STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555237	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Gabriel Valley Medical Ctr D/P Snf	438 W. Las Tunas Drive San Gabriel, CA 91776

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to meet professional standards of quality for one (1) of one sampled resident (Resident 19) reviewed for abuse, by failing to assess and notify the physician after Resident 19 reported hitting his head on the headboard while getting repositioned up in bed (to move a Resident ensure a timely from the foot of the bed back toward the head of the bed) by Licensed Vocational Nurse 4 (LVN 4). This deficient practice has the potential to result in a lack of or delay in delivery of necessary care and services.Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE] . During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a concurrent observation and interview, on 4/25/2026, at 10:20 AM in Resident 19's room, Resident 19 was observed awake in bed, wearing a Passy Muir Valve (PMV- a one-way speaking valve placed on a tracheostomy tube to allow patients to speak, swallow, and breathe more naturally), and accompanied by his Responsible Party (RP 1). Resident 19 stated LVN 4 hit him on the head sometime in 11/2025. Resident 19 stated he informed the Nurse Manager (NM) about the incident but could not remember the date he informed NM. During an interview on 4/26/2026, at 2:50 PM, with NM, NM stated sometime in 11/2025, Resident 19 and RP 1 informed her that Resident 19 hit his head while getting pulled up on the bed by LVN 4. NM stated she did not assess or notify the physician after Resident 19 informed her he hit his head on the headboard. During a concurrent interview and record review of Resident 19's medical records on 4/27/2026, at 8:58 AM with the MDS Nurse (MDS 1), MDS 1 stated there was no documentation in Resident 19's medical record indicating that staff assessed the Resident 19 or notified his physician after he reported hitting his head while being pulled up in bed by LVN 4 in 11/2025. During an interview on 4/27/2026, at 10:44 AM, with LVN 2, LVN 2 stated licensed nurses should assess the resident and notify the physician if the resident reports hitting his head while receiving care from staff. LVN 2 stated it was important to notify the physician what the resident reported so proper tests and assessments are ordered. LVN 2 stated it was important that assessments and tests are done after a resident report being hurt to ensure their safety in the facility. During an interview, on 4/27/2026, at 11:30 AM, with Registered Nurse (1) RN 1, RN 1 stated it was standard practice for facility staff to perform a head to toe assessment (a systemic physical examination used by nurses to evaluate a resident's overall health status) after receiving a report that a resident hit his head while receiving care. RN 1 stated facility staff should (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also interview the resident and check for injuries. RN 1 stated it was important to notify the physician about the incident so diagnostic tests and specific assessments can be ordered. RN 1 stated it was standard practice to perform a neuro check (neurological check- a quick test to evaluate head injuries) for 72 hours after hitting his head. RN 1 stated if a resident reported hitting his head while getting pulled on the bed then it was considered a change in the resident's condition. During a review of the facility's policy and procedure (P&P), titled, Change in Resident Condition, dated 4/2022, the P&P indicated the following:It is the policy of this facility that all changes of conditions will be communicated to the physician and family or legal representative.All symptoms and unusual signs will be communicated to the physician promptly.The nurse in charge is responsible for notification of physician and family or legal representatives prior to the end of assigned shift when a change in resident's condition is noted.Document resident change in condition and response in Nursing Progress Notes, on 24-Hour Report and update resident care plan as indicated. During a review of the facility's P&P, titled, Charting, Guidelines, dated 4/2022, the P&P indicated the following:Charting should include all assessments of resident condition, all interventions taken to resolve a problem and the progress/lack of progress with the written care plan.Document normal findings as well as abnormal findings as this shows the resident was being assessed.All residents are assessed every shift and a nurse's note is written documenting any change in condition and the care given and at least once daily a nurse note is written.

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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** Based on interview and record review, the facility failed to ensure the medical records were complete and accurately documented for one (1) of 1 sampled resident (Resident 19) reviewed for abuse, (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) by failing to document Resident 19's report of hitting his head on the headboard while getting repositioned up in bed (to move a resident from the foot of the bed back toward the head of the bed) by Licensed Vocational Nurse 4 (LVN 4). This deficient practice had the potential to result in incomplete assessment of Resident 19's needs and could lead to a lack of or delay in delivery of necessary care and services.Findings: During a review of Resident 19's admission Record, the admission Record indicated Resident 19 was admitted to the facility on [DATE]. During a review of Resident 19's History and Physical (H&P), dated 1/19/2026, the H&P indicated Resident 19 had diagnoses that included status post cholecystectomy (previously undergone surgical removal of the bladder), recurrent aspiration pneumonia (repeated episodes of lung infection caused by the recurring inhalation of foreign materials into the airways and lungs), and coronary artery disease status post bypass (previous surgical treatment to bypass blocked arteries in the heart using a vessel taken from another part of the body). During a review of Resident 19's Minimum Data Set (MDS- a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 19 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 19 was dependent (helper does all of the effort) with eating, toileting hygiene, upper/lower body dressing, personal hygiene, and rolling left and right. During a concurrent observation and interview, on 4/25/2026, at 10:20 AM in Resident 19's room, Resident 19 was observed awake in bed, wearing a Passy Muir Valve (PMV- a one-way speaking valve placed on a tracheostomy tube to allow patients to speak, swallow, and breathe more naturally), and accompanied by his Responsible Party (RP 1). Resident 19 stated LVN 4 hit him on the head sometime in 11/2025. Resident 19 stated he informed the Nurse Manager (NM) about the incident but could not remember when he informed NM. During an interview on 4/26/2026, at 2:50 PM, with NM, NM stated sometime in 11/2025, Resident 19 and RP 1 informed her that Resident 19 hit his head while getting pulled up on the bed by LVN 4. NM stated she spoke to LVN 4 about the incident and LVN 4 confirmed Resident 19 head hit his head while LVN 4 provided care and pulled Resident 19 up on the bed. NM stated she did not document the incident between Resident 19 and LVN 4 in Resident 19's medical record. During a concurrent interview and record review of Resident 19's medical records on 4/27/2026, at 8:58 AM with the Minimum Data Set Nurse (MDS 1), MDS 1 stated there was no documentation in Resident 19's medical record by LVN 4 or any licensed nurse that Resident 19 hit his head while pulling him up on the bed. During an interview on 4/27/2026, at 10:44 AM, with LVN 2, LVN 2 stated if a resident reported getting hurt while receiving care, the report should be documented in the residents' medical record. LVN 2 stated the facility staff who was involved in the residents' care and who received the report were responsible for documenting the incident in the residents' medical record. During an interview, on 4/27/2026, at 11:30 AM, with Registered Nurse (1) RN 1, RN 1 stated it was standard practice for facility staff to document incidents that involved residents' care in the medical record. RN 1 stated the documentation should include a description of the incident, head to toe assessment (a systemic physical examination used by nurses to evaluate a resident's overall health status), interventions performed, injuries, and if the physician was notified. RN 1 stated the facility's policy for documentation was not followed. During a review of the facility's policy and procedure (P&P), titled, Charting, Guidelines, dated 4/2022, the P&P indicated the following:All charting should be done as soon as possible after a given event.Keep entries factual and specific. They must be accurate and informative. Document any changes in (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident condition as well as steps taken in response to the change. Continue to chart on a resident as often as condition warrants until the condition is resolved. During a review of the facility's P&P, titled, Documentation in the Medical Record, Legal, dated 4/2022, the P&P indicated the following:A clear, concise, accurate, legible, and chronological written history of the Resident's stay will be documented, in accordance with state and federal guidelines, and The Joint Commission (JCAHO- an accreditation organization for hospitals, clinics and nursing homes) standards.Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the residents' continuing care.