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	04/15/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49252 Based on interview and record review, the facility failed to ensure one of seven sampled residents (Residents 1) had a complete neurological (of, relating to, or affecting the functioning of the brain, spine or nerves) assessment check (neurocheck - evaluates brain and nervous system [network of cells, tissues, and organs that controls and coordinates bodily functions) for the 72-hour monitoring period after a resident-to-resident altercation. This failure resulted in incomplete neurological assessments for Resident 1 after a change in condition and had the potential to negatively affect the delivery of necessary care and services in assessing for possible neurological complications. 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 (a mental illness that is characterized by disturbances in thought) and depression (a mood disorder that may cause persistent sadness or loss of interest in activities). During a review of Resident 1's History & Physical (H&P), dated 12/18/2024, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/26/2024, the MDS indicated Resident 1 had intact cognition (ability to understand, learn, and process information). During a review of Resident 1's Change in Condition Evaluation (CICE), dated 4/12/2025, timed at 1:10 pm, the CICE indicated on 4/12/2025, untimed, Resident 1 was hit in the face by another resident (Resident 2). The CICE indicated Resident 1 had no major injury. During a review of Resident 1's Care Plan (CP) titled, Care Plan Report, dated 4/14/2025, the CP indicated Resident 1 had a psychosocial (involving both social and individual thought and behavior) well-being problem related to emotional distress and feelings of insecurity following an alleged incident of being hit by another resident on 4/11/2025. (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 - Few	During an interview on 4/15/2025 at 12:05 pm with Resident 1, Resident 1 stated on 4/11/25 at approximately 7:30 pm, Resident 2 hit Resident 1 with a closed fist to Resident 1's left cheek. Resident 1 stated staff had not been doing neurochecks on him since the incident. During a concurrent interview and record review on 4/15/2025 at 12:24 pm with Licensed Vocational Nurse (LVN) 1, Resident 1's Neurocheck Flowsheet (NF - used to document neurochecks on a resident which checks their level of consciousness, pupil response, motor functions [hand grasp strength and movement of extremities], ability to follow simple instructions, pain level, nausea/vomiting, and vital signs with a monitoring frequency of every 4 hours for 24 hours, then every shift for 2 days) started on 4/12/2025 at 11:16 am and ended on 4/15/2025 during the 11 pm to 7 am shift (time not specified) was reviewed. The NF indicated the assessment and nurse initials were blank for 4/14/2025 for the 3 pm to 11 pm shift. LVN 1 stated, the assigned licensed nurse (LN) should have completed the blank areas of documentation on Resident 1's NF. LVN 1 stated, Resident 1 needed the 72-hour neurochecks because Resident 2 hit Resident 1 on Resident 1's face. LVN 1 stated for any head injury, it was the facility's policy to initiate neurochecks. LVN 1 stated, it was important to do the neurochecks to monitor the resident for any neurological changes. During an interview on 4/15/2025 at 4:44 pm with the Director of Nursing (DON), the DON stated, after a resident-to-resident altercation that included a hit to the head, the facility's process included initiating neurochecks for 72 hours to make sure the resident was stable. The DON stated, neurological assessments were important to identify any abnormalities. The DON stated, Resident 1's NF documentation was incomplete, and the assigned LN should have completed the documentation. During a review of the facility's policy and procedure (P&P) titled, Neurological Assessment, revised 8/1/2014, the P&P indicated, Nursing Staff will perform a neurological assessment in the following circumstances . Following a fall or other accident/injury involving head trauma; or . When indicated by the resident's condition. The P&P indicated, The following information will be documented in the resident's medical record . All assessment data obtained during the procedure, including: a. Eye opening b. Verbal response c. Motor response d. Pupillary response e. Limb response . The signature and title of the person recording the data. During a review of the facility's P&P titled, Documentation-Nursing, dated 10/1/2023, the P&P indicated, Nursing documentation will be concise, clear, pertinent, and accurate Checklists, flow charts, and other documentation tools will be used as appropriate. The P&P indicated, Documentation will be completed by the end of the assigned shift. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, dated 7/9/2024, the P&P indicated, Resident assessments . are performed to monitor resident needs and address behaviors .