STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A360	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penn Mar Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to develop a care plan (CP) for one of four sampled residents (Resident 1) who was identified as a high risk for elopement (leaving without permission or supervision). Consequently, Resident 1 eloped while attending a court hearing on 12/18/2024. This failure had the potential to result in Resident 1 sustaining a serious injury. Findings: During a review of Resident 1 ' s Admission Record (AR) the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (serious mental disorder in which people interpret reality abnormally). During a review of Resident 1 ' s History and Physical (H&P, formal document of a medical provider ' s examination of a patient) dated 7/28/2024, the H&P indicated Resident 1 lacked capacity to make medical decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 10/31/2024, the MDS indicated Resident 1 ' s cognitive abilities (ability to think, learn, and process information) were intact. During an interview on 12/20/2024 at 11:29 AM with the Director of Nursing (DON), the DON stated residents in the facility are a high risk for elopement because all residents are in a special treatment program (STP). During a concurrent interview and record review on 12/20/2024 at 11:36 AM with Licensed Vocational Nurse 1 (LVN), Resident 1 ' s untitled CP was reviewed. LVN 1 stated there was no CP for risk for elopement. LVN 1 stated if the resident was identified as a high risk for elopement there should be a CP. The CP guides staff on what intervention to provide and how to monitor the resident. LVN 1 stated the risk of not having a CP was that staff would not know the specific at-risk behavior and how to provide care. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/2024 at 12:43 PM with the DON, the DON stated there was no CP for high risk of elopement as Resident 1 was in an STP. The DON stated there should be a CP indicating the resident was a high risk for elopement and stated the risk of not having a CP was that direct staff members would not be aware that Resident 1 was a high risk for elopement. During a review of the facility ' s policy and procedure (P&P) titled, Care Planning dated 10/1/2023, the P&P indicated a licensed nurse will initiate the CP and the plan will be finalized in accordance with OBRA/MDS guidelines and updated as indicated for changes in condition, onset of new problems, resolution of current problems, and as deemed appropriate by clinical assessment and judgement on an as needed basis.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to implement its policy on wandering and elopement (leaving without permission or supervision) and perform an elopement risk assessment upon admission for one of four sampled residents (Resident 1). This failure resulted in Resident 1 eloping on 12/18/2024 when Resident 1 attended a court hearing with Resident 1's public conservator. This failure had the potential to result in Resident 1 sustaining a serious injury during elopement. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (serious mental disorder in which people interpret reality abnormally). During a review of Resident 1's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 7/28/2024, the H&P indicated Resident 1 lacked capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 10/31/2024, the MDS indicated Resident 1's cognitive abilities (ability to think, learn, and process information) were intact. During a concurrent interview and record review on 12/20/2024 at 11:36 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's Nursing Admission Assessment (NAA) dated 4/17/2024 was reviewed. The NAA indicated Section N of Wandering and Elopement Assessment was blank. LVN 1 stated Resident 1's elopement risk assessment was not completed on admission and stated LVN 1 was unsure if the assessment was required to be completed on admission. LVN 1 stated the risk of not completing the elopement risk assessment was that staff would not be able to identify if the resident was a high risk to elope. During an interview on 12/20/2024 at 12:43 PM with the Director of Nursing, the DON stated the elopement risk assessment should have been completed on admission per facility policy. The DON stated if a resident was a high risk for elopement and was required to leave the facility the resident would need to be placed in restraints and escorted with a trained staff to monitor the resident. The DON stated this was not done for Resident 1 because Resident 1 had left with Resident 1's public conservator previously with no issues. The DON stated the risk of not completing the elopement risk assessment was not being able to identify residents who are a high risk. During a review of the facility's policy and procedure (P&P) titled, Wandering and Elopement dated 10/1/2023, the P&P indicated the licensed nurses will assess residents upon admission, readmission, quarterly, and upon identification of significant change in condition according to RAI guidelines to determine their risk of wandering and or elopement.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to ensure the Medical Doctor's (MD) notification of a change of condition (COC) was documented in the resident's medical record for one of four sampled residents (Resident 1) when Resident 1 eloped (leaving without permission or supervision) from a court hearing on 12/18/2024. This failure had the potential to negatively impact the delivery of services for Resident 1. Findings: During a review of Resident 1's Admission Record (AR) the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (serious mental disorder in which people interpret reality abnormally). During a review of Resident 1's History and Physical (H&P, formal document of a medical provider's examination of a patient) dated 7/28/2024, the H&P indicated Resident 1 lacked capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 10/31/2024, the MDS indicated Resident 1's cognitive abilities (ability to think, learn, and process information) were intact. During a concurrent interview and record review on 12/20/2024 at 11:36 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's COC's were reviewed. LVN 1 stated there was no COC completed when Resident 1 eloped from the court hearing on 12/18/2024. LVN 1 stated the MD was notified on 12/18/2024 via text message and stated there was no documentation in Resident 1's medical record. LVN 1 stated the purpose of documenting a COC was to indicate communication between the staff and the MD, document an assessment pertaining to the COC, indicate the MD and Resident Representative (RP) were notified, and if orders were obtained. LVN 1 stated the phone is not the resident's medical record and stated MD notification should've been documented in Resident 1's medical record. LVN 1 stated the risk of not documenting a COC was that there would be no proof the facility notified the MD, and the care team would not be aware the MD was notified. During an interview on 12/20/2024 at 12:43 PM with the Director of Nursing (DON), the DON stated a COC was not completed on 12/18/2024 when Resident 1 eloped before the court hearing. The DON stated it should have been documented in the resident's medical record so it is easily accessible to all care members because the care team should not have to scroll through the phone to check if the MD was notified. The DON stated the risk of not documenting the COC notification was that staff would not be aware if there was a change in condition, if the MD was notified, or if the MD had any new orders. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Change of Condition Notification dated 10/1/2023, the P&P indicated the licensed nurse will document the time the Attending Physician was contacted, the method by which he or she was contacted, the response time, and whether orders were received. The P&P indicated documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record.