

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/21/2026
NAME OF PROVIDER OR SUPPLIER Beacon Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure necessary care and services were provided for two of three sampled residents (Residents 1 & 2) when: a. Resident 1's ceftriaxone (an antibiotic medication used to treat urinary tract infections [UTI- an infection in the bladder/urinary tract]) order did not indicate the accurate reason for use. b. Resident 2's urinalysis (UA- a laboratory test that checks urine for signs of infection) and urine culture (a laboratory test that checks urine for bacteria) orders were not transcribed (written/ordered) and implemented as directed by the medical doctor (MD). These failures resulted in Resident 2 not receiving ordered laboratory tests and had the potential for Residents 1 and 2's medical needs not being addressed, posing a serious risk to the residents' overall health. Cross reference F770 Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/8/2026 with diagnoses including unspecified fracture of first lumbar vertebra (a broken bone in the lower back), subsequent encounter for fracture with routine healing (a follow up visit indicating the break is healing normally), unspecified fracture of unspecified thoracic vertebra (a broken bone in the middle of the back) subsequent encounter for fracture with routine healing, and unstable burst fracture of second lumbar vertebra (a severe break in the lower back), subsequent encounter for fracture with routine healing. During a review of Resident 1's History and Physical (H&P) dated 1/12/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's ceftriaxone order dated 1/20/2026, the order indicated for licensed staff to administer ceftriaxone 1 gram (gm- a unit of measurement) to be given intravenously (IV - fluids given directly into the blood stream) for increase white blood cells (WBC- a blood cell that helps attack infection or injury in the body). The order indicated the Medical Doctor (MD) was the prescriber and was confirmed by the Director of Nursing (DON). During a review of Resident 1's ceftriaxone order dated 1/22/2026, the order indicated for licensed staff to administer ceftriaxone 1gm to be given intramuscularly (injected into the muscle tissue) for increased WBCs. The order indicated that the MD was the prescriber and was confirmed by the Infection Prevention Nurse (IPN). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 2/3/2026, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired. The MDS indicated Resident 1 was dependent on eating, oral/personal/toileting hygiene, bathing, and dressing and mobility. During a telephone interview on 7/21/2026 at 12:15 PM with the MD, the MD stated increased white blood cells would not be a reason to give ceftriaxone. The MD stated the MD would not order ceftriaxone to be given for increased WBCs. During a concurrent interview and record review on 7/21/2026 at 12:34 PM with the DON, Resident 1's ceftriaxone order dated 1/20/2026 was reviewed. The DON stated the DON did not remember why the order indicated ceftriaxone should be given for increased WBCs. The DON stated it was important to indicate an accurate reason for the use (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of ceftriaxone to ensure Resident 1 received the correct treatment. During a concurrent interview and record review on 7/21/2026 at 1:35 PM with the IPN, Resident 1's ceftriaxone order dated 1/22/2026 was reviewed. The IPN stated the IPN did not clarify the reason for the ceftriaxone use with the MD. The IPN stated it was important to indicate an accurate reason for ceftriaxone use to ensure Resident 1 received the correct treatment. b. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 7/1/2026 with diagnoses including retention of urine (inability to completely empty the bladder), benign prostatic hyperplasia (BPH-enlargement of the prostate gland), and UTI. During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were intact. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) and supervision or touching assistance with self-care and mobility. During a review of Resident 2's H&P dated 7/6/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 7/9/2026, the SBAR's situation indicated, Blood-tinged urine, purulent output (cloudy or milky urine) in urinary tubing and tender abdomen. The SBAR's nursing notes indicated, .MD gave orders to change foley [catheter-a hollow tube inserted into the bladder to drain or collect urine] and send UA, urine culture.UA collected and stored in specimen fridge. During a review of Resident 2's Order Summary Report (OSR) dated 7/1/2026 - 7/15/2026, the OSR did not indicate a UA or a urine culture were ordered for Resident 2. During an interview on 7/20/2026 at 2:30 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 7/9/2026 Resident 2's urine was cloudy and red which could indicate Resident 2 had a UTI. LVN 1 stated the MD was informed of Resident 2's urine symptoms and responded with a text message indicating the MD wanted a urinalysis and urine culture to be done for Resident 2. LVN 1 stated Resident 2's urine was collected and placed in the specimen refrigerator. LVN 1 stated LVN 2 was supposed to document the UA and urine culture order in Point Click Care (PCC-an electronic health record). LVN 1 stated it was important to ensure the UA and urine culture were sent to the laboratory for examination to ensure Resident 2's condition was addressed. During an interview on 7/20/2026 at 3:07 PM with the IPN, the IPN stated on 7/9/2026, Resident 2's UA and urine culture were not ordered or sent to the laboratory to be tested. The IPN stated the order should have been placed in PCC but was not. The IPN stated it was important to test Resident 2's urine to find out if Resident 2 had a UTI. The IPN stated if Resident 2's urine was not tested, and the resident had a UTI then treatment would be delayed. During a concurrent interview and record review on 7/21/2026 at 11:07 AM with LVN 2, the facility phone's MD text messages were reviewed. The facility phone's text message dated 7/9/2026, timed at 2:21 PM indicated the MD texted, change foley and send UA, urine culture [for Resident 2]. LVN 2 stated the UA and urine culture order were not placed in PCC/computer system. LVN 2 stated it was important to ensure the MD orders were placed in PCC so nursing staff would know what needed to be monitored for Resident 2. LVN 2 stated the purpose of the UA and urine culture was to check for any infection in Resident 2's urine. During a review of the facility's Policy and Procedure (P&P) titled, Physician Orders and Physician Notification, revised April 2025, the P&P indicated, The facility ensures that all resident care is provided in accordance with timely, complete.physician orders.All orders and notifications shall be documented accurately to ensure continuity of care and regulatory compliance. The P&P under physician orders indicated, .telephone orders must be.documented immediately.orders shall be implemented promptly. The P&P under responsibilities indicated, Licensed nurses: Identify changes, notify physicians, document accurately, and implement orders. During a review of the facility's P&P titled, Lab and Diagnostic Test (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Results-Clinical Protocol, revised November 2025, the P&P's assessment and recognition indicated, The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests.		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to provide laboratory services for one of three sampled residents (Resident 2) when the facility failed to send a urinalysis (UA-a laboratory test that checks urine for signs of infection) and urine culture (a laboratory test that checks urine for bacteria) to be tested as ordered by the medical doctor (MD) for Resident 2. This failure resulted in Resident 2's urine not being tested and had the potential to result in the delay of necessary care and services potentially leading to sepsis (a life-threatening blood infection). Findings: During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 7/1/2026 with diagnoses including retention of urine (inability to completely empty the bladder), benign prostatic hyperplasia (BPH-enlargement of the prostate gland), and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 2's Minimum Data Set (MDS- standardized assessment tool) dated 7/4/2026, the MDS indicated Resident 2's cognitive skills (ability to understand) for daily decision making were intact. The MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) and supervision or touching assistance with self-care and mobility. During a review of Resident 2's History and Physical (H&P) dated 7/6/2026, the H&P indicated Resident 2 had the capacity to understand and make decisions. During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) dated 7/9/2026, the SBAR's situation indicated, Blood-tinged urine, purulent output (cloudy or milky urine) in urinary tubing and tender abdomen. The SBAR's nursing notes indicated, .MD gave orders to change foley [catheter-a hollow tube inserted into the bladder to drain or collect urine] and send UA, urine culture.UA collected and stored in specimen fridge. During a review of Resident 2's Order Summary Report (OSR) dated 7/1/2026 - 7/15/2026, the OSR did not indicate a UA or a urine culture were ordered for Resident 2. During an interview on 7/20/2026 at 2:30 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated on 7/9/2026 Resident 2's urine was cloudy and red which could indicate Resident 2 had a UTI. LVN 1 stated the MD was informed of Resident 2's urine symptoms via text message. LVN 1 stated the MD responded on 7/9/2026 with a text message indicating the MD would like a urinalysis and urine culture to be done for Resident 2. LVN 1 stated Resident 2's urine was collected and placed in the specimen refrigerator. LVN 1 stated LVN 2 was supposed to document the urinalysis and urine culture order in Point Click Care (PCC-an electronic health record). LVN 1 stated it was important to ensure the UA and urine culture were sent to the laboratory for examination to ensure Resident 2's condition was addressed. During an interview on 7/20/2026 at 3:07 PM with the Infection Prevention Nurse (IPN), the IPN stated on 7/9/2026, Resident 2's UA and urine culture were not ordered or sent to the laboratory to be tested. The IPN stated the order should have been placed in Point Click Care (PCC-an electronic health record) but was not. The IPN stated it was important to test Resident 2's urine to find out if Resident 2 had a UTI. The IPN stated if Resident 2's urine was not tested, and the resident had a UTI then treatment would be delayed. During a concurrent interview and record review on 7/21/2026 at 11:07 AM with LVN 2, the facility phone's MD text messages were reviewed. The facility phone's text message dated 7/9/2026, timed at 2:21 PM indicated the MD texted, change foley and send UA, urine culture [for Resident 2]. LVN 2 stated the UA and urine culture order were not placed in PCC/computer system. LVN 2 stated it was important to ensure the MD orders were placed in PCC so nursing staff would know what needed to be monitored for Resident 2. LVN 2 stated the purpose of the UA and urine culture was to check for any infection in Resident 2's urine. During a review of the facility's Policy (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Procedure (P&P) titled, Lab and Diagnostic Test Results-Clinical Protocol, revised November 2025, the P&P's assessment and recognition indicated, The physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. During a review of the facility's P&P titled, Physician Orders and Physician Notification, revised April 2025, the P&P indicated, The facility ensures that all resident care is provided in accordance with timely, complete.physician orders.All orders and notifications shall be documented accurately to ensure continuity of care and regulatory compliance. The P&P under physician orders indicated, .telephone orders must be.documented immediately.orders shall be implemented promptly. The P&P under responsibilities indicated, Licensed nurses: Identify changes, notify physicians, document accurately, and implement orders.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of three sampled residents (Resident 1) when Resident 1's discharge assessment (DA-a final evaluation conducted by healthcare workers before a resident leaves the facility) was not completed. This failure resulted in incomplete medical records for Resident 1 and had the potential for Resident 1 to receive inappropriate care and treatment. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/8/2026 with diagnoses including unspecified fracture of first lumbar vertebra (a broken bone in the lower back), subsequent encounter for fracture with routine healing (a follow up visit indicating the break is healing normally), unspecified fracture of unspecified thoracic vertebra (a broken bone in the middle of the back) subsequent encounter for fracture with routine healing, and unstable burst fracture of second lumbar vertebra (a severe break in the lower back), subsequent encounter for fracture with routine healing. During a review of Resident 1's History and Physical (H&P) dated 1/12/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 2/3/2026, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired. The MDS indicated Resident 1 was dependent with eating, oral/personal/toileting hygiene, bathing, and dressing and mobility. During a concurrent interview and record review on 7/21/2026 at 12:57 PM with the Treatment Nurse (TN), Resident 1's DA dated 2/3/2026 was reviewed. The TN stated there was no head-to-toe assessment completed on Resident 1's DA dated 2/3/2026. The TN stated it was the policy of the facility to document a head-to-toe assessment prior to transferring a resident (in general) to the hospital. The TN stated it was important to document the head-to-toe assessment in case Resident 1 acquired a new injury while being transferred. During an interview on 7/21/2026 at 2:57 PM with the Director of Nursing (DON), the DON stated it was important to document the head-to-toe assessment on the DA to ensure the hospital was aware of Resident 1's medical condition. During a review of the facility's Policy and Procedure (P&P) titled, Charting and Documentation, revised March 2025, the P&P indicated, Documentation in the medical record will be . complete, and accurate.		