STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056331	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Healthcare Center	919 N Sunset Ave West Covina, CA 91790

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 37198 Based on interview and record review, the facility failed to ensure complete documentation regarding discharge planning was done for one of three sampled residents (Resident 1). This deficient practice had the potential to not provide full information regarding the discharge plans that were discussed for Resident 1. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/22/2024, with diagnoses of non-pressure chronic ulcer (non-healing open sore caused by poor circulation) of the left heel and midfoot (middle of the foot) with unspecified severity (unknown how severe), local infection of the skin and subcutaneous tissue (deepest layer of the skin), and type 2 diabetes mellitus (characterized by high levels of blood sugar in the blood). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 1/25/2024, the MDS indicated Resident 1 had the ability to understand others and was understood by others. The MDS indicated Resident 1 was dependent (helper does all of the effort) with toileting, lower body dressing, and putting on and taking off footwear. During a review of Resident 1's late entry Social Service Note (SSN), dated 4/8/2024 at 3:50 pm, the SSN indicated Family Member 1 (FM 1) met with the interdisciplinary team (IDT) to discuss Resident 1's discharge plan. The SSN indicated FM 1 would like assistance with long term placement to another skilled nursing facility (SNF). The SSN indicated assistance for a board and care option was offered to FM 1 but FM 1 stated would like to try a SNF first. The SSN did not indicate if the option to remain in the facility, which was also a long-term care facility, was offered or discussed with FM 1. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 on 5/30/2024 at 2:28 pm and on 6/3/2024 at 12:17 pm, with the Director of Social Services (DSS), the DSS stated when she spoke to FM 1 regarding discharge planning, DSS stated she discussed with FM 1 the options regarding placement for Resident 1. DSS stated she discussed and offered the option of Resident 1 staying at the current facility since the facility was also a long-term care facility. DSS stated she did not document anything in Resident 1's medical record that the option to stay at the facility was discussed during discharge planning. The DSS stated it was very important to document any assessments and discussion regarding options, because if it was not documented, it did not happen. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, revised in March 2023, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.