

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2024
NAME OF PROVIDER OR SUPPLIER Penn Mar Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3938 Cogswell Road El Monte, CA 91732	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905</p> <p>Based on interview and record review, the facility failed to follow a Medical Doctor's (MD) order dated 3/27/2024 at 9:59 PM for neurological checks (neuro-checks, assessing the resident's mental status by evaluating sensory [things a person sees, hears, smells, tastes, or touches] and motor functions) every four hours for 24 hours, then every shift for two days for one of four sampled residents (Resident 3) when Resident 3 sustained a hit to the head from a physical altercation with Resident 1.</p> <p>This failure had the potential for Resident 3 to develop complications from an injury to the head.</p> <p>Findings:</p> <p>During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnosis that included anxiety, insomnia (difficulty in falling and or staying asleep), and stimulant (class of drugs that make people feel more awake, alert, or energetic) abuse.</p> <p>During a review of Resident 3's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 4/2/2024, the MDS indicated Resident 3's cognitive abilities (ability to think, learn, and process information) were intact.</p> <p>During a review of Resident 3's Situation, Background, Assessment, and Recommendation (SBAR, standardized form to communicate information about a resident's conditions, needs, or problems) dated 3/27/2024, the SBAR indicated the MD was made aware of Resident 3 being punched behind the head on 3/27/2024 at 9:11 PM with orders to conduct neuro-checks every four hours for 24 hours then every shift for two days, and administer Tylenol (medication used to treat mild to moderate pain) 650 milligrams (mg) four times a day as needed for 14 days.</p> <p>During a review of Resident 3's order details (OD) dated 3/27/2024 at 9:59 PM, the OD indicated Resident 3 had an MD order for neuro-checks every four hours for 24 hours, then every shift for two days.</p> <p>During an interview on 4/2/2024 at 9:40 AM with Resident 3, Resident 3 stated he was hit on the left side of his face by Resident 1 during medication pass on 3/27/2024. Resident 3 stated Resident 1 hit him with a closed fist, and he developed a headache after the incident.</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/2024 at 10:57 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 hit Resident 3 behind on the head with a closed fist. LVN 1 stated Resident 3 had redness on the forehead, lower neck, and right arm. LVN 1 stated Resident 3 reported a headache, with a pain level of 6 out of 10 in severity in the head 30 to 45 minutes after the incident. LVN 1 stated the MD was made aware and received an order for neuro-checks every four hours for the first 24 hours then every shift for two days and Tylenol.</p> <p>During a concurrent interview and record review on 4/2/2024 at 3:42 PM with the Director of Nurses (DON), Resident 3's neuro-check assessments (NCA) dated 3/27/2024 to 3/28/2024 were reviewed. The NCA's indicated neuro-checks were completed on the following days:</p> <p>3/27/2024 at 10:10 PM.</p> <p>3/28/2024 at 1:16 AM.</p> <p>3/28/2024 at 4:13 AM; and</p> <p>3/28/2024 at 1:02 PM.</p> <p>The DON stated Resident 3's NCA should have ended on 3/30/2024 in the evening based on the MD order. The DON stated the NCA's were not completed, and staff did not follow the MD order. The DON stated the risk of not completing the NCA per MD order places a risk of not properly assessing the resident's neurological functions.</p> <p>During a review of the facility's policy and procedure (P&P), titled Physician Orders, dated 10/1/2023, the P&P indicated orders will include a description complete enough to ensure clarity of the physician's plan of care. The P&P indicated the Licensed Nurse receiving the order will be responsible for documenting and implementing the order.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905</p> <p>Based on interview and record review, the facility failed to identify and reduce the risk of elopement (when a person wanders away, walks away, runs away, escapes, or otherwise leaves the facility unsupervised, unnoticed, and or prior to the scheduled discharge date) in the resident's environment for one of four sampled residents (Resident 4) by failing to ensure locked Gates 1 and 2 were opened one at a time. The Director of Staff Development (DSD) unlocked and opened locked Gate 1 to the patio while entering the facility. While, at the same time, Staff Member (SM) 5 unlocked and opened locked Gate 2 facing the facility's parking lot. Consequently, Resident 4 pushed away the employees (DSD and SM 5) and ran away from the facility.</p> <p>This failure resulted in Resident 4 being missing from the facility and his whereabouts unknown for four days, which had the potential to result in injury and harm.</p> <p>Findings:</p> <p>During a review of Resident 4's Admission Record (AR), the admission record indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included anxiety, psychosis (when a person loses the ability to recognize reality or relate to others), and schizoaffective disorder (mental disorder that is characterized by abnormal thought processes and an unstable mood).</p> <p>During a review of Resident 4's History and Physical (H&P, formal document of a medical provider's examination of a patient), dated 3/28/2024 at 9:49 AM, the H&P indicated Resident 4 was alert and oriented times four (oriented to time, place, person, and situation). The H&P indicated Resident 4's cognitive abilities (ability to think, learn, and process information) were intact.</p> <p>During a review of Resident 4's untitled care plan (CP) dated 3/28/2024, the CP indicated Resident 4 was on absent without leave (AWOL-a non-approved leave) precautions. The CP indicated on 3/30/2024 staff will ensure Resident 4 was not on the patio and would perform one-to-one therapy to monitor AWOL behavior.</p> <p>During a review of the facility's Headcount Sheet (HS) dated 3/29/2024, the HS indicated Resident 4 was on the patio at 2 PM and at 2:15 PM Resident 4 was AWOL.</p> <p>During a review of Resident 4's Nursing Note (NN) dated 3/29/2024 at 5:47 PM, the NN indicated an employee opened [Gate 1] to go inside the facility and another employee opened [Gate Two] at the same time. The NN indicated Resident 4 pushed away the employees and ran away from the facility.</p> <p>During a review of Resident 4's Situation, Background, Assessment and Recommendation (SBAR, standardized form to communicate information about a resident's conditions, needs, or problems) dated 3/29/2024, the SBAR form indicated Resident 4's conservator (court appoints a person to manage the financial and personal affairs of an incapacitated [inability to make and communicate own decisions] person) was notified on 3/29/2024 at 3 PM. The SBAR indicated Resident 4's Medical Doctor (MD) was notified about Resident 4's elopement on 3/29/2024 at 3:34 PM.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/2024 at 9:22 AM with Resident 1, Resident 1 stated he was on the patio and saw Resident 4 run out of the facility. Resident 1 stated as soon as one of the employees opened Gate 1 in the visitor area, Resident 4 ran out. Resident 1 stated Resident 4 was not at the facility for a long time and was recently admitted .</p> <p>During an interview on 4/2/2024 at 10:18 AM with the DSD, the DSD stated to enter and exit the facility, staff need to enter and exit through two locked gates (Gate 1 and Gate 2). The DSD stated each gate needs to be locked before opening the next gate. The DSD stated she was entering the facility through Gate 1. The DSD stated there was no one in the cage (space between Gate 1 and Gate 2). The DSD stated both she and SM 1 opened the gate at the same time and Resident 4 ran out. The DSD stated Resident 4 has not been found. The DSD stated both she and SM 1 did not see each other when they opened the gates.</p> <p>During an interview on 4/2/2024 at 10:32 AM with SM 1, SM 1 stated she thought it was safe to open one of the locked gates and did not see the DSD inside of the cage. SM 1 stated if two people are coming in different directions, then it needs to be communicated to the other person to wait so the other staff member can enter or exit first. SM 1 stated one gate needs to lock first before opening the next gate. SM 1 stated this was not done because SM 1 and DSD did not see each other.</p> <p>During an interview on 4/2/2024 at 10:57 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated one gate needs to be locked before opening the second locked gate. LVN 1 stated staff are to make sure the environment around Gate 1 is clear with no residents standing close behind staff members or near the gate prior to opening it, and to make sure residents are behind the yellow line. LVN 1 stated residents are to stay behind the yellow line, a few feet, away from Gate 1. LVN 1 stated the yellow line is to ensure staff can open Gate 1 safely with residents at a safe distance to prevent residents from eloping from the facility.</p> <p>During an interview on 4/2/2024 at 1:39 PM with SM 3, SM 3 stated she saw SM 5 holding Gate 2 open for SM 1 because SM 1 was rolling a barrel of dirty linen. SM 3 stated she saw Resident 4 standing above the yellow line in the patio area near Gate 1. SM 3 stated she was approaching Resident 4 and telling Resident 4 to step back behind the yellow line. SM 3 stated she was telling staff members who were opening Gate 1 to close the gate. SM 3 stated SM 1 did not look behind prior to opening Gate 1. SM 3 stated SM 1 and DSD should've listened to staff to close Gate 1 while SM 5 had Gate 2 open. SM 3 stated when Resident 4 saw DSD open Gate 1, Resident 4 pushed the staff members away and ran out through both gates (Gate 1 and Gate 2). SM 3 stated Resident 4's elopement was preventable because locked gates need to be opened one at a time.</p> <p>During an interview on 4/2/2024 at 2 PM with SM 4, SM 4 stated Resident 4's elopement was preventable as Gate 2 was held open. SM 4 stated SM 1 did not look back to check if a resident was behind her as SM 1 and DSD were opening Gate 1. SM 4 stated she saw Resident 4 above the yellow line and stated Resident 4 ran out before staff members could stop Resident 4.</p> <p>During an interview on 4/2/2024 at 2:39 PM with the Director of Nursing (DON), the DON stated staff are instructed to open locked gates one at a time when entering or exiting the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/2024 at 3:45 PM with SM 1, SM 1 stated she was leaving from inside of the facility and was headed to the parking lot while pushing a container that had dirty linen. SM 1 stated DSD opened Gate 1 and SM 5 held open Gate 2. SM 1 stated both gates (1 and 2) were open, and Resident 4 ran out. SM 1 stated Resident 4's elopement was preventable because locked gates need to be opened one at a time.</p> <p>During a review of Resident 4's Social Services Note (SSN) dated 4/1/2024 at 4:41 PM, the SSN indicated the Social Worker (SW) spoke with the local police departments for updates on Resident 4's whereabouts, the SSN indicated no other information was available.</p> <p>During a concurrent interview and record review on 4/2/2024 at 5 PM with the DON, the facility's P&P titled, Elopement Risk Reduction Approaches, dated 10/2023 was reviewed. The P&P indicated the facility staff need to know the resident's propensity (natural tendency to behave) to wander and the triggering conditions. The P&P indicated facility staff need to know the consequences of unsafe wandering and the protocols to follow to minimize successful exiting. The P&P indicated ways to minimize the risk of elopement in the environment are to make exits less obvious by reducing visual cues for exiting. The DON stated staff did not follow the facility's P&P. The DON stated staff should've been aware of their surroundings and doubled check to make sure Gate 2 was locked before opening Gate 1. The DON stated Gate 2 should not have been held open because it made an exit obvious to the resident. The DON stated Resident 4's elopement was considered avoidable because both locked gates were opened at the same time. The DON stated the risk of not following the facility's P&P would put other residents at risk for eloping.</p> <p>During a review of the facility's P&P titled, Wandering & Elopement dated 10/1/2023, the P&P indicated the facility will identify residents at risk for elopement and minimize any possible injury because of elopement.</p>