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	05/14/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to promptly notify one of five sampled residents' (Resident 1's) doctor of a change in condition in accordance with the facility's policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol, when:a. Resident 1's doctor (DR 2) was not promptly informed of Resident 1's signs and symptoms (S&S) of a urinary tract infection (UTI- an infection in the bladder/urinary tract) which started on [DATE] at 12:00 PM.b. DR 2 was not promptly informed of an increase in size of Resident 1's right and left leg edema (swelling caused by too much fluid trapped in the body's tissues) which started on [DATE].These failures had the potential for Resident 1 not to receive timely treatment for Resident 1's changes in condition.(Cross reference F641, F658, F686, and F842)During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses that included multiple fractures of the vertebrae (broken backbones), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications (has DM but it has not resulted in further health problems), and dementia (a progressive state of decline in mental abilities). The AR did not indicate Resident 1 had peripheral neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and to move around in bed including rolling left and right, sitting to lying, and lying to sitting on side of bed and to transfer in and out of bed. The MDS indicated Resident 1 was at risk of developing pressure ulcers/injuries.During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 1 had an impaired skin integrity related to edema on both legs. The CPR interventions included monitoring Resident 1's edema and reporting promptly to Resident 1's doctor if there was an increase in edema size.During a concurrent interview and record review on [DATE] at 3:32 PM with DR 2, Resident 1's Treatment Administration Record (TAR), for [DATE] and February 2026, were reviewed. The TAR for [DATE] indicated on [DATE] Resident 1's right and left leg edema increased in swelling from plus 1 (+1) to plus 2 (+2) according to the pitting edema scale (measures how deep an indentation [or pit] remains in the skin after applying firm pressure) and remained +2 until [DATE]. DR 2 stated DR 2 did not recall the facility informing DR 2 of Resident 1's increased edema on both legs. DR 2 stated the facility needed to inform DR 2 when a resident's (in general) edema size increased.During a concurrent interview and record review on [DATE] at 10:15 AM with the Infection Preventionist (IP) 1, Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form (SBAR), dated [DATE], and the facility's document showing screen shots of text messages to DR 2, dated [DATE], were reviewed. The SBAR indicated that on [DATE] at 12:00 PM, Resident 1 gained 6.6 pounds in one week, had generalized (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weakness, and had frequency and urgency with urinating. IP 1 stated S&S of a UTI included frequency and urgency with urinating, and foul-smelling urine. IP 1 stated Resident 1's nurse (in general) should have notified DR 2 of Resident 1's S&S of UTI. IP 1 stated the nurse should notify DR 2 or the facility's medical director (MD) within the same shift the S&S started. The screen shots indicated facility staff (unidentified) texted DR 2 on [DATE] at 7:35 AM that Resident 1 was experiencing general weakness and was unable to eat on their own. The screen shot indicated the facility staff (unidentified) did not inform DR 2 of Resident 1's frequency and urgency with urinating.During a concurrent interview and record review on [DATE] at 10:04 AM with the Director of Nursing (DON), Resident 1's TAR, for [DATE] and February 2026, were reviewed. The DON confirmed Resident 1's edema on both legs increased in size on [DATE]. The DON stated the increase in size would be considered a change in condition. The DON stated DR 2 should have been notified of the increase in size of Resident 1's edema on both legs. The DON stated the facility did not notify DR 2 of the increase in size since Resident 1's medical record did not document that DR 2 was notified.During a concurrent interview and record review on [DATE] at 11:01 AM with the MD, Resident 1's H&P, dated [DATE] was reviewed. The H&P indicated DR 2 documented Resident 1 did not have edema. The MD stated if facility nurses (in general) documented Resident 1 had edema, then Resident 1 had edema. The MD stated nursing documentation is generally more thorough than doctor's documentation.During a review of the facility's P&P titled, Acute Condition Changes - Clinical Protocol, revised [DATE], the P&P indicated, The physician will help identify individuals with a significant risk for having acute changes of condition during their stay. The P&P indicated, The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less) . The attending physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status. The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response. The nurse and physician will discuss and evaluate the situation. The physician should request information to clarify the situation; for example, vital signs, physical findings, a detailed sequence of events and description of symptoms.

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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 a Minimum Data Set (MDS, a resident assessment tool) was accurate for one of five sampled residents (Resident 1) when Resident 1's MDS, dated [DATE], incorrectly indicated Resident 1 did not have any pressure ulcer/injury pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) upon discharge from the facility on 2/3/2026.This failure had the potential to result in Resident 1 not receiving appropriate treatment and/or services.(Cross reference F580, F658, F686, and F842)During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/8/2026 with diagnoses that included multiple fractures of the vertebrae (broken backbones), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications (has DM but it has not resulted in further health problems), and dementia (a progressive state of decline in mental abilities). The AR did not indicate Resident 1 had peripheral neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). The AR also indicated Resident 1's Family/Friend (RR 1) was one of Resident 1's emergency contact.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/11/2026, the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and to move around in bed including rolling left and right, sitting to lying, and lying to sitting on side of bed and to transfer in and out of bed. The MDS indicated Resident 1 was at risk of developing pressure ulcers/injuries.During a review of Resident 1's Grievance Report and Resolution Form (GRRF), dated 1/21/2026, the GRRF indicated RR 1 filed multiple complaints to the facility on 1/21/2026. The GRRF indicated to see the attached document for complaints by RR 1. The attached document indicated multiple complaints including, On January 20, 2026, I was advised that a nurse mischaracterized [Resident 1's] pressure sores (bedsores) as diabetic ulcers [Resident 1] has never had diabetic ulcers .During a concurrent interview and record review on 5/12/2026 at 11:18 AM with Treatment Nurse 1 (TN 1), Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form (SBAR), dated 1/13/2026 and timed at 5:10 PM, was reviewed. The SBAR indicated Resident 1's change in condition was regarding a diabetic ulcer (an open sore or wound on a person with diabetes, most commonly on the foot, caused by nerve damage [neuropathy] and poor circulation) on Resident 1's left fifth toe. The SBAR indicated on 1/13/2026 at 4:15 PM TN 1 noted a new wound on Resident 1's left fifth toe. The SBAR indicated, The patient is 6'3 in height and had been sliding down in bed, causing feet to make contact with the footboard. The bed was extended to accomodate [sic] the patient's height. TN 1 stated that on 1/13/2026, RR 1 visited Resident 1 and pointed out a new wound on Resident 1's left lateral (toward the side) metatarsal head (rounded, knobby end of the long bones in your midfoot that connects to your toe bones) of the fifth toe to TN 1. TN 1 stated TN 1 observed that the area of the foot where the wound developed was making contact with the bed's footboard. TN 1 stated TN 1 had the maintenance staff extend the frame of Resident 1's bed. TN 1 stated Resident 1's foot contact to the footboard caused skin injury to Resident 1's left fifth toe. TN 1 described the wound as non-blanchable redness (intact skin that is red and does not turn white when pressed; the earliest sign of a pressure injury). TN 1 stated since Resident 1 was diabetic, TN 1 documented the wound as being a diabetic ulcer. TN 1 stated TN 1 did not consult with the Wound Care Specialist (WCS) or with Resident 1's physician before identifying the wound as a diabetic ulcer.During a concurrent telephone interview and record review on 5/12/2026 at 12:28 PM with the WCS, Resident 1's wound care progress note (WCPN), dated 1/14/2026, was reviewed. The WCPN indicated the WCS evaluated and (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treated Resident 1's skin wounds on 1/14/2026. The WCPN indicated the WCS was a nurse practitioner (NP- a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) and a wound care specialist. The WCPN indicated the WCS determined Resident 1's wound to the left fifth toe was a diabetic wound. The surveyor asked the WCS why the WCS did not diagnose Resident 1's left fifth toe wound to be pressure injury since TN 1 documented pressure from Resident 1's footboard caused the injury. The WCS stated the WCS did not consider the etiology (the cause or origin of a disease or condition) of the wound when determining if the wound was a diabetic wound versus pressure injury. The WCS stated because Resident 1 had diabetes, the WCS determined the wound to be a diabetic wound. The WCS stated the WCS would not deny that the etiology of the wound was pressure from the footboard.During a concurrent interview and record review on 5/12/2026 at 12:47 PM with the MDS Coordinator (MDSC), Resident 1's MDS, dated [DATE], was reviewed. The MDSC stated because the WCS documented Resident 1's pressure injury as being a diabetic ulcer, MDSC documented in the MDS that Resident 1 did not have any pressure ulcer/injury.During a concurrent telephone interview and record review on 5/12/2026 at 1:40 PM with the WCS's supervising physician (DR 1), Resident 1's WCPN, dated 1/14/2026, was reviewed. DR 1 stated DR 1 had not assessed or treated Resident 1 while Resident 1 was at the facility. The Surveyor asked DR 1 if a diabetic resident (in general) could be diagnosed with a pressure ulcer or must the foot wound always be diagnosed as a diabetic wound. DR 1 stated a diabetic resident (in general) could have a pressure ulcer on the foot. The Surveyor asked DR 1 to explain how a WCS should determine whether a wound on the foot was a diabetic wound versus a pressure injury. DR 1 stated if the resident (in general) was diabetic, had poor sensation in the feet, and the wound was not over a bony area, the wound would be considered a diabetic wound. The surveyor asked DR 1 how a WCS determined if a resident (in general) had poor sensation to the feet. DR 1 stated a WCS should assess a resident's (in general) feet sensation by probing the feet and moving up the leg, assessing if the resident (in general) can feel the probing to the feet. The WCPN did not indicate the WCS assessed if Resident 1 had poor sensation to Resident 1's feet. The Surveyor asked DR1 if DR 1 would consider Resident 1's left fifth toe wound to be a pressure wound if the wound area on the foot was discovered sitting against the footboard of Resident 1's bed. DR 1 stated if Resident 1 was unable to move Resident 1's feet, and if the foot rested against the footboard for a long time, DR 1 would consider the wound to be a pressure injury (instead of a diabetic wound).During a review of the facility's manual titled, CMS's RAI Version 3.0 Manual, dated October 2025, the manual described a diabetic foot ulcer as, Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful. The manual described a pressure ulcer/injury as, A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual indicated, It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. The manual indicated, Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.During a review of the facility's policy and procedure (P&P) titled, Resident Assessment Instrument, revised September 2024, the P&P indicated, The Interdisciplinary Assessment Team must use the MDS form currently mandated by Federal and State regulations to conduct the resident assessment.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Wound Care Specialist (WCS) inaccurately diagnosed on e of five sampled resident's (Resident 1's) pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) on the left fifth toe as a diabetic wound (diabetic ulcer, an open sore or wound on a person with diabetes, most commonly on the foot, caused by nerve damage [neuropathy] and poor circulation).This failure had the potential for Resident 1 to receive inappropriate care and treatment for Resident 1's pressure injury on the left fifth toe.(Cross reference F580, F641, F686, and F842)During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses that included multiple fractures of the vertebrae (broken backbones), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications (has DM but it has not resulted in further health problems), and dementia (a progressive state of decline in mental abilities). The AR did not indicate Resident 1 had peripheral neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). The AR also indicated Resident 1's Family/Friend (RR 1) was one of Resident 1's emergency contact.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and to move around in bed including rolling left and right, sitting to lying, and lying to sitting on side of bed and to transfer in and out of bed. The MDS indicated Resident 1 was at risk of developing pressure ulcers/injuries.During a review of Resident 1's Care Plan Report (CPR), dated [DATE], the CPR indicated that on [DATE], Resident 1 developed a skin breakdown on Resident 1's left lateral (toward the side) metatarsal head (MTH, rounded, knobby end of the long bones in your midfoot that connects to your toe bones) of the fifth toe. The CPR interventions included initiating a wound assessment and providing appropriate treatment as ordered.During a review of Resident 1's Grievance Report and Resolution Form GRRF, dated [DATE], the GRRF indicated RR 1 issued multiple complaints to the facility on [DATE]. The GRRF indicated to see the attached document for complaints by RR 1. The attached document indicated complaints including, On [DATE], I was advised that a nurse mischaracterized [Resident 1's] pressure sores (bedsores) as diabetic ulcers. [Resident 1] has never had diabetic ulcers. [Resident 1] has never had pressure sores (bedsores).During an interview on [DATE] at 10:55 AM with RR 1, RR 1 stated RR 1 was Resident 1's caregiver. RR 1 stated when Resident 1 was admitted to the facility, Resident 1 was admitted to a bed that was too short for Resident 1. RR 1 stated RR 1 was not aware that Resident 1's bed was too short until [DATE]. RR 1 stated RR 1 was visiting Resident 1 on [DATE] and that Resident 1 could not move Resident 1's legs. RR 1 stated RR1 removed the sheet from over Resident 1's legs and observed Resident 1's feet pressed against the footboard of the bed. RR 1 stated RR 1 notified a nurse (unidentified), so facility staff extended Resident 1's bed frame.During a concurrent interview and record review on [DATE] at 11:18 AM with Treatment Nurse 1 (TN 1), Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form (SBAR), dated [DATE] and timed at 5:10 PM, was reviewed. The SBAR indicated Resident 1's change in condition was regarding a diabetic ulcer (an open sore or wound on a person with diabetes, most commonly on the foot, caused by nerve damage [neuropathy] and poor circulation) on Resident 1's left fifth toe. The SBAR indicated on [DATE] at 4:15 PM TN 1 noted a new wound on Resident 1's left fifth toe. The SBAR indicated, The patient is 6'3 in height and had been sliding down in bed, causing feet to make contact with the footboard. The bed was extended to accomodate [sic] the patient's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	height. TN 1 stated that on [DATE], RR 1 visited Resident 1 and pointed out a new wound on Resident 1's left lateral (toward the side) MTH of the fifth toe to TN 1. TN 1 stated TN 1 observed that the area of the foot where the wound developed was making contact with the bed's footboard. TN 1 stated TN 1 had the maintenance staff extend the frame of Resident 1's bed. TN 1 stated Resident 1's foot contact to the footboard caused skin injury to Resident 1's left fifth toe. TN 1 described the wound as non-blanchable redness (intact skin that is red and does not turn white when pressed; the earliest sign of a pressure injury). TN 1 stated since Resident 1 was diabetic, TN 1 documented the wound as being a diabetic ulcer. TN 1 stated TN 1 did not consult with the Wound Care Specialist (WCS) or with Resident 1's physician before identifying the wound as a diabetic ulcer.During a concurrent telephone interview and record review on [DATE] at 12:28 PM with the WCS, Resident 1's wound care progress note (WCPN), dated [DATE], was reviewed. The WCPN indicated the WCS evaluated and treated Resident 1's skin wounds on [DATE]. The WCPN indicated the WCS was a nurse practitioner (NP- a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) and a wound care specialist. The WCPN indicated the WCS determined Resident 1's wound to the left fifth toe was a diabetic wound. The surveyor asked the WCS why the WCS did not diagnose Resident 1's left fifth toe wound to be pressure injury since TN 1 documented pressure from Resident 1's footboard caused the injury. The WCS stated the WCS did not consider the etiology (the cause or origin of a disease or condition) of the wound when determining if the wound was a diabetic wound versus pressure injury. The WCS stated because Resident 1 had diabetes, the WCS determined the wound to be a diabetic wound. The WCS stated the WCS would not deny that the etiology of the wound was pressure from the footboard.During a concurrent telephone interview and record review on [DATE] at 1:40 PM with the WCS's supervising physician (DR 1), Resident 1's WCPN, dated [DATE], was reviewed. DR 1 stated DR 1 had not assessed or treated Resident 1 while Resident 1 was at the facility. The Surveyor asked DR 1 if a diabetic resident (in general) could be diagnosed with a pressure ulcer or must the foot wound always be diagnosed as a diabetic wound. DR 1 stated a diabetic resident (in general) could have a pressure ulcer on the foot. The Surveyor asked DR 1 to explain how a WCS should determine whether a wound on the foot was a diabetic wound versus a pressure injury. DR 1 stated if the resident (in general) was diabetic, had poor sensation in the feet, and the wound was not over a bony area, the wound would be considered a diabetic wound. The surveyor asked DR 1 how a WCS determined if a resident (in general) had poor sensation to the feet. DR 1 stated a WCS should assess a resident's (in general) feet sensation by probing the feet and moving up the leg, assessing if the resident (in general) can feel the probing to the feet. The WCPN did not indicate the WCS assessed if Resident 1 had poor sensation to Resident 1's feet. The Surveyor asked DR1 if DR 1 would consider Resident 1's left fifth toe wound to be a pressure wound if the wound area on the foot was discovered sitting against the footboard of Resident 1's bed. DR 1 stated if Resident 1 was unable to move Resident 1's feet, and if the foot rested against the footboard for a long time, DR 1 would consider the wound to be a pressure injury (instead of a diabetic wound).During a review of the facility's manual titled, CMS's RAI Version 3.0 Manual, dated [DATE], the manual described a diabetic foot ulcer as, Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful. The manual described a pressure ulcer/injury as, A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual indicated, It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. The manual indicated, Residents with diabetes mellitus (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.

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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 prevent one of five sampled residents (Resident 1) from developing a pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) when:a. Licensed Vocational Nurse (LVN) 4 failed to document a skin assessment on Resident 1 upon Resident 1's admission to the facility on 1/8/2026.b. Resident 1's bed was too short for Resident 1.These failures resulted in Resident 1 developing pressure injury to Resident 1's left fifth toe on 1/13/2026.(Cross reference F580, F641, F658, and F842)During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/8/2026 with diagnoses that included multiple fractures of the vertebrae (broken backbones), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications (has DM but it has not resulted in further health problems), and dementia (a progressive state of decline in mental abilities). The AR did not indicate Resident 1 had peripheral neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). The AR also indicated Resident 1's Family/Friend (RR 1) was one of Resident 1's emergency contact.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/11/2026, the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for all activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily) and to move around in bed including rolling left and right, sitting to lying, and lying to sitting on side of bed and to transfer in and out of bed. The MDS indicated Resident 1 was at risk of developing pressure ulcers/injuries. The MDS indicated Resident 1's height was 75 inches (6 ft 3 in).During a concurrent observation, interview, and record review on 5/13/2026 at 2:00 PM with the Maintenance Supervisor (MS), an unoccupied bed was observed in an empty room. The MS stated the bed was the standard bed all residents in the facility used. The MS confirmed Resident 1 had the same bed since Resident 1 was admitted to the facility. The bed frame measured 81 inches from the headboard to the footboard. The MS demonstrated how the bed could be extended to accommodate a taller resident. The length of the bed extended was 85.5 inches from headboard to footboard. The facility's manual, titled Service Manual for Basic American's Matrix 709 Series, indicated the sleep surface of the bed was 76 inches (Resident 1's height is 75 inches) and 80 inches when extended.During a review of Resident 1's Grievance Report and Resolution Form GRRF, dated 1/21/2026, the GRRF indicated RR 1 issued multiple complaints to the facility on 1/21/2026. The GRRF indicated to see the attached document for complaints by RR 1. The attached document indicated multiple complaints including, [Resident 1] .developed pressure sores .on [Resident 1's] toes, feet, ankles and legs because [Resident 1] was placed in a bed that was too short.During an interview on 5/6/2026 at 10:55 AM with RR 1, RR 1 stated RR 1 was Resident 1's caregiver. RR 1 stated when Resident 1 was admitted to the facility, Resident 1 was admitted to a bed that was too short for Resident 1. RR 1 stated RR 1 was not aware that Resident 1's bed was too short until 1/13/2026. RR 1 stated RR 1 visited Resident 1 on 1/13/2026 and Resident 1 could not move Resident 1's legs. RR 1 stated RR1 removed the sheet from over Resident 1's legs and observed Resident 1's feet pressed against the footboard of the bed. RR 1 stated RR 1 notified a nurse (unidentified), so facility staff (unidentified) extended Resident 1's bed frame.During a concurrent interview and record review on 5/12/2026 at 11:18 AM with TN 1, Resident 1's Admission/readmission Screener (ARS), dated 1/8/2026, was reviewed. The ARS did not indicate Resident 1 had any skin issues. TN 1 stated TN 1 assessed Resident 1's skin on 1/9/2026, the day after Resident 1 was admitted to the facility. TN 1 stated Resident 1's skin issues should have been assessed and documented by the admitting nurse (in general) when Resident 1 was admitted on [DATE].During a concurrent interview and record review on 5/12/2026 at 11:18 AM with Treatment (continued on next page)

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	056331	A. Building B. Wing	05/14/2026

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse 1 (TN 1), Resident 1's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form (SBAR), dated 1/13/2026 and timed at 5:10 PM, was reviewed. The SBAR indicated Resident 1's change in condition was regarding a diabetic ulcer (an open sore or wound on a person with diabetes, most commonly on the foot, caused by nerve damage [neuropathy] and poor circulation) on Resident 1's left fifth toe. The SBAR indicated on 1/13/2026 at 4:15 PM TN 1 noted a new wound on Resident 1's left fifth toe. The SBAR indicated, The patient is 6'3 in height and had been sliding down in bed, causing feet to make contact with the footboard. The bed was extended to accomodate [sic] the patient's height. TN 1 stated that on 1/13/2026, RR 1 visited Resident 1 and pointed out a new wound on Resident 1's left lateral (toward the side) metatarsal head (rounded, knobby end of the long bones in your midfoot that connects to your toe bones) of the fifth toe to TN 1. TN 1 stated TN 1 observed that the area of the foot where the wound developed was making contact with the bed's footboard. TN 1 stated TN 1 had the maintenance staff extend the frame of Resident 1's bed. TN 1 stated Resident 1's foot contact to the footboard caused skin injury to Resident 1's left fifth toe. TN 1 described the wound as non-blanchable redness (intact skin that is red and does not turn white when pressed; the earliest sign of a pressure injury).During a concurrent telephone interview and record review on 5/12/2026 at 12:28 PM with the WCS, Resident 1's wound care progress note (WCPN), dated 1/14/2026, was reviewed. The WCPN indicated the WCS evaluated and treated Resident 1's skin wounds on 1/14/2026. The WCPN indicated the WCS was a nurse practitioner (NP- a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) and a wound care specialist. The WCPN indicated the WCS determined Resident 1's wound to the left fifth toe was a diabetic wound. The surveyor asked the WCS why the WCS did not diagnose Resident 1's left fifth toe wound to be pressure injury since TN 1 documented pressure from Resident 1's footboard caused the injury. The WCS stated the WCS did not consider the etiology (the cause or origin of a disease or condition) of the wound when determining if the wound was a diabetic wound versus pressure injury. The WCS stated because Resident 1 had diabetes, the WCS determined the wound to be a diabetic wound. The WCS stated the WCS would not deny that the etiology of the wound was pressure from the footboard.During a concurrent telephone interview and record review on 5/12/2026 at 1:40 PM with the WCS's supervising physician (DR 1), Resident 1's WCPN, dated 1/14/2026, was reviewed. DR 1 stated DR 1 had not assessed or treated Resident 1 while Resident 1 was at the facility. The Surveyor asked DR 1 if a diabetic resident (in general) could be diagnosed with a pressure ulcer or must the foot wound always be diagnosed as a diabetic wound. DR 1 stated a diabetic resident (in general) could have a pressure ulcer on the foot. The Surveyor asked DR 1 to explain how a WCS should determine whether a wound on the foot was a diabetic wound versus a pressure injury. DR 1 stated if the resident (in general) was diabetic, had poor sensation in the feet, and the wound was not over a bony area, the wound would be considered a diabetic wound. The surveyor asked DR 1 how a WCS determined if a resident (in general) had poor sensation to the feet. DR 1 stated a WCS should assess a resident's (in general) feet sensation by probing the feet and moving up the leg, assessing if the resident (in general) can feel the probing to the feet. The WCPN did not indicate the WCS assessed if Resident 1 had poor sensation to Resident 1's feet. The Surveyor asked DR1 if DR 1 would consider Resident 1's left fifth toe wound to be a pressure wound if the wound area on the foot was discovered sitting against the footboard of Resident 1's bed. DR 1 stated if Resident 1 was unable to move Resident 1's feet, and if the foot rested against the footboard for a long time, DR 1 would consider the wound to be a pressure injury (instead of a diabetic wound).During a concurrent telephone interview and record review on 5/12/2026 at 3:10 PM with LVN 4, Resident 1's ARS, dated 1/8/2026, was reviewed. The ARS failed to indicate Resident 1's skin issues. LVN 4 stated Resident 1 had some scabs on Resident 1's arms and legs but LVN 4 forgot to document on the ARS. During a concurrent telephone interview and record review on 5/14/2026 at 10:04 PM with the Director of Nursing (DON), Resident 1's Delivery (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ticket (DT), dated 1/13/2026 was reviewed. The DT indicated a mattress extender was delivered to the facility for Resident 1's bed. The DON stated the facility ordered a mattress extension for Resident 1 because Resident 1 would slide down in bed and Resident 1's feet might touch the footboard.During a review of the facility's manual titled, CMS's RAI Version 3.0 Manual, dated October 2025, the manual described a diabetic foot ulcer as, Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful. The manual described a pressure ulcer/injury as, A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual indicated, It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. The manual indicated, Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.During a review of the facility's Policy and Procedure (P&P) titled, Prevention of Pressure Injuries, revised September 2025, the P&P indicated, Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors, and prior to discharge. The P&P indicated, Select appropriate support surfaces based the resident's risk factors, in accordance with current clinical practice.

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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 maintain a complete and accurate medical record for three of five sampled residents (Resident 1, Resident 2, and Resident 3) when:1. On [DATE], Licensed Vocational Nurse (LVN) 4 inaccurately documented that Resident 1 did not have any edema (swelling caused by too much fluid trapped in the body's tissues).2. Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], inaccurately indicated Resident 1 did not have edema.3. Resident 1's, Resident 2's, and Resident 3's medical record did not contain documentation that the residents were turned and repositioned every two hours in accordance with the residents' care plans.These failures resulted in Resident 1's, Resident 2's, and Resident 3's medical records containing inaccurate information and had the potential for Resident 1, Resident 2, and Resident 3 to receive inappropriate care and treatment.(Cross reference F580, F641, F658, and F686)a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] with diagnoses that included multiple fractures of the vertebrae (broken backbones), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications (has DM but it has not resulted in further health problems), and dementia (a progressive state of decline in mental abilities). The AR did not indicate Resident 1 had peripheral neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 1 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort to complete the activity) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and to move around in bed including rolling left and right, sitting to lying, and lying to sitting on side of bed and to transfer in and out of bed. The MDS indicated Resident 1 was at risk of developing pressure ulcers/injuries.During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], the H&P indicated that the resident does not have the capacity to understand and make decisions. The H&P also indicated Resident 1 did not have any edema.During a review of Resident 1's Care Plan Report (CPR), initiated on [DATE], the CPR indicated Residernt1 needed assistance with repositioning and turning every two hours for ADLs.During a review of Resident 1's CPR, initiated on [DATE], the CPR indicated Resident 1 needed a turning and repositioning schedule for altered skin integrity. During a review of Resident 1's medical record, there was no documentation regarding repositioning and turning Resident 1 every two hours found in the medical record.During a review of Resident 1's Treatment Administration Record (TAR), for [DATE] and February 2026, the TAR indicated facility licensed nurses (in general) documented that Resident 1 had edema.During a concurrent telephone interview and record review on [DATE] at 3:10 PM with LVN 4, Resident 1's Admission/readmission Screener (ARS), dated [DATE], was reviewed. The ARS indicated Resident 1 did not have any edema. LVN 4 stated LVN 4 documented inaccurately. LVN 4 stated Resident 1 had edema on Resident 1's arms and legs when LVN 4 assessed Resident 1 on [DATE].During a concurrent interview and record review on [DATE] at 3:05 PM with the Director of Nursing (DON), Resident 1's ARS, dated [DATE], was reviewed. The DON stated LVN 4 should have documented Resident 1's edema on arms and legs when Resident 1 was admitted on [DATE].During a concurrent interview and record review on [DATE] at 11:01 AM with the facility's Medical Director (MD), Resident 1's H&P, dated [DATE], was reviewed. The H&P indicated Resident 1's doctor (DR 2) documented Resident 1 did not have edema. The MD stated if facility nurses (in general) documented Resident 1 had edema, then Resident 1 had edema. The MD stated nursing documentation is generally more thorough than doctor's documentation.b. During a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident 2's AR, the AR indicated Resident 2 was admitted to facility on [DATE] with diagnoses including enterocolitis (an inflammation that occurs throughout intestines), acute respiratory failure with hypoxia (a life threatening condition where there's not enough oxygen or too much carbon dioxide in the tissues in body), and muscle weakness.During a review of Resident 2's H&P, dated [DATE], the H&P indicated Resident 2 could make needs known but could not make medical decisions.During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was moderately impaired in cognitive skills. The MDS indicated Resident 2 was dependent on staff for ADLs.During a review of Resident 2's CPR, initiated on [DATE], the CPR indicated Resident 2 needed turning and repositioning schedule for altered skin integrity.During a review of Resident 2's CPR, initiated on [DATE], the CPR indicated Resident 2 needed turning and repositioning every two hours and as needed when in bed or wheelchair because Resident 2 was at high risk for developing pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence).During a review of Resident 2's medical record, there was no documentation regarding repositioning and turning Resident 2 every two hours found in the medical record.c. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to facility on [DATE] with diagnoses including fracture of fifth metatarsal bone (the long bone on the outside of the foot that connects the ankle to the pinky toe) and right foot and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).During a review of Resident 3's H&P, dated [DATE], the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was severely impaired in cognitive skills. The MDS indicated Resident 3 was dependent on staff with toileting hygiene, to shower/bathe self, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 3 required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort to complete the activity) with oral hygiene and personal hygiene.During a review of Resident 3's CPR, initiated on [DATE], the CPR indicated Resident 3 needed turning and repositioning schedule for altered skin integrity and coccyx (tailbone) pressure injury.During a review of Resident 3's CPR, initiated on [DATE], the CPR indicated Resident 3 needed turning and repositioning every two hours and as needed when in bed or wheelchair because Resident 3 was at high risk for developing pressure injury.During a review of Resident 3's Monitor - Tuning and Repositioning record (MTR), the MTR did not contain any documentation from [DATE] to [DATE].During an interview on [DATE] at 3:15 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated nursing staff (in general) should document repositioning and turning of residents after providing the service to the resident (in general).During an interview on [DATE] at 1:58 PM with CNA 3, CNA 3 stated Resident 1 is on repositioning and turning program which included repositioning and turning the resident every 2 hours and documenting the different time and position after performing the procedure. CNA 3 stated residents (in general) in the repositioning and turning program should have documentation in the medical record of the time the resident was repositioned and where the resident was positioned to. Documentation must be done soon after the care is provided.During a concurrent interview and record review on [DATE] at 11:10 AM with the Director of Nursing (DON), Resident 1, 2, and 3's CPR and MTR were reviewed. The DON stated there was no MTR or any turning and repositioning documentation for Resident 1 and 2 after Resident 1 and 2's care plan regarding repositioning and turning every two hours were initiated. The DON stated that there was no documentation on the MTR from [DATE] to [DATE] for Resident 3 after Resident 3 was placed in a repositioning and turning program on [DATE]. The DON stated that it is important to document on the MTR as evidence that care plan interventions were implemented and residents on repositioning and turning program were provided care.During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, revised [DATE], the P&P indicated, Documentation in the medical record will be . complete, and accurate.