025. The fall risk care plan interventions indicated to provide bilateral floor mats for all fall precautions, to keep Resident 1's call light within easy reach and answer the call light promptly and within reasonable time, provide resident with a safe and clutter-free environment. During a review of Resident 1's Fall Risk Evaluation, dated 2/9/2025, The Fall Risk Evaluation indicated Resident 1 had confusion, had balance problem while standing and walking, had decreased coordination (ability to use different parts of the body together smoothly and efficiently), and was at risk for falls. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment and care planning tool), dated 5/9/2025, the MDS indicated Resident 1 had severely impaired cognitive (ability to think and reason) skills for decision making and required extensive assistance of staff to move around in bed, to move to or from bed, chair, wheelchair, or standing position, to dress, to eat, to use the toilet, and to maintain personal hygiene (includes combing hair, brushing teeth, shaving, washing/drying face and hands). During a concurrent observation and interview 6/10/2025 at 11:35 am, Resident 2 was sitting in bed, watching television. Resident 2 stated my roommate Resident 1 crawls down to the floor every day multiple times a day, and crawls to my side of the room near my bedside table right here. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 1 on 6/10/2025 at 2:17 pm, LVN 1 stated LVN 1 was assigned to care for Resident 1 on 6/5/2025 and 6/6/2025. LVN 1 stated Resident 1 had a wander guard (device worn by individuals at risk of wandering, often residents in assisted living or memory care facilities, to trigger alerts when they move outside of a designated safe zone) on Resident 1's ankle, but LNV 1 did not document in Resident 1's wander guard trial in Resident 1's medical record. LVN 1 stated per the facility's policy and procedure (P&P) Tt is my responsibility to document in medical record and I did not follow the policy. During an interview with the Director of Nursing (DON) on 6/10/2025 at 3:30 pm, the DON a change in condition like a wander guard trial should have been endorsed from one staff to another but It was not. The DON stated the assigned LVNs should have endorsed and documented information regarding Resident 1's wander guard trial in Resident 1's medical record per the facility's policy. A review of the facility's P&P titled, Goals and Objectives, Care Plans, dated 2001, (Revised July 2017), indicated All medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care Documentation in the medical record may be electronic, manual or a combination The following information is to be documented in the resident's medical record: Treatments or services.