

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055544	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2026
NAME OF PROVIDER OR SUPPLIER Harvard Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 - Some	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 individualized and resident-centered care plans (CP) for two of two sampled residents (Residents 26 and 53). These deficient practices had the potential for Residents 26 and 53 to not receive appropriate care, treatment, and/or services related to their specific needs. Findings: a. During a review of Resident 26's admission Record (AR), the AR indicated Resident 26 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract) and bronchitis (the air tubes in the lungs got swollen and made breathing hard). During a review of Resident 26's History and Physical (H&P) dated 1/19/2026, the H&P indicated Resident 26 did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool) dated 1/23/2026, the MDS indicated Resident 26 had moderately impaired cognition (ability to understand). The MDS indicated Resident 26 required supervision from staff with eating. The MDS indicated Resident 26 required maximal assistance (helper did more than half the effort) from staff with oral hygiene. The MDS indicated Resident 26 was dependent (helper did all the effort) on staff with toileting hygiene, showering/ bathing, and bed-to-chair transferring. During a concurrent record review and interview with MDS Nurse 1 (MDSN 1) on 2/12/2026 at 12:06 pm, all of Resident 26's CP were reviewed. MDSN 1 stated there were no specific CP to address Resident 26's UTI or bronchitis. MDSN 1 stated the licensed nurse should have developed the CP to address Resident 26's UTI and bronchitis. MDSN 1 stated the CP should be specific and resident centered. MDSN 1 stated the CP should have included monitoring for signs and symptoms of recurrent infection and respiratory issues to ensure individualized care. MDSN 1 stated not having specific resident centered CP placed Resident 26 at risk for recurrent infection. MDSN 1 stated having a specific CP for UTI and bronchitis would have been beneficial to both Resident 26 and the nursing staff by ensuring the resident's needs were addressed and individualized. During an interview on 2/12/2026 at 2:28 pm, with the Director of Nursing (DON), the DON stated the CP was a guide for staff to provide individualized care to residents. The DON stated the MDSN should have completed the comprehensive care plan within two weeks of admission. The DON stated the CP should be comprehensive that covered the overall care of the residents. The DON stated the CP should be specific and resident centered so that staff could provide proper care and treatment to the residents. The DON stated it was important to have specific and resident-centered CP. The DON stated the CP should have been adjusted with each medical diagnosis and medications. The DON (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated if the resident's needs were not met, it could result in resident's decline. b. During a review of Resident 53's admission Record (AR), the AR indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including liver carcinoma (type of cancer), malignant neoplasm (group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body) of the pancreas, and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 53's Initial Psychiatric Evaluation (IPE) dated 12/5/2025, the IPE indicated Resident 53 was diagnosed with major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 53's Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool) dated 10/9/2025, the MDS indicated Resident 53 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 53 was dependent (helper did all the effort) on staff for showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 53 needed moderate assistance (helper does less than half the effort) on staff for oral hygiene, upper body dressing and personal hygiene. During a review of Resident 53's Physicians Order (PO) dated 12/5/2025, the PO indicated to increase Remeron (a medication to treat depressive disorder) tablet 22.5 mg one tablet by mouth at bedtime for depression manifested by self-report of feeling of sadness. During an interview and concurrent record review on 2/12/2026 at 11:17 am, with the Assistant Director of Nursing (ADON) of Resident 9's medical records (PointClickCare - PCC, a cloud-based software) and physical chart, the ADON stated there was no CP initiated and implemented for the management of Resident 53's depression and use of Remeron oral tablet. The ADON stated, resident specific CP should have been initiated and implemented for Resident 53's depression and the use of Remeron oral tablet to guide nurses on how to provide proper care and treatment to Resident 53. During an interview on 2/12/2026 at 2:29 pm with the facility's Director of Nursing (DON), the DON stated a resident specific and resident centered CP should have been initiated and implemented for Resident 53's depression and use of Remeron oral tablet for staff to be able to provide specific care and treatment to Resident 53. During a review of the facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial functional needs is developed and implemented for each resident. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to ensure the kitchen handwashing sink was draining. This failure had the potential to result in overflow of wastewater and lead to contamination. Findings: During an observation on 2/10/2026 at 8:59 AM in the kitchen, the handwashing sink was half-full of soapy, dirty water. During an interview on 2/10/2026 at 9:00 AM with Dietary Supervisor (DS), DS stated the sink drains slow, it could be clogged. DS stated the sink should be draining smoothly otherwise it might overflow and contaminate surrounding kitchen area. During a review of the facility's policy and procedure (P&P) titled, Policy: Plumbing Policy, updated 1/8/2026, the P&P indicated the facility's Environmental Services performs weekly checks of all kitchen sinks and drains, maintenance staff uses enzymatic solutions on monthly basis to prevent buildup, and staff is trained to report clogged or slow-draining sinks immediately.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to obtain written informed consent for one of five sampled residents (Resident 53) for the use of psychotropic (any medication capable of affecting the mind, emotion, and behavior) medication. This deficient practice had the potential for Resident 53 not receiving adequate information regarding psychotropic medications necessary to make an informed health care decision. Findings: During a review of Resident 53's admission Record (AR), the AR indicated Resident 53 was admitted to the facility on [DATE] with diagnoses including liver carcinoma (type of cancer), malignant neoplasm (group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body) of the pancreas, and heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 53's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/9/2025, the MDS indicated Resident 53 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 53 was dependent (helper did all the effort) on staff for showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 53 needed moderate assistance (helper does less than half the effort) on staff for oral hygiene, upper body dressing and personal hygiene. During a review of Resident 53's Physicians Order (PO) dated 12/5/2025, the PO indicated to increase Remeron (a medication to treat depression [a feeling of severe sadness or hopelessness]) tablet 22.5 mg one tablet by mouth at bedtime for depression manifested by self report of feeling of sadness. During an interview and concurrent record review on 2/11/2026 at 2:23 pm, with the Assistant Director of Nursing (ADON) of Resident 53's medical records (physical chart), the ADON stated, informed consent was not obtained from Resident 53 or the resident's Responsible Party (RP) prior to administration of Remeron 22.5 mg. The ADON stated, consent for the use of Remeron should have been updated with the right dosage and Resident 53's target behavior. The ADON stated informed consent should have been obtained by the doctor from Resident 53 or resident's RP and verified by the Licensed Nurse. The ADON stated risks and benefits of psychotropic medications should have been discussed to Resident 53 for the resident to be aware of the adverse effects (harmful effects) and risk and benefits of the medication. During a review of the facility's policy and procedure (P&P) titled, Informed Consent Antipsychotic Medications, revised 8/22/2016, the P&P indicated, The purpose of this procedure is to provide guidelines for obtaining informed consent for residents prescribed psychotropic medications. Licensed nurse should document in the resident's health record, he or she verified with the physician informed consent was obtained. Licensed Nurse shall document in the resident's health record the date, medication/treatment, diagnosis and corresponding behavior if applicable, dosage range if pertinent and name of the licensed healthcare practitioner. Licensed nurse shall complete the INFORMED CONSENT document in the resident's health record prior to administering the medication or treatment. Licensed nurse will administer medication or treatment after consent obtained and documented in the resident's health record. An increase in dosage of the psychotherapeutic or antipsychotic medication shall require a new informed consent to be obtained, verified and documented in the resident's health record.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the order for lorazepam (a medication used for anxiety- a feeling of fear, dread, or uneasiness) as needed (PRN) was limited to a 14-day duration for one of five sampled residents (Resident 5). This deficient practice had the potential to result in unnecessary or prolonged use of lorazepam that could lead to Resident 5 experiencing adverse effects (unwanted, uncomfortable, or dangerous effects of a drug) related to medication therapy. Findings: During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (brain dysfunction caused by a chemical imbalance in the blood that affected the brain's normal functioning) and anxiety disorder. During a review of Resident 5's untitled (CP) for anti-anxiety medication revised on 1/25/2026, the CP goal indicated Resident 5 would be free from discomfort or adverse reactions related to anti-anxiety therapy. During a review of Resident 5's History and Physical (H&P) dated 1/28/2026, the H&P indicated Resident 5 did not have the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 1/28/2026, the MDS indicated Resident 5 had severely impaired cognition (ability to understand). The MDS indicated Resident 5 required moderate assistance (helper did less than half the effort) from staff with eating. The MDS indicated Resident 5 required maximal assistance (helper did more than half the effort) from staff with oral hygiene and personal hygiene. The MDS indicated Resident 5 was dependent (helper did all the effort) on staff with toileting hygiene, showering/ bathing, and bed-to-chair transferring. During a review of Resident 5's Order Summary Report (OSR) with active orders as of 2/10/2026, the OSR indicated a physician's order for licensed staff to administer lorazepam every six hours PRN for anxiety for 30 days starting on 2/4/2026. During a concurrent record review and interview with the Assistant Director of Nursing (ADON) on 2/11/2026 at 2:33 pm, Resident 5's medical records (PointClickCare - PCC, a cloud-based software) and physical chart were reviewed. The ADON stated there were no documentations indicated the physician's rationale for Resident 5's 30-day lorazepam PRN order. The ADON stated it was the standard of practice to obtain psychotropic medication (a drug that changed how the brain worked and affected a person's thoughts, feelings, or behavior) PRN order for 14 days. The ADON stated psychotropic medication included antianxiety medication. The ADON stated the 14-day duration allowed the staff to notice any adverse effects from the medication on the residents. The ADON stated the licensed staff should have clarified Resident 5's lorazepam order with the physician and documented it in the progress notes. The ADON stated it was important that the physician documented the rationale of the 30-day lorazepam use in Resident 5's progress note. The ADON stated Resident 5 could experience adverse effect of lorazepam with increased risks of fall and confusion. During a concurrent record review and interview with the Director of Nursing (DON) on 2/12/2026 at 2:36 pm, the facility's Policy and Procedure (P&P) titled Psychotropic Drug, revised on 11/2020, was reviewed. The DON stated the P&P indicated the PRN psychotropic medications were limited to 14 days unless the prescribing physician document the rationale and the duration for the PRN order in the resident's medical record. The DON stated the facility should have limited the use of psychotropic medications. The DON stated the psychotropic medication's adverse effects were dehydration and gastrointestinal discomfort. The DON stated the 14-day duration warranted the resident's need of psychotropic medication due to the behavior.		

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete one of three sampled residents (Resident 41) quarterly Minimum Data Set (MDS, a resident assessment and care screening tool). This failure had the potential to result in not meeting the resident's care needs and/or identifying a change in the resident's physical and mental care needs. Findings: During a review of Resident 41's admission Record, the admission Record indicated Resident 41 was admitted on [DATE] with diagnoses including but not limited to peripheral vascular disease (a decrease in blood flow to the limbs, primarily on the legs, causing cramps, pain, death of body tissue and amputation), diabetes mellitus (a chronic condition in which the body does not produce enough of the hormone insulin or becomes resistant to it leading to high blood sugar levels in the body), protein-calorie malnutrition (an insufficient intake of protein and calories leading to loss of muscle mass, strength and immune function). During a review of Resident 41's History and Physical (H&P), dated 11/28/2025, the H&P indicated Resident 41 has multiple medical problems and the capacity to understand and make decisions. During a review of Resident 41's MDS indicated an initial comprehensive assessment was completed on 10/8/2025. During a review of Resident 41's MDS assessments, the MDS assessments did not indicate a quarterly assessment was completed by January 2026. During an interview on 02/11/2026 at 11:12 AM with MDS Nurse (MDSN), MDNSN stated Resident 41's quarterly assessment was not completed three months after the initial comprehensive assessment. MDSN stated MDS quarterly assessments must be completed every three months or when there is change of condition to assess the resident's overall physical function and needs, if not done, unidentified changes in resident condition can be missed and not addressed. During a review of the facility's policy and procedure (P&P) titled, MDS Completion and Submission Timeframes, dated July 2017, the P&P indicated the MDS Coordinator is responsible for completing and submitting MDS assessments to Medicare in accordance with federal and state submission timeframes.		

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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 one sampled resident's (Resident 43), Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/24/2025 accurately documented the resident's dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) treatment. This failure had the potential to result in delay of treatment and inaccurate plan of care and interventions for Resident 43. Findings: During a review of Resident 43's admission Record (AR), the AR indicated Resident 43 was admitted to the facility on [DATE] with diagnoses including heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), End Stage Renal Disease (ESRD-irreversible kidney failure), and dependence on dialysis. During a review of Resident 43's Care Plan (CP) revised on 7/24/2025, the CP indicated Resident 43 needed hemodialysis related to ESRD. During a review of Resident 43's History & Physical (H&P) dated 7/26/2025, the H&P indicated the resident was receiving HD three times a week. During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 had moderately impaired cognition (ability to understand). The MDS did not indicate Resident 43 was receiving dialysis while under the care of the facility. During a review of Resident 43's Order Summary Report (OSR) dated 1/31/2026, the OSR indicated Resident 43 had the following active orders for: HD on Mondays, Wednesdays, and Fridays, ordered on 7/20/2025 Extra dialysis on Saturdays, ordered on 8/6/2025. During an interview on 2/11/2026 at 2:35 pm with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 43 had been receiving dialysis since admission on [DATE]. During an interview on 2/12/2026 at 8:10 am with Resident 43, Resident 43 stated Resident 43 was receiving dialysis treatments. During an interview on 2/12/2026 at 12:33 pm with the Minimum Data Set Nurse (MDSN), the MDSN stated Resident 43 was receiving dialysis treatments and the MDSN failed to indicate it on Resident 43's MDS assessment dated [DATE]. The MDSN stated the MDS was submitted to CMS (Centers for Medicare and Medicaid Services) and was a reference of the resident's current needs which needed to be accurate. During an interview on 2/12/2026 at 2:31 pm with the facility's Director of Nursing (DON), the DON stated the MDS needed to be submitted accurately to CMS to allow the facility to provide the correct care to the residents. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument: Minimum Data Set and Comprehensive Care Plan, revised September 2024, the P&P indicated, a registered nurse shall be responsible for coordinating the input from the appropriate health disciplines to complete the MDS and would sign and certify completion of the assessment. The P&P indicated, the services provided should meet the professional standards of quality and are provided by appropriate qualified persons in accordance with the resident's written plan of care. During a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1, dated October 2025, the manual indicated the RAI process had multiple regulatory requirements. The manual indicated, federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) required that the assessment accurately reflect the resident's status.		

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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 ensure one of one sampled resident (Resident 43)'s care plan (CP) was revised to address 1,000 milliliters (ml- unit of measurement) fluid restriction. This failure had the potential to place Resident 43 at risk for fluid overload and other related complications. Findings: During a review of Resident 43's admission Record (AR), the AR indicated Resident 43 was admitted to the facility on [DATE] with diagnoses including heart failure (when the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen), End Stage Renal Disease (ESRD-irreversible kidney failure), and dependence on dialysis (procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances). During a review of Resident 43's Care Plan (CP) revised on 7/24/2025, the CP indicated Resident 43 had dehydration or had the potential for fluid deficit related to ESRD, being on hemodialysis (HD- a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) and having a 1,500 ml fluid restriction. During a review of Resident 43's History & Physical (H&P) dated 7/26/2025, the H&P indicated the resident was receiving hemodialysis three times a week. During a review of Resident 43's Minimum Data Set (MDS, a resident assessment tool) dated 12/24/2025, the MDS indicated Resident 43 had moderately impaired cognition (ability to understand). During a review of Resident 43's Order Summary Report (OSR) dated 1/31/2026, the OSR indicated Resident 43 had an active order for fluid restriction of 1,000 ml over 24 hours, ordered on 12/30/2025. During a concurrent interview and record review on 2/11/2026 at 2:35 pm with Licensed Vocational Nurse 1 (LVN 1), Resident 43's CP was reviewed. The CP indicated Resident 43 was on HD and had a 1,500 ml fluid restriction. LVN 1 stated, Resident 43 was receiving dialysis and had a current fluid restriction of 1,000 ml per day and received 500 ml during the day shift. LVN 1 stated the fluid restriction of 1,000 ml per day for Resident 43 was ordered on 12/30/2025 and Resident 43's CP should have been updated to keep the resident's plan of care current and ensure the resident received necessary care. During an interview on 2/12/2026 at 8:10 am with Resident 43, Resident 43 stated Resident 43 was receiving dialysis treatments. During an interview on 2/12/2026 at 11:32 am with the Assistant Director of Nursing (ADON), the ADON stated Resident 43 had a 1,000 ml fluid restriction and the resident's CP was not updated from the previous order of 1,500 ml fluid restriction. The ADON stated, Resident 43's CP should have been updated, and any licensed nurse could have updated the CP to reflect the care being currently provided to Resident 43. During an interview on 2/12/2026 at 2:31 pm with the facility's Director of Nursing (DON), the DON stated the resident's CP should be updated when there's a change with the resident, a new order, quarterly, and annually. The DON stated, it was important for the resident to have an updated CP to individualize care and allow the facility staff to monitor if the care provided was working for the resident or needed to be altered. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised December 2016, the P&P indicated a comprehensive, person-centered CP that included measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs were developed and implemented for each resident. The P&P indicated assessments of residents were ongoing and CPs were revised as information about the residents and the residents' conditions changed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the suprapubic catheter (a soft tube inserted directly into the bladder through a small incision to drain urine into a bag) bag was not touching the floor for one of two sampled residents (Resident 1). This deficient practice resulted in contamination of Resident 1's care equipment and placed the resident at risk of infection. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including encounter for urinary tract infection (UTI- infection that affects part of the urinary tract), encounter for fitting and adjustment of urinary device and neuromuscular dysfunction of the bladder (lack of bladder control). During a review of Resident 1's Order Summary Report (OSR) dated 1/7/2026, the OSR indicated suprapubic catheter 22 (size of the catheter) French (a type of catheter) per 10 milliliters (ml, unit of measurement) attached to bedside drainage bag for neurogenic bladder every shift for Resident 1. During a review of Resident 1's History and Physical (H&P) dated 1/8/2026, the H&P indicated Resident 1's had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/12/2026, the MDS indicated Resident 1 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During an observation on 2/10/2026 at 9:31 am, Resident 1 was awake lying in bed in Resident 1's room. During an observation on 2/10/2026 at 9:32 am together with Infection Prevention Nurse (IPN), Resident 1's suprapubic catheter bag was touching the floor. During an interview on 2/10/2026 at 9:34 am, the IPN stated the catheter bag should not be touching the floor because it could cause cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and could lead to UTI. During an interview on 2/10/2026 at 12:48 pm with the Assistant Director of Nursing (ADON), the ADON stated, FC bag should not be touching the floor because the floor was dirty and bacteria could travel from the floor to the bag and could lead to UTI. During a review of the facility's Policy and Procedure (P&P), titled, Urinary Catheter Care, dated 9/2014, the P&P indicated the purpose of this procedure was to prevent catheter-associated urinary tract infections. For infection control, be sure the catheter tubing and drainage bag are kept off the floor.		

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NAME OF PROVIDER OR SUPPLIER Harvard Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 519 W. Badillo St. Covina, CA 91722	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to administer continuous oxygen therapy (treatment that provides supplemental, or extra, oxygen) for one of one sampled resident (Resident 15) according to accepted standards of clinical practice and in accordance with the facility's policy and procedure (P&P) titled, Oxygen Administration. This deficient practice placed Resident 15 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which could lead to serious complications. Findings: During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 1/7/2026 with diagnoses including Chronic Obstructive Pulmonary Disease (COPD- a type of obstructive lung disease characterized by long term poor airflow) and dependence of supplemental oxygen. During a review of Resident 15's Physician Order (PO) dated 1/7/2026, the PO indicated for licensed staff to administer two (2) liters per minute (L/min) of oxygen via nasal cannula (tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen) continuously every shift for COPD. During a review of Resident 15's History and Physical (H&P) dated 1/8/2026, the H&P indicated Resident 15 had the capacity to understand and make medical decisions. During a review of Resident 15's untitled Care Plan (CP) dated 1/11/2026, the CP indicated Resident 15 was at risk for respiratory distress related to shortness of breath and irregular respirations. The CP interventions included for nursing staff to administer oxygen as ordered to Resident 15. During a review of Resident 15's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/12/2026, 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 did all the effort) on staff for toileting hygiene, showering/bathing self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 15 needed moderate assistance (helper does less than half the effort) on staff for oral hygiene and upper body dressing. During an observation on 2/10/2026 at 9:47 am, together with the Infection Prevention Nurse (IPN), Resident 15 was asleep, lying in bed with ongoing oxygen flowing at 2LPM via concentrator (a medical device that concentrates oxygen from environmental air and delivers it to the resident in need of supplemental oxygen). Resident 15's nasal cannula tubing was hanging on the left side of the bed and the nasal cannula tubing prongs were not placed in Resident 15's nares. During a concurrent observation and interview on 2/10/2026, at 9:55 am, with the IPN, the IPN stated Resident 15's nasal cannula was placed on top of Resident 15's bed and the oxygen concentrator was running oxygen at 2LPM. The IPN stated the nasal cannula should be placed inside the bag if not in use to prevent infection and to turn off the oxygen concentrator if not in use. During an interview and concurrent record review on 2/10/2026 at 12:43 pm, with the Assistant Director of Nursing (ADON) of Resident 15's medical records (PointClickCare - PCC, a cloud-based software), the ADON stated Resident 15 had an order of continuous 2 LPM of oxygen via nasal cannula. The ADON stated Resident 15 should have been on continuous oxygen at all times as ordered to prevent respiratory distress or respiratory failure. The ADON stated if oxygen was not in use, the nasal cannula should be placed inside the plastic bag to prevent cross contamination. During a review of the facility's Policy and Procedure (P&P) titled, Oxygen Administration, dated 10/2010, the P&P indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure hemodialysis (HD - a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) device access dressing was removed as ordered by the physician for one of one sampled resident (Resident 43).This deficient practice had the potential for Resident 43 to develop complications related to HD device access.Findings:During a review of Resident 43's admission Record (AR), the AR indicated Resident 43 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal hemodialysis, and congestive heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently).During a review of Resident 43's Order Summary Report (OSR) dated 7/20/2025, the OSR indicated Resident 43 had an order for hemodialysis on Mondays, Wednesdays and Fridays with extra dialysis on Saturdays. During a review of Resident 43's OSR, dated 8/6/2025, the OSR indicated to remove dialysis dressing to left upper arm 4-6 hours post (after) dialysis treatment on Mondays, Wednesdays, Fridays and Saturdays.During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 12/24/2025, the MDS indicated Resident 43 had a moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 43 was independent (resident completes the activity by themselves with no assistance from a helper) with eating, oral hygiene, toileting and upper body dressing, needed setup or clean-up assistance (helper sets up or cleans up, resident completes the activity) with personal hygiene) and required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with shower. During a review of Resident 43's Nurses Dialysis Communication Record (NDCR) dated 2/9/2026, the NDCR indicated Resident 43 had left for dialysis at 7:30 am and came back to the facility at 12:10 pm with an intact dressing on the left upper arm.During a review of the facility's Nurses Communication Record (NCR) dated 2/9/2026 at 2:46 pm, the NCR indicated Licensed Vocational Nurse 1 (LVN 1) endorsed to the next shift to remove Resident 43's dialysis dressing.During a concurrent observation inside Resident 43's room and interview on 2/10/2026 at 9:42 am with Assistant Director of Nursing (ADON), Resident 43 was sitting in bed with gauze dressing taped around Resident 43's left upper arm. The ADON stated Resident 43 had a arteriovenous (AV - a direct, surgically created connection between an artery and a vein for hemodialysis) shunt on Resident 43's left upper arm as access for hemodialysis. The ADON stated Resident 43 received hemodialysis on Mondays. Wednesdays, Fridays and Saturdays. The ADON stated Resident 43's last hemodialysis was on 2/9/2026.During a concurrent interview and record review on 2/10/2026 at 3:05 pm with LVN 1, Resident 43's OSR dated 8/6/2025 and NDCR dated 2/9/2026 were reviewed. LVN 1 stated Resident 43 had an order to remove the dialysis dressing 4-6 hours after dialysis. LVN 1 stated Resident 43 came back from HD on 2/9/2026 at 12:10 pm with gauze dressing taped around Resident 43's left upper arm. LVN 1 stated the dressing was due to be removed between 4:10 to 6:10 pm. LVN 1 stated Resident 43 still had a dressing on Resident 43's left upper arm in the morning of 2/10/2026. LVN 1 stated the dialysis access dressing on Resident 43's left upper arm should be removed 4-6 hours after dialysis as ordered by the physician to prevent the risk of developing blood clot and skin damage.During an interview on 2/12/2026 at 3:14 pm with the Director of Nursing (DON), the DON stated HD device dressing should be removed as ordered by the physician to prevent the risk of developing infection and blood clot to the site clogging the device. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis Access Care, revised September 2010, the P&P indicated, Care involves the primary goals of preventing infection and maintaining patency of the catheter (preventing clots).		

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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 ensure one of one sampled resident (Resident 19) was properly identified during Resident 19's medication administration. This failure had the potential to result in medication errors from Resident 19 receiving incorrect medications. Findings: During a review of Resident 19's admission Record (AR), the AR indicated Resident 19 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing) and hypertension (HTN-high blood pressure). During a review of Resident 19's History & Physical (H&P) dated 4/25/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 19's Minimum Data Set (MDS, a resident assessment tool), dated 1/23/2026, the MDS indicated Resident 19 had intact cognition (ability to understand). During a Medication Administration observation on 2/12/2026 at 8:11 am in Resident 19's room, Resident 19 was lying in bed and did not have resident identification (ID) band on both arms. Licensed Vocational Nurse 1 (LVN 1) greeted Resident 19 stating Resident 19's first name, explained LVN 1 would administer medications and proceeded with completing a blood pressure and pulse check on Resident 19. LVN 1 returned to Resident 19's bedside after preparing medication and stated LVN 1 had medications, elevated the head of the bed of Resident 19 and questioned the resident regarding bowel movement and pain status. LVN 1 explained the medications that were being given while completing the medication administration without checking any resident identifier prior to medication administration. During an interview on 2/12/2026 at 9:41 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated to identify a resident for medication administration, LVN 1 should have asked the resident's last name and date of birth (DOB) or cross reference the resident's picture in the medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) with the resident. LVN 1 stated the licensed nurse should check the resident's ID band and if the resident was alert, ask the resident's DOB and last name. LVN 1 stated, the purpose of identifying the resident properly before medication administration was to ensure the correct person was identified before giving medications, for resident safety. During an interview on 2/12/2026 at 11:43 am with Assistant Director of Nursing (ADON), the ADON stated prior to medication administration, licensed nurses should use the resident's ID band, MAR photo, and date of birth (DOB) as resident identifiers. The ADON stated licensed nurses should use two resident identifiers and if the resident was alert, the resident's full name and date of birth should be verified. The ADON stated if the licensed nurses fail to do this, they were not identifying the resident correctly. The ADON stated resident identification was necessary to prevent medication errors that could potentially lead to serious harm for the resident. During an interview on 2/12/2026 at 3:41 pm with the facility's Director of Nursing (DON), the DON stated if the resident could speak, the licensed nurse should check the resident's name band and ask the resident to state the resident's name. The DON stated if the resident had no ID band, the licensed nurse should use the resident's MAR photo and ask the resident's name. The DON stated, this process was important to identify the correct resident and give the correct medication to prevent a medication error from occurring. During a review of the facility's policy and procedure (P&P) titled, Adminstrating Medications, revised 4/2019, the P&P indicated medications were administered in a safe and timely manner. The P&P indicated the individual administering medications verified the resident's identity before giving the resident his/her medications with methods of identification including: a. checking identification band; b. checking photograph attached to medical record; and c. if necessary, verifying resident identification with other facility personnel.		

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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 four sampled residents (Resident 1) by failing to wear required personal protective equipment (PPE, equipment that protects people from injury or illness in hazardous environments) while providing care to Resident 1 who was 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 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 to Resident 1 and staff that could result in a widespread infection in the facility. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including encounter for urinary tract infection (UTI- infection that affects part of the urinary tract), encounter for fitting and adjustment of urinary device and neuromuscular dysfunction of the bladder (lack of bladder control). During a review of Resident 1's Order Summary Report (OSR) dated 1/7/2026, the OSR indicated to place Resident 1 on EBP to reduce the spread of MDRO due to indwelling catheter (tube inserted into the bladder and left in place in order to drain urine). During a review of Resident 1's History and Physical (H&P) dated 1/8/2026, the H&P indicated Resident 1's had the capacity to understand and make medical decisions. During a review of Resident 1's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/12/2026, the MDS indicated Resident 1 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 1 was dependent (helper does all of the effort) on staff for oral hygiene, toileting, showering/bathing self, upper/lower body dressing, and personal hygiene. During a review of Resident 1's untitled and undated Care Plan (CP), the CP indicated to place Resident 1 on EBP due to presence of indwelling medical device: suprapubic catheter (a soft tube inserted directly into the bladder through a small incision to drain urine into a bag). The CP indicated for nursing staff to observe proper donning and doffing of PPE to protect skin and soiling of clothing during procedures and high-contact activities that could cause contact with blood and body fluids, secretions, or excretions. During an observation on 2/10/2026 at 9:31 am, Resident 1 was awake lying in bed in Resident 1's room. During an observation on 2/10/2026 at 9:32 am, Resident 1 was lying in bed. The Infection Prevention Nurse (IPN, a healthcare professional who specializes in preventing the spread of infections in healthcare settings) did not wear gown while assessing Resident 1's suprapubic catheter bag and tubing. During an interview on 2/11/2026 at 9:00 am with the IPN, the IPN stated Resident 1 was on EBP due to Resident 1's suprapubic catheter. The IPN stated the IPN did not wear protective gown when touching Resident 1's suprapubic catheter bag and tubing because the IPN was not doing a high contact activity with Resident 1. The IPN stated, Staff does not need to wear a gown when touching a foley catheter (sterile tube inserted into the bladder to drain urine). During an interview on 2/11/2026 at 9:47 am with the Assistant Director of Nursing (ADON), the ADON stated, staff needed to wear gown, gloves and mask before touching Resident 1 who was placed on EBP due to the presence of an indwelling device (suprapubic catheter) to avoid the spread of infection from staff to other residents. The IPN stated staff needed to wear required PPE to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an interview on 2/12/2026 at 2:56 pm with the facility's Director of Nursing (DON), the DON stated, EBP was indicated for residents who had medical devices such as foley catheter. The DON stated that staff needed to wear gloves and gown when touching medical devices to prevent the spread of infection. During a review of the facility's P&P titled, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Infection Control: Enhanced Barrier Precautions, dated 6/18/2024, the P&P indicated, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Indwelling medical device examples include. urinary catheters. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities. Device care or use: . urinary catheter.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure staffing information on the Nurse Staffing Sheet (posted information that contains the facility's current resident census and total number and actual hours worked by licensed and unlicensed nursing staff) was posted in a prominent place readily accessible to residents and visitors. This deficient practice had the potential to mislead the residents and visitors that may affect the quality of nursing care provided to the residents. Findings: During observations on 2/11/2026 at 9:27 am the Nurse Staffing Sheet was only posted on an enclosed bulletin board across from Nursing Station 2. During a concurrent observation and interview on 2/12/2026 at 1:10 pm with the Director of Staff Development (DSD), the Nurse Staffing Sheet was posted on the bulletin board across from Nursing Station 2. The DSD stated there were no other postings within the facility which didn't allow it to be readily accessible to all residents and visitors. The DSD further stated posting the Nurse Staffing Sheet where it was accessible allowed residents and visitors to determine if the facility had adequate staffing and ensured the facility was in compliance with required nurse staffing hours. During an interview on 2/12/2026 at 3:37 pm with the facility's Director of Nursing (DON), the DON stated the Nurse Staffing Sheet should be displayed in common areas where visitors, family, and staff could view it. The DON stated this would allow everyone to be aware of the nurse to resident ratio and showed that the facility could provide the proper care to their residents. During a review of the facility's policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, revised 7/2016, the P&P indicated within two hours of the beginning of each shift, the number of Licensed Nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a minimum of 80 square feet (sq. ft., unit of measurement) per resident area for eighteen (18) out of twenty-four (24) resident rooms (Rooms 101, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, and 122). This deficient practice had the potential to impact the ability to provide safe nursing care and privacy to the residents. Findings: During an interview with the facility's Administrator (ADM) on 2/10/2026 at 9:26 am, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) for Rooms 101, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, and 122. The ADM stated nothing was changed and the number of bed occupancy in the 18 rooms. During a review of the facility's letter to request for room waiver dated 2/10/2026, the room waiver request indicated there was ample room to accommodate wheelchairs (a chair fitted with wheels for use as a means of transport by a person who is unable to walk as a result of illness, injury, or disability) and other medical equipment, as well as space for mobility and movement of ambulatory residents. The letter indicated there was adequate space for nursing care, and the health and safety of residents occupying these rooms are not in jeopardy. The letter further indicated these rooms are in accordance with the special needs of the residents, and do not have an adverse effect on the residents' health and safety or impedes the ability of any resident in the rooms to attain his or her highest practicable well-being. The room waiver letter indicated the following: Room Sq. Ft. Beds 101 154 2 103 154 2 104 154 2 105 154 2 106 154 2 107 154 2 108 280 4 109 280 4 110 154 2 111 154 2 112 154 2 114 147 2 115 147 2 116 154 2 117 154 2 118 154 2 119 154 2 122 280 4 During the Health Recertification Survey conducted from 2/10/2026 to 2/13/2026, Rooms 101, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, and 122 had adequate space, nursing care and comfort, and privacy was provided to the residents. The residents were observed to have enough space to move freely inside the rooms. There was an adequate room for the operation and use of the wheelchairs, walkers (a device that gave additional support to maintain balance or stability while walking,) and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). Each resident inside the affected rooms had beds and bedside tables with drawers. The room size did not affect the care and services provided by the staff to the residents when staff were observed providing care to the residents. During a concurrent observation and interview with Resident 26 on 2/10/2026 at 12:42 pm, in Resident 26's room (room [ROOM NUMBER]), Resident 26 was having lunch. Resident 26 stated Resident 26 had enough space in the room to move around with no concerns. During a concurrent observation and interview on 2/13/2026 at 10:39 am with Certified Nurse Assistant 2 (CNA 2), CNA 2 was moving the front-wheeled walker in room [ROOM NUMBER]. CNA 2 stated CNA 2 had enough space to move around in the room to provide resident care. During an interview on 2/13/2026 at 10:43 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated there was space to provide care and treatment to the residents. LVN 2 stated LVN 2 was able to move wheelchairs, Hoyer Lifts, and walkers inside the rooms.		