

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify, one of one sampled resident's (Resident 8), physician (Physician 1) of Resident 8's weight changes on 9/1/2025 and 10/7/2025. This deficient practice had the potential to result in serious health complications to Resident 8 due to the lack of notification to Physician 1 and delayed implementation of interventions. Findings: During a review of Resident 8's admission Record (AR), the AR indicated the resident was admitted to the facility 7/16/2025 with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD - irreversible kidney failure), and Hypersensitive chronic kidney disease (progressive kidney damage and loss of function caused by long-term uncontrolled high blood pressure that stiffens kidney arteries, reduce blood flow, and impair filtration creating a dangerous cycle where failing kidneys worsen blood pressure, leading to further damage and potential kidney failure or heart disease). During a review of Resident 8's Interdisciplinary Team (IDT, a collaborative group of professionals from different specialties who work together to provide resident centered care) Weight Change Review, dated 9/1/2025, the IDT review indicated Resident 8 had a weight change and gained 12.3 lbs. in one month. During a review of Resident 8's IDT Weight Change Review, dated 10/7/2025, the IDT review indicated Resident 8 had a weight change of an eight lb. weight loss in one month. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 10/19/2025, the MDS indicated Resident 8's cognition (anything related to thinking, learning, and understanding) was severely impaired for decision making. The MDS indicated Resident 8's cognitive (the ability to think and process information) was severely cognitively impaired for daily decision making. During an interview on 1/14/2026 at 11:41 AM with the Director of Nursing (DON), the DON stated on 10/7/2025 IDT [members] determined a weight loss of 8 lbs. for Resident 8. The DON stated Physician 1 should have been contacted [notified of Resident 8's weight loss] and [the notification should be] documented in the progress notes. The DON stated on 9/1/2025, the IDT discussed a weight gain of 12 lbs. for Resident 8. The DON stated licensed [nursing] staff should have notified Physician 1 and documented the notification the progress notes. The DON stated the DON could not find progress notes dated 9/1/2025 or 10/7/2025 indicating Physician 1 was notified of Resident 8's weight changes. During a concurrent interview and record review on 1/15/2026 at 9:16 AM with the DON, the facility's policy and procedure (P&P) titled, Nutrition Care, revised November 2025, was reviewed. The P&P's subject indicated weight variance P&P. The P&P indicated, The LN [license nurse] staff will document identified significant weight changes, MD [medical doctor] notification, and responsible party notification in the resident's medical record. The DON stated the P&P fit the scenario [Resident 8's weight changes] and further stated it was important to notify the MD [Physician 1] of weight changes to see if there were new orders from Physician 1 and to address the changes [carry out the orders].		

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 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** Based on observation, interview, and record review the facility failed to effectively assess one of one sampled resident's (Resident 29) characteristics of pain as indicated in the facility's policy and procedure (P&P) titled, Pain Assessment. This deficient practice had the potential to result in ineffective pain management, unnecessary discomfort and pain to Resident 29, and had the potential to affect Resident 29's physical and psychosocial well-being. Findings: During a review of Resident 29's admission Record (AR), the AR indicated the resident was admitted on [DATE] with diagnoses including stage 3 chronic kidney disease (the kidneys have moderate damage and are not filtering waste as well, with function between 30-59%, leading to potential symptoms like fatigue, swelling, and higher risk for complications like high blood pressure, requiring careful management with diet and medication), and a urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of the Minimum Data Set (MDS- a resident assessment tool), dated 11/11/2025, the MDS indicated Resident 29's cognition (the ability to think and process information) was moderately impaired. During a review of Resident 29's Medication Administration Record (MAR), dated 1/2026, the MAR indicated Resident 29 had 5 out of 10 pain on 1/13/2026 and Resident 29 received 500 milligrams (unit of measurement) of Tylenol (medication used to treat pain). During an interview on 1/14/2026 at 11:21 AM in Resident 29's room with Resident 29, Resident 29 stated, yesterday [1/13/2026] Resident 29's family member spoke to the nurse (unidentified) about Resident 29's pain because Resident 29 felt pain during urination and despite completing antibiotics. Resident 29 stated they [staff] all knew [about] Resident 29's pain because Resident 29 told them, including the therapists (unidentified) and Resident 29 could not sleep well because Resident 29 was in pain. During an interview on 1/14/2025 at 1:46 PM with License Vocational Nurse (LVN) 2, LVN 2 stated, on 1/13/2026, Resident 29 complained of pain, under there and Resident 29 was rubbing Resident 29's stomach. LVN 2 stated LVN 2 assisted Resident 29 back to Resident 29's room and LVN 2 assessed Resident 29. LVN 2 stated [during the assessment] LVN 2 did not ask Resident 29 questions [relating to Resident 29's pain] such as if [the pain was] throbbing or stabbing. LVN 2 stated Resident 29 complained 6 out of 10 (10 being the strongest pain ever felt) inguinal (groin area) pain. LVN 2 stated asking questions about the location of the pain, type of pain, and [using the] pain scale during a pain assessment provided more details that helped treat the resident's pain (in general). During an interview on 1/15/2026 at 9:20 AM with the Director of Nursing (DON), the DON stated if a resident had pain, we [the facility] asked them [residents] what the nature of the pain was, the intensity of the pain [by using a pain] scale, assessed and palpated the site, and asked for the type [description] of pain: e.g., sharp, throbbing, etc. During a concurrent interview and record review on 1/15/2026 at 9:20 AM with the DON, the facility's P&P titled, Pain Assessment, revised November 2025 was reviewed. The P&P indicated, Assessing Pain: 1. During a comprehensive pain assessment gather the following information as indicated from the resident (or legal representative): b. Characteristics of pain: (1) Location of pain; (2) Intensity of pain (as measured on a standardized pain scale); (3) Description of pain; (4) Pattern of pain; and (5) Frequency, timing and duration of pain. The DON stated the importance of [following the P&P] was to address the pain according to how intense the pain was [to know and describe the pain accurately] when reporting [the pain] to the doctor.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure a thermometer was easily visible inside one of two refrigerators (Reach-in Refrigerator 2) in the facility's kitchen on 1/14/2026 as indicated in the facility's Policy and Procedure (P&P) titled, Procedure for Refrigerated Storage. This failure had the potential to result in the food stored inside Reach-in Refrigerator 2 not being maintained at proper temperatures and the potential to result in foodborne illness (an illness caused by eating contaminated food) to the residents consuming the food. Findings: During a concurrent observation and interview on 1/12/2026 at 8:45 AM with [NAME] (CK) 1 in the kitchen, Reach-in Refrigerator 2 was observed without a thermometer visible on the inside of the refrigerator. CK 1 stated CK 1 could not find the thermometer and the thermometer should be located inside Reach-in Refrigerator 2. CK 1 stated the thermometer was used to verify the temperature on the thermometer located on the outside of Reach-in Refrigerator 2. CK 1 stated it was important to have a second thermometer inside of Reach-in Refrigerator 2 to ensure the refrigerator was at the correct temperature. During an interview on 1/14/2026 at 2:41 PM with the Dietary Supervisor (DSS), the DSS stated there should be a second thermometer located on the inside of Reach-in Refrigerator 2. The DSS stated it was important for there to be a second thermometer inside Reach-in Refrigerator 2 to ensure the food inside Reach-in Refrigerator 2 was cooled properly. During a review of the facility's P&P titled, Procedure for Refrigerated Storage, dated 2023, the P&P indicated, two thermometers, placed to be easily visible for checking, should be inside all walk-in, reach-in refrigerators. The P&P indicated the second thermometer is a check against the first thermometer for accuracy.		