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	11/17/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation and record review, the facility failed to ensure two of two sampled residents (Residents 7 and 15), were provided privacy curtains for the residents during incontinence care. These failures prevented Residents 7 and 15 from having privacy during care and had the potential to affect Residents 7 and 15's dignity and self-worth. Findings: a. During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition [such as viral infection or toxins in the blood]), dysphagia (difficulty swallowing), and contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of the right and left hips, right knee and right and left ankles. During a review of Resident 7's Care Plan (CP) titled Activities of Daily Living (ADLs, activities related to personal care, initiated 6/24/2024, the CP indicated the goal was for Resident 7 to increase ADLs independently. The interventions indicated to provide Resident 7 with assistance and encourage all efforts at independence. During a review of review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 9/30/2024, the MDS indicated Resident 7 had moderate impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 7 depended (helper does all the effort or the assistance of two or more helpers is required for the resident to complete the activity) on staff for ADLs. During an observation for an incontinence care for Resident 7, Resident 7's curtain was not completely closed during the incontinent care. b. During a review of Resident 15's Admission Record, the Admission Record indicated Resident 15 was initially admitted to the facility on ,d+[DATE] /2022 and readmitted on [DATE] with diagnoses including dysphagia, abnormal posture, and unsteadiness on feet. During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15 had an intact cognition and depended on staff for toileting hygiene. (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation for an incontinence care for Resident 15, Resident 15's curtain was not closed during the incontinent care. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised on 11/2023, the P&P indicated for facility staff to promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment. During a review of the facility's P&P titled, Quality of Life-Dignity, revised on 11/2023, indicated the facility staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. The P&P indicated treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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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	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to ensure a Minimum Data Set (MDS, a standardized assessment and care-screening tool) was accurately completed for one of one sampled resident (Residents 99). Resident 99's MDS did not accurately reflect the resident's hearing abilities and limitations. This deficient practice had the potential for Resident 99 not to receive necessary treatment and/or services. Cross Referenced with F676 Findings: During a review of Resident 99's Admission Record (AR), the AR indicated Resident 99's was admitted to the facility on [DATE] with diagnoses that included intestinal obstruction (blockage in the intestine), hydronephrosis (swelling of the kidneys), atelectasis (complete or partial collapse of the lungs) and lack of coordination. During a review of Resident 99's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/4/2024, the MDS indicated Resident 99 was cognitively intact (able to make decisions) and had adequate (no difficulty in normal conversation, social interaction) with hearing. The MDS also indicated Resident 99 did not use hearing aid or other hearing appliance. During an observation and concurrent interview with Resident 99 at the resident's bedside, on 11/15/2024 at 2:30 p.m. and on 11/16/2024 at 8:54 a.m., Resident 99 was asked questions by the surveyor. The surveyor was standing at the foot of Resident 99's bed. Resident 99 gestured to the surveyor to come closer to the resident's ear and stated, I can't hear you, come closer to me. The surveyor needed to speak within 1 foot of Resident 99's ear for the resident to hear the questions asked. During an interview with Family Member 2 (FM 2) on 11/16/2024 at 2:12 p.m. FM 2 stated Resident 99 was hard of hearing prior to admission to the facility. During an interview with Certified Nursing Assistant 1 (CNA 1), on 11/16/2024 at 3:23 p.m., CNA 1 stated Resident 99 could not hear well and often asks CNA 1 to come closer in order for Resident 99 to read CNA 1's lips while talking. CNA 1 also stated Resident 99 did not have hearing aids or any devices to assist with hearing. During an interview with the Activities Director (AD) on 11/16/2024 at 3:31 p.m., the AD stated Resident 99 was hard of hearing and AD would sit close to the resident to communicate. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview at Resident 99's bedside, with the MDS coordinator (MDSC), on 11/16/2024 at 3:40 p.m., MDSC attempted to speak with Resident 99 from the foot of the resident's bed. Resident 99 pointed to her ear and gestured for MDSC to come closer stating I can't hear you.' MDSC walked towards Resident 99's head of bed and communicated with Resident 99. MDSC stated MDSC needed to speak about 10 inches from Resident 99's ear in order for the resident to hear the MDSC. The MDSC stated Resident 99 was hard of hearing. During the same observation, a concurrent record review of Resident 99's admission MDS was reviewed. The MDSC stated Resident 99's MDS indicated the resident had adequate hearing and the MDS was not accurate. MDSC stated, the resident's MDS assessment needed to be accurate in order for the facility to provide quality of care for Resident. 99. During an interview with Registered Nurse 1 (RN 1), on 11/16/2024 at 3:47 p.m., RN 1 stated Resident 99 was hard of hearing. RN 1 stated if a resident was admitted with hard of hearing, RN 1 would check if the resident utilized hearing aids, would provide temporary aids to ensure hearing, and would inform the resident's physician for a possible Ear Nose and Throat (ENT- a medical professional who specializes in diagnosing, treating, and preventing diseases and conditions of the ear, nose, and throat) consult to determine the cause of the hearing loss. RN 1 stated the ability to hear was important because Resident 99 needed to be informed of all aspects of the resident's care. During an interview and concurrent record review of Resident 99's chart, with LVN 1, on 11/16/2024 at 3:54 p.m., LVN 1 stated Resident 99 was hard of hearing. LVN 1 stated upon admission of a resident who was hard of hearing, licensed staff needed to determine if the resident used a hearing aid and inform the physician. LVN 1 stated LVN 1 did not inform Resident 99's physician that the resident was HOH, and there was no ENT consult ordered for Resident 99. LVN 1 stated hearing was important because that was how the resident communicated with others in order for staff to know the resident's needs. During a review of the facility's Policy and Procedure (P&P), titled Care of Hearing-Impaired Resident, revised 2/2024, the P&P indicated staff will assist hearing impaired resident to maintain effective communication with clinician, caregivers, other resident and visitors. Staff will assist the resident (or representative) with locating available resources To obtain needed services. When interacting with the hearing impaired or deaf residents, staff will implement the following: evaluate the resident's preferred method of communication (lip reading, tablet) with staff and other residents. Provide pencil and paper or tablet to communicate in writing. During a review of the facility's P &P titled Resident Assessment, revised on 9/2023, the P&P indicated all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. During a review of the facility's undated MDSC's - Job Description, the MDSC's job description indicated to evaluate each resident's condition and pertinent medical data to determine any need for special assessment activities . Complete accurate coding of the MDS with information obtained via medical record review as well as observation and interview with facility staff, resident and family members.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 99) received necessary treatment to prevent a decline, maintain or improve Resident 99's hearing abilities and quality of life. This deficient practice had the potential to result in Resident 99's decline in hearing, social interaction, and overall quality of life. Findings: During a review of Resident 99's Admission Record (AR), the AR indicated Resident 99's was admitted to the facility on [DATE] with diagnoses that included intestinal obstruction (blockage in the intestine), hydronephrosis (swelling of the kidneys), atelectasis (complete or partial collapse of the lungs) and lack of coordination. During a review of Resident 99's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 10/4/2024, the MDS indicated Resident 99 was cognitively intact (able to make decisions) and had adequate (no difficulty in normal conversation, social interaction) with hearing. The MDS also indicated Resident 99 did not wear hearing aid or other hearing appliance. During a review of Resident 99's Admission/Readmission Screener dated 9/24/2024 completed by Licensed Vocational Nurse 1 (LVN 1), the Admission/Readmission Screener indicated Resident 99 had highly impaired hearing. During an observation and concurrent interview with Resident 99 at the resident's bedside, on 11/15/2024 at 2:30 p.m. and on 11/16/2024 at 8:54 a.m., Resident 99 was asked questions by the surveyor. The surveyor was standing at the foot of the resident's bed. Resident 99 gestured for the surveyor to come closer to the resident's ear and stated, I can't hear you, come closer to me. The surveyor needed to speak within 1 foot of Resident 99's ear for the resident to hear the questions asked. During an interview with Family Member 2 (FM 2) on 11/16/2024 at 2:12 p.m. FM 2 stated Resident 99 was hard of hearing prior to admission to the facility. During an interview with Certified Nursing Assistant 1 (CNA 1), on 11/16/2024 at 2:23 p.m., CNA 1 stated Resident 99 could not hear well and often asks CNA 1 to come closer in order for Resident 99 to read CNA 1's lips while talking. CNA 1 also stated Resident 99 did not have hearing aids or any devices to assist with hearing. During an interview with the Activities Director (AD) on 11/16/2024 at 3:31 p.m., the AD stated Resident 99 was hard of hearing and AD would sat close to the resident to communicate. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Registered Nurse 1 (RN 1), on 11/16/2024 at 3:47 p.m., RN 1 stated Resident 99 was hard of hearing. RN 1 stated if a resident was admitted with hard of hearing, RN 1 would check if the resident utilized hearing aids, would provide temporary aids to ensure hearing, and would inform the resident's physician for a possible Ear Nose and Throat (ENT- a medical professional who specializes in diagnosing, treating, and preventing diseases and conditions of the ear, nose, and throat) consult to determine the cause of the hearing loss. RN 1 stated the ability to hear was important because Resident 99 needed to be informed of all aspects of the resident's care. During an interview and concurrent record review of Resident 99's chart, with LVN 1, on 11/16/2024 at 3:54 p.m., LVN 1 stated Resident 99 was hard of hearing. LVN 1 stated upon admission of a resident who was hard of hearing, licensed staff needed to determine if the resident used a hearing aid and inform the physician. LVN 1 stated LVN 1 did not inform Resident 99's physician that the resident was HOH, and there was no ENT consult ordered for Resident 99. LVN 1 stated hearing was important because that was how the resident communicated with others in order for staff to know the resident's needs. During a review of the facility's Policy and Procedure (P&P) titled Care of Hearing-Impaired Resident, revised on 2/2024, the P&P indicated staff will assist hearing impaired resident to maintain effective communication with clinician, caregivers, other resident and visitors. Staff will assist the resident (or representative) with locating available resources To obtain needed services. When interacting with the hearing impaired or deaf residents, staff will implement the following: evaluate the resident's preferred method of communication (lip reading, tablet) with staff and other residents. Provide pencil and paper or tablet to communicate in writing. During a review of the facility's P&P titled Resident Assessment, revised on 9/2023, the P&P indicated all persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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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. 44027 Based on observation, interview, and record review, the facility failed to properly apply a pressure relief boot (PRB) for one of three sampled residents (Resident 2) who had a pressure ulcer (localized injury to the skin and or underlying tissue usually over a bony prominence because of pressure or pressure in combination with shear and/or friction) on Resident 2's right heel. This failure had the potential to worsen Resident 2's pressure ulcer. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 10/1/2024 with diagnoses including pressure-induced deep tissue damage (a pressure injury, occurs when the tissue between the heel bone and the skin is compressed and deformed by pressure, shear, or strain) of right heel, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and cognitive communication deficit (reduced awareness and ability to initiate and effectively communicate needs). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 10/4/2024, the MDS indicated Resident 2 was moderately impaired in cognitive skills (decisions poor; cue/supervision required). The MDS indicated Resident 2 was dependent on staff for bathing, toileting, and dressing. The MDS indicated Resident 2 had multiple pressure injuries. During a review of Resident 2's IDT (Interdisciplinary Team) - Skin integrity Review, dated 10/11/2024, the IDT indicated Resident 2 had pressure injury to Resident 2's right heel. The IDT indicated nursing interventions included to float Resident 2's heel. During a concurrent observation and interview on 11/16/2024 at 9:36 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's PRB was observed to be on Resident 2's right foot incorrectly. The PRB was on Resident 2's foot upside-down. The surveyor asked LVN 1 if she noticed anything wrong with how Resident 2's right foot looked. LVN 1 stated she did not see anything wrong. LVN 1 removed the PRB from Resident 2's right foot and showed the surveyor the dressing on Resident 2's right heel. LVN 1 replaced the PRB in an upside-down position. The surveyor asked if the PRB was on Resident 2's right foot correctly. LVN 1 stated the PRB was on Resident 2's right foot correctly. The surveyor pointed out the tag on the PRB which showed an image of foot in the PRB. LVN 1 then confirmed the PRB was not properly applied to Resident 2's right foot. LVN 1 stated LVN 1 had never received training from the facility on how to apply the PRB to residents (in general). LVN 1 stated LVN 1 did not know who had incorrectly applied the PRB to Resident 2's right foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 11/16/2024 at 10:49 a.m. with the Treatment Nurse (TN), Resident 2's right heel was observed. Resident 2 was wearing a PRB on the resident's right foot. The TN stated Resident 2 had a deep tissue injury (DTI, a form of pressure injury). The TN stated the purpose of the PRB to relieve pressure off Resident 2's right heel. The TN stated Resident 2 had an ulcer (an open sore) on Resident 2's right heel. The TN stated if Resident 2's right heel was not protected from pressure, Resident 2 might experience a delay in the resident's ulcer healing, or the pressure injury could worsen. The TN stated if the PRB was applied the wrong way to Resident 2's foot, Resident 2's right heel would not be provided proper pressure relief. During a concurrent interview and record review on 11/17/2024, at 8:58 a.m. with the Director of Nursing (DON), Resident 2's care plan titled, Pressure Injury; Rt Heel ., dated 10/4/2024, the care plan indicated, may have heel protector. The DON stated that residents (in general) with pressure sores on their heels need the intervention of offloading pressure from the heel. The DON stated the PRB provided the intervention to offloading pressure from the heel. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised September 2023, the P&P indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 100) who received oxygen therapy, was provided safety in accordance with the facility's Policy and Procedure (P&P) on oxygen administration and professional standards of practice by ensuring a cautionary sign was posted on the resident's door indicating oxygen was in use. This deficient practice placed Resident 100's safety at risk regarding oxygen use. Findings: During a review of Resident 100's Admission Record (AR), the AR indicated Resident 100 was admitted to the facility on [DATE] with diagnoses that included compression fracture of the vertebra (a break in a bone in the spine), hypertension (elevated blood pressure) and hyperlipidemia (abnormally high concentration of fats in the blood). During a review of Resident 100's Physician Orders (PO) dated 11/12/2024, the PO indicated for Resident 100 to receive oxygen at two (2) liters per minute (L/min) via nasal cannula (NC- tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen) continuously to keep oxygen saturation (amount of oxygen carried in blood) above 93 percent (%). During a review of Resident 100's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 11/15/2024, the MDS indicated Resident 100 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 100 was dependent with staff with eating, oral hygiene, toilet hygiene, showers, and upper and lower body dressing. During an observation on 11/15/2024 at 6:36 pm, Resident 100 was asleep lying in bed connected to an oxygen machine with a nasal cannula. Resident 100's room did not have a sign posted to indicate oxygen was in used in the room and that smoking was prohibited. During a concurrent observation and interview on 11/15/2024 at 6:40 pm with Licensed Vocational 2 (LVN 2) in Resident 100's room, Resident 100 was asleep lying in bed with a NC, connected to an oxygen machine. LVN 2 stated there was no sign posted on Resident 100's door to indicate oxygen was in used in the room. LVN 2 stated there should be a smoking sign to remind visitors or other residents that oxygen was in use and be cautious. During an observation and concurrent interview with the Director of Staff Development (DSD) on 11/15/2024 at 6:45pm, outside Resident 100's room, the DSD stated oxygen in use sign should be posted at the entrance door of the resident receiving oxygen therapy for fire safety because oxygen was combustible (flammable). During a review of the facility's P&P titled, Oxygen Administrator, revised 3/2024, P&P indicated the purpose of the procedure is to provide guidelines for safe oxygen administration. Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure: No Smoking/Oxygen in Use signs.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to properly assess resident's pain for one of one sampled resident (Resident 23) during a medication pass observation. This deficient practice had the potential to negatively affect Resident 23's physical comfort and psychosocial well-being. Findings: During a review of the Admission Record, the Admission Record indicated Resident 23 was admitted to the facility on [DATE] with diagnosis including Dementia (a progressive state of decline in mental abilities) and anxiety (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress). During a review of the Minimum Data Set (MDS - a resident assessment tool) dated 10/28/2024, indicated Resident 23's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. The MDS indicated Resident 1 required moderate to maximal assistance from staffs for toileting/personal hygiene, upper and lower body dressing. A review of Resident 23's Order Summary indicated physician ordered the following: i. Dated 4/23/2024, Pain evaluation ever shift for pain scale 0-10 (score of 0 means no pain, and 10 means the worst pain you have ever felt) ii. Dated 9/2/2024, Acetaminophen (Tylenol, medication used to treat minor aches and pains, and reduces fever) 325 milligrams (mg - unit of measurement) give two tablets mouth every four hours as needed for pain scale of 1-3 (mild pain). iii: Dated 9/2/2024, Tramadol HCL oral table 50 mg, give 1 tablet by mouth every 24 hours as needed for pain scale of 7-10 (severe pain). During a concurrent observation of medication pass and an interview with Licensed Vocational Nurse (LVN) 3 on 11/17/2024 from 9:04 a.m. to 9:10 a.m., LVN 3 was observed administering the morning medication to Resident 23. LVN 3 asked Resident 23 Are you ok? Resident 23 stated I have a stomachache. LVN 3 stated Maybe you need to go to the bathroom more, the CNA reported to me you had a BM (bowel movement) today. LVN 3 stated, LVN 3 did not assess Resident 23 for pain when Resident 23 complained of pain due to Resident 23 always complaining of back pain when the resident was in a sitting position. LNV 3 stated Resident 23 would start to complain of pain when Resident 23 sat on the wheelchair for a while (for a short time). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedures (P&P) titled, Pain Assessment and Management, revised on 11/2024, the P&P indicated, The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. The P&P indicated the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the residents' choices related to pain management. The P&P indicated steps in the procedure included: a. Recognizing pain. b. Assessing Pain. c. Identifying the cause of pain. d. Defining Goals and appropriate interventions. e. Implementing pain management strategies. f. Monitoring and modifying approaches of the pain management.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 44027 Based on interview and record review, the facility failed to post actual worked nursing hours at the start of each shift for one of three dates (11/14/2024) according to the facility's policy and procedure (P&P) titled, Consumer Information, revised 1/18/2023. This failure had the potential to result inaccurately reflecting the actual nurses providing direct care to the residents. Findings: During a concurrent interview and record review on 11/17/2024 at 9:19 a.m. with the Director of Staff Development (DSD), the facility's Census and Direct Care Service Hours Per Patient Day (DHPPD), dated 11/14/2024 and Projection of Nursing Hours, dated 11/14/2024 were reviewed. The DHPPD indicated the actual total Certified Nursing Assistant (CNA) direct care service hours for 11/14/2024 was 92.34 hours. The Projection of Nursing Hours indicated there was supposed to be 97.5 hours of CNA direct care service hours scheduled for 11/14/2024. The DSD stated a Daily Direct Care Staffing was posted at Nurses Station 1. The Projection of Nursing Hours indicated there were supposed to be 4 CNA's working on the second shift. The DSD stated 3 CNAs worked the entire second shift and 1 CNA only worked 3 hours during the second shift. The DSD stated the DSD posted a Projection of Nursing Hours document by the nurse's station every evening for the following day's nursing hours. The DSD stated the posted nursing hours was just the projection and was not changed when a staff person where to call off. During a review of the facility's P&P titled, Consumer Information, revised 1/18/2023, the P&P indicated, The following consumer information shall be posted: 1. Posting of: . g. Staffing, based on resident census, the number of nursing staff on duty for each shift (staff to resident ratio), including registered nurses, licensed vocational nurses, certified nurse aides, any staff who provide direct care to residents or who supervise those giving direct care. h. The facility will post the nurse staffing data on a daily basis at the beginning of each shift. i. Data will be posted as follows: 1) Clear and readable format 2) In a prominent place readily accessible to residents and visitors ii. Posting will include: 1) Facility name 2) The current date (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) The total number and the actual hours worked by the following categories of licensed and licensed nursing staff directly responsible for resident care per shift: a) Registered nurses b) Licensed practical nurses or licensed vocational nurses (as defined under State Law) c)Certified Nurse Assistants 4) Resident census .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 40913 Based on interview and record review the facility failed to ensure one of five sampled residents (Resident 149) was reviewed for the McGeer's criteria (criteria used for retrospectively counting true infections. To meet the criteria for definitive infection, more diagnostic information [e.g., positive laboratory tests] is often necessary) when Resident 149 was receiving antibiotics (medications that fight bacterial infections). This deficient practice had the potential for Resident 149 from receiving unnecessary antibiotic. Findings: During a review of Resident 149's Admission Record, the Admission Record indicated Resident 149 was admitted to the facility 11/14/2024 with diagnoses including spastic quadriplegic cerebral palsy (a severe form of cerebral palsy where all four limbs [arms and legs] are affected by increased muscle stiffness, resulting in significant limitations in movement and often causing difficulties with walking, speaking, and other daily activities) and contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) of the right and left hips, right and left knees, left elbow and left wrist. During a review of Resident 149's Physician's Order Summary (POS), the POS indicated Resident 149 has an order for Cefepime Hydrochloride (Cefepime HCL, medication used to treat a bacterial infection. Cefepime is indicated to treat gram-positive and gram-negative bacterial infections susceptible to its antimicrobial activity) Solution 1 gram (gm)/50 milliliter (ml) intravenously (via vein) every 8 hours for sepsis for 7 days. During a review of Resident 149's Antibiotic Surveillance Data Collection dated 11/17/2024, the Antibiotic Surveillance Data Collection indicated Resident 149 did not have the McGeer's criteria indicating antibiotic use. During a concurrent interview and record review on 11/17/2024 at 4:25 p.m., with the Infection Prevention Nurse (IPN), the IPN stated Resident 149 was prescribed Cefepime HCL in the hospital, but the admission nurse did not fill out the McGeer's criteria for Resident 149. The IPN stated she encourage the nurses (in general) to fill up the McGeer's criteria for the residents. During a review of the facilities policy and procedure (P&P) titled Antibiotic Stewardship revised dated December/2022, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The P&P indicated if an antibiotic is indicted and appropriate indicates of the use of antibiotic include criteria met for clinical definition of active infection or suspected sepsis (McGreer's criteria and pathogen susceptibility, based on culture and sensitivity to antimicrobial.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 38108 Based on observation, interview, and record review the facility failed to prepare food by method that conserved flavor, texture, and appearance by servicing at a safe temperature. During a tray-line observation, soup temperature from the requested test tray measured at 120 degrees Fahrenheit (F, a scale of temperature) for one of one facility kitchen. This deficient practice had the potential to result in meal dissatisfaction, decreased intake, and placed the residents at risk for unplanned weight loss. Findings: During an initial facility tour on 11/15/2024 at 8:38 p.m., complaints about the texture and flavor and temperature of the food were identified. During a review of the facility's menu, black bean soup was to be served on 11/16/2024 with the evening's dinner. During an observation and interview in the facility's kitchen [NAME] 1 (C1) on 11/16/2024 at 4:42 p.m., black bean soup was observed in the tray line. C1 stated black bean soup will be served with dinner. During the test tray tasting and observation on 11/16/2024 at 5:45 p.m. with the Dietary Supervisor (DS), the black bean soup temperature was taken. The black bean soup temperature was 120 degrees Fahrenheit. During the same observation and interview, the DS stated the black bean soup temperature was lukewarm (only moderately warm; tepid) and was not within acceptable temperatures. The DS stated the quality of food can improve and residents can get sick if food was served outside acceptable temperatures. During a review of the facility's Policy and Procedure (P&P) titled Meal Service dated 2023, the P&P indicated meal that meets the nutritional needs of the resident will be served in an accurate and efficient manner and served the appropriate temperatures. Hot food serving temperature must be at or above minimum holding temperature of 140 degrees Fahrenheit (F). Food Items: soups and hot beverages serving temperatures = 170F to 190F.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38108 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food handling service. During initial tour of the kitchen on 11/15/24, one open bag of frozen patties and one open frozen bag of eggrolls were unlabeled and undated in the facility freezer for one of one facility kitchen. This deficient practice had the potential to result in foodborne illnesses (illness caused by consuming contaminated food or beverages) to the residents. Findings: During an initial tour of the kitchen on 11/15/24 at 5:24 pm, with the Dietary Supervisor (DS), one open bag of four hamburger patties and one opened bag of eggrolls were observed inside the facility freezer. The DS stated open food items should be labeled and dated to determine the food item in the bags and to determine the good by date of the food to prevent possible food borne illness to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Procedure for Frozen Storage: Freezer Storage, dated 2023, the P&P indicated all frozen food should be labeled and dated. During a review of the facility's P&P titled, Labeling and Dating of Foods, dated 2023, the P&P indicated All food items in the storeroom refrigerator, and freezer need to be labeled and dated. Newly opened food items will need to be closed and labeled with an open date and used by date .

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 44027 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 2), who signed an Arbitration Agreement (Binding Arbitration Agreement), had the capacity to understand and make an informed decision. This failure had the potential to result in Resident 2 to not be able to make an informed decision and/or Resident 2's rights to be denied. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 10/1/2024 with diagnoses including pressure-induced deep tissue damage (occurs when the tissue between the heel bone and the skin is compressed and deformed by pressure, shear, or strain) of right heel, type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and cognitive communication deficit (reduced awareness and ability to initiate and effectively communicate needs). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 10/4/2024, the MDS indicated Resident 2 was moderately impaired in cognitive skills (decisions poor; cue/supervision required). The MDS indicated Resident 2 was dependent on staff for bathing, toileting, and dressing. During an interview on 11/16/2024 at 2:15 p.m. with Resident 2, the surveyor asked Resident 2 if Resident 2 understood what an arbitration agreement was. Resident 2 stated an arbitration agreement meant Resident 2 would let Resident 2's daughter (FM 1) spend FM 1's time at the office. Resident 2 was not able to explain what an arbitration agreement was. The surveyor explained what an arbitration agreement was. Resident 2 stated Resident 2 does not remember anyone at the facility telling Resident 2 what an arbitration agreement was. During an interview on 11/16/2024 at 2:22 p.m. with FM 1 (who was at the bedside of Resident 2 when surveyor was interviewing Resident 2), FM 1 stated Resident 2 thinks Resident 2 worked at the facility most days. FM 1 stated Resident 1 came to the facility from a General Acute Care Hospital (GACH). FM 1 stated Resident 2 was very confused at the GACH, and that Resident 2 had not fully recovered from the confusion. FM 1 stated FM 1 was currently going through the process of getting Power of Attorney over Resident 2 because Resident 2 was not able to care for himself. FM 1 stated Resident 2 should not make medical decisions for himself. During a concurrent interview and record review on 11/16/2024 at 3:36 p.m. with the Case Manager (CM), Resident 2's Arbitration Agreement, signed 10/7/2024 was reviewed. The Arbitration Agreement indicated Resident 2 signed the document on 10/7/2024. The CM stated the CM explained arbitration agreement to Resident 2 and that Resident 2 signed the Arbitration Agreement. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 11/16/2024 at 4:17 p.m. with the MDS Coordinator (MDSC), Resident 14's MDS was reviewed. The MDSC confirmed the MDS indicated Resident 2 was moderately impaired in cognitive skills. The MDSC stated moderate impairment meant Resident 2 made poor decisions. During a concurrent interview and record review on 11/17/2024 at 8:17 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's Alert Charting, dated 10/7/2024 was reviewed. The Alert Charting indicated, LVN 1 documented, . (Resident 2) is alert x2 with confusion and forgetfulness.No altered mental status to baseline. LVN 1 stated when LVN 1 documented, No altered mental status to baseline, LVN 1 meant that Resident 2's confusion and forgetfulness was unchanged from the previous shifts in which LVN 1 took care of Resident 2. LVN 1 stated Resident 2 was forgetful, and that sometimes Resident 2 would ramble. During a review of the facility's policy and procedure (P&P) titled, Consents - Admission & General, revised 11/15/2023, the P&P indicated, Residents have the right to consent to treatment and other consents specified by the facility at the time of admission and throughout their stay . The P&P indicated, The resident shall be presumed to have capacity unless otherwise documented in the clinical record, thus all consents will be signed by the resident in those cases where the resident has the capacity to sign and/or the physical ability to sign. Where that is not the case, the person either legally authorized or designated representative may sign on behalf of the resident. The P&P indicated, Any Arbitration Agreement shall be separate from the Standard Admission Agreement .