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	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penn Mar Healthcare Center	3938 Cogswell Road El Monte, CA 91732

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on observation, interview, and record review, the facility failed to report an alleged sexual abuse incident between Resident 1 and Resident 2 immediately, but no later than two hours to the California Department of Public Health (CDPH), local law enforcement, and Ombudsman (resident advocate who investigated and resolved complaints, usually through recommendations or mediation) as indicated in the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program. This deficient practice violated the Federal mandated reporting timeframe and had the potential to subject Resident 1 to possible further sexual abuse and psychological (mental and/or emotional) harm. Cross reference F689 and F657 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 to the facility on [DATE] with diagnoses including but not limited to schizoaffective disorder (mental health disorder that involves psychosis [loss of contact with reality] as well as mood symptoms), suicidal behavior, and insomnia (difficulties with falling and or staying asleep). During a review of Resident 1's Minimum Data Set (MDS, a standardized comprehensive assessment and care planning tool) dated 2/8/2024, the MDS indicated Resident 1's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 1 had feelings of being down, depressed, or hopeless for one day. During a review of Resident 1's Nursing Note (NN) dated 2/14/2024, timed at 8:03 PM, the NN indicated Resident 1 notified the Recreational Activities Assistant (RAA) of Resident 2 allegedly pulling down his pants and asking Resident 1 for oral sex three or four days ago. The NN indicated Resident 2 denied the allegations. The NN indicated Licensed Vocational Nurse (LVN) 1 notified the previous Director of Nursing through the phone and the Social Worker (SW) through voicemail. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 to the facility on [DATE] with diagnoses including but not limited to schizoaffective disorder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Psychiatric Evaluation (PE), dated 3/23/2023, the PE indicated Resident 2 was alert and oriented to person, place, and time. During a review of Resident 2's untitled CP, initiated on 9/5/2023, the CP indicated Resident 2 had socially inappropriate behavior such as stealing items, going into other residents' rooms, being intrusive with others, removing clothing in front of others, and dressing inappropriate in situations. The CP interventions indicated for staff to ask Resident 2 to identify triggers one time weekly, discuss and evaluate the effectiveness and side effects of current medication treatment, and for Resident 2 to attend Anger Management, Coping Skills, and Dual Diagnosis group once weekly. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive abilities were intact. During an interview on 3/19/2024 at 1:33 PM with the SW, the SW stated she was not made aware of the alleged incident between Resident 1 and Resident 2 (on 2/14/2024). During an interview on 3/19/2024 at 1:52 PM with Resident 1, Resident 1 stated Resident 2's room shared a bathroom with Resident 1's room. Resident 1 stated Resident 2 came to the doorway of Resident 1's room through the shared bathroom and asked Resident 1 a question but was unsure of what Resident 2 wanted. Resident 1 stated he followed Resident 2 through the shared bathroom to Resident 2's room. Resident 1 stated Resident 2 then pulled down his pants and asked Resident 1 for oral sex. Resident 1 stated, What are you doing? Stop! Resident 1 stated he walked away and reported the incident to a staff member (unidentified). Resident 1 stated it was stuck in his mind the whole day, and stated, I felt so upset. Resident 1 stated after the incident, he did not feel safe with Resident 2 in the next room, until Resident 2 was moved to a different room on 2/17/2024. During an interview on 3/19/2024 at 2:28 PM with the current Director of Nursing (DON), the DON stated staff must report any allegation of abuse to the charge nurse and Administrator (ADM), separate and assess the affected residents, and notify the residents' physician (MD) and conservator. The facility would then initiate an investigation and the ADM would report the instances of alleged abuse to CDPH, local law enforcement, and Ombudsman. The DON stated staff did not follow the facility's P&P titled, Abuse Prevention and Prohibition Program, and failed to report the alleged sexual abuse (between Resident 1 and Resident 2) within two hours. During an interview on 3/19/2024 at 3:06 PM with Resident 2, Resident 2 stated he asked Resident 1 to come to Resident 2's room then Resident 1 sat on Resident 2's bed. Resident 2 stated he sat next to Resident 1 on the bed. Resident 2 stated he pulled out his genitals out of his pants to show Resident 1. Resident 2 stated Resident 1 said, No, what are you doing? Resident 2 stated he thought Resident 1 wanted to play with him since Resident 1 followed Resident 2 to Resident 2's room. During a concurrent interview and record review on 3/20/2024 at 9:15 AM with the ADM, Resident 1's NN dated 2/14/2024 was reviewed. The ADM stated he was not aware of the alleged sexual abuse incident that occurred on 2/14/2024 between Resident 1 and Resident 2. The ADM stated he was unsure of why the incident was not reported to him. The ADM stated the risk of not reporting to him was the delay to start an initial investigation. The ADM stated the incident between Resident 1 and Resident 2 would be considered alleged sexual abuse because Resident 2 exposed his genitals to Resident 1 and Resident 2 stated he wanted to engage in oral sexual activity with Resident 1. The ADM stated staff did not follow the facility's P&P titled, Abuse Prevention and Prohibition Program. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2024 at 1:36 PM with LVN 1, LVN 1 stated the RAA reported the incident to her on 2/14/2024. LVN 1 stated LVN 1 reported the incident to the previous DON and left a voicemail for the SW on 2/14/2024. LVN 1 stated the previous DON said he would take care of the reporting. LVN 1 stated Resident 2 had a history of inappropriate behaviors. LVN 1 stated no new interventions were placed for Resident 2 on 2/14/2024. LVN 1 stated the incident would be considered alleged sexual abuse as Resident 2 asked Resident 1 to perform oral sex. During a review of the facility's P&P titled, Abuse Prevention and Prohibition Program, dated 10/1/2023, the P&P indicated the facility promptly and thoroughly investigated reports of resident abuse, neglect, mistreatment, misappropriation of property, injuries of unknown injuries, and criminal acts. The P&P indicated facility owners, operators, employees, managers, agents, and contractors were obligated by the Elder Justice Act and the California Elder Abuse and Dependent Adult Civil Protection Act to report known or suspected instances of abuse of elder or dependent adults. The P&P indicated facility staff reported known or suspected instances of abuse to the ADM or his/her designee. The P&P indicated the facility reported allegations of abuse, neglect, mistreatment, injuries of unknown source, misappropriation of resident property, or other incidents that qualify as a crime immediately but no later than two hours after forming the suspicion- if the alleged violation involved abuse or results in serious bodily injury to the state survey agency, adult protective services, law enforcement, and the Ombudsman.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48905 Based on interview and record review, the facility failed to revise residents' care plans to be individualized to address residents' specific behaviors for three of eight sampled residents (Resident 2, 4, 7). 1. For Resident 2, the facility failed to revise Resident 2's care plan after having three incidents of alleged inappropriate sexual behavior on 2/14/2024 when Resident 1 reported to staff that Resident 2 pulled down his pants and asked Resident 1 for oral sex, on 2/28/2024 when Resident 2 reported to staff having multiple instances of oral sex with Resident 3, and on 3/17/2024 when Resident 4 stated Resident 2 came into Resident 4's room at night, pulled down his blanket, and asked Resident 4 for oral sex. 2. For Resident 4, the facility failed to revise Resident 4's care plan after Resident 4 hit Resident 2 on the face on 3/18/2024 at 8:45 AM. 3. For Resident 7, the facility failed to revise Resident 7's care plans after having multiple physical altercations with Resident 6 on 2/23/2024, 3/1/2024, and 3/13/2024. These deficient practices had the potential for Resident 2, 4, and 7 to not receive consistent and appropriate care, treatment, and/or services and could affect the safety of other residents in the facility. Cross Reference F609 and F689 Findings: 1. During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 to the facility on [DATE] with diagnoses including but not limited to schizoaffective disorder (mental health disorder that involves psychosis [loss of contact with reality] as well as mood symptoms). During a review of Resident 2's Psychiatric Evaluation (PE), dated 3/23/2023, the PE indicated Resident 2 was alert and oriented to person, place, and time. During a review of Resident 2's Minimum Data Set (MDS, a standardized comprehensive assessment of each resident's functional capabilities and identifies health problems) dated 12/29/2023, the MDS indicated Resident 2 cognitive abilities (ability to think, learn, and process information) were intact. During a review of Resident 2's Order Summary Report (OSR) dated 3/19/2024, the OSR indicated Resident 2 had an active order dated 3/22/2023 for Assaultive Precautions. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's untitled CP, initiated on 9/5/2023, the CP indicated Resident 2 had socially inappropriate behavior such as stealing items, going into other residents' rooms, being intrusive with others, removing clothing in front of others, and dressing inappropriate in situations. The CP interventions indicated for staff to ask Resident 2 to identify triggers one time weekly, discuss and evaluate the effectiveness and side effects of current medication treatment, and for Resident 2 to attend Anger Management, Coping Skills, and Dual Diagnosis group once weekly. During a review of Resident 2's untitled CP, initiated on 9/5/2023, the CP indicated Resident 2 had poor impulse control outbursts of aggression against property or people, explosive emotional outbursts, combative/assaultive behaviors, and or self-injurious behaviors. The CP interventions indicated for staff to monitor for impulsive behaviors once every morning and every night. During an interview on 3/19/2024 at 9:52 AM with Resident 2, Resident 2 stated he engaged in oral sex with Resident 3 three to four times in Resident 2's room in February 2024. Resident 2 stated Resident 3 was his roommate and stated he was unsure why he participated in oral sex with Resident 3. Resident 2 stated he reported the incident to the Social Worker (SW). During an interview on 3/19/2024 at 10:02 AM with Resident 4, Resident 4 stated Resident 2 came into his room in the middle of the night on 3/17/2024, pulled down Resident 4's blanket, and grabbed Resident 4's genitals. During an interview on 3/19/2024 at 1:52 PM with Resident 1, Resident 1 stated Resident 2's room shared a bathroom with Resident 1's room. Resident 1 stated (on 2/14/2024) Resident 2 came to the doorway of Resident 1's room through the shared bathroom and asked Resident 1 a question but was unsure of what Resident 2 wanted. Resident 1 stated he and followed Resident 2 through the shared bathroom to Resident 2's room. Resident 1 stated Resident 2 then pulled down his pants and asked Resident 1 for oral sex. Resident 1 stated, What are you doing?! Stop! Resident 1 stated he walked away and reported the incident to a staff member (unidentified). Resident 1 stated it was stuck in his mind the whole day, and stated, I felt so upset. During an interview on 3/19/2024 at 3:06 PM with Resident 2, Resident 2 stated he asked Resident 1 to come to Resident 2's room then Resident 1 sat on Resident 2's bed. Resident 2 stated he sat next to Resident 1 on the bed. Resident 2 stated he pulled out his genitals out of his pants to show Resident 1. Resident 2 stated Resident 1 said, No, what are you doing? Resident 2 stated he thought Resident 1 wanted to play with him since Resident 1 followed Resident 2 to Resident 2's room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 3/20/2024 at 11:00 AM with the Director of Nurses (DON), Resident 2's untitled care plans and Interdisciplinary Team (IDT, team that comprises of professionals from various disciplines who work in collaboration to address a residents multiple physical and psychological needs) Notes were reviewed. The DON stated Resident 2's CP did not address the alleged sexual abuse incidents between Resident 1 and Resident 2, between Resident 3 and Resident 2, and between Resident 4 and Resident 2. The DON stated from 2/1/2024 to 3/17/2024 no new interventions were placed for Resident 2. The DON stated the risk of not having new interventions placed for Resident 2 would be Resident 2 continuing the sexually inappropriate behaviors and affecting other residents and safety of other residents. The DON stated Resident 2's care plan needed to be revised to include individualized interventions such as psychiatric consult, reviewing current medication regimen to assess if Resident 2 was compliant with medications, assessing for side effects of medications, and additional monitoring every 30 minutes for Resident 2. The DON stated the CP was to be individualized for each resident and to guide staff in providing care for each resident. The DON stated Resident 2's current CP was not individualized to meet Resident 2's needs as it did not address the inappropriate sexual behaviors. The DON stated interventions on the CP were monitored through IDT meetings. The DON stated the IDT meeting for Resident 2 was not completed to address the alleged sexual abuse incidents that occurred on 2/14/2024 and 2/28/2024 as a result, the Resident 2's CP was not revised. During an interview on 3/20/2024 at 1:36 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 2 had a history of inappropriate behaviors. LVN 1 stated Resident 2's care plan was not revised, and no new interventions were placed to monitor Resident 2 after the incident with Resident 1 on 2/14/2024. 2. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 to the facility on [DATE] with diagnoses including but not limited to schizophrenia (severe mental disorder that affects how a person thinks, acts, expresses emotions, perceives reality, and relates to others), hyperlipidemia (high levels of fats in the blood), and tobacco use. During a review of Resident 4's History and Physical (H&P) dated 10/7/2023 at 2:25 PM, the H&P indicated Resident 4 was alert and oriented to person. During a review of Resident 4's untitled CP dated 11/3/2023, the CP indicated Resident 4 had a psychosocial well-being problem as evidenced by getting hit by a male peer. The CP interventions indicated for staff to allow Resident 4 time to answer questions and to verbalize feelings, perceptions, and fears. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognitive abilities were intact. During a review of Resident 4's OSR dated 3/18/2024, the OSR indicated Resident 4 had an active MD order dated 10/5/2023 for Assaultive Precautions. During a review of Resident 4's Nursing Notes (NN) dated 3/18/2024 at 8:50 AM, the NN indicated Resident 4 hit Resident 2 on the back of the head during medication pass in the hallway at around 8:45 AM on 3/18/2024. The NN indicated Resident 4 stated Resident 2 came into his room last night and wanted oral sex. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/2024 at 10:02 AM with Resident 4, Resident 4 stated Resident 2 came into his room in the middle of the night on 3/17/2024, pulled down Resident 4's blanket, and grabbed Resident 4's genitals. Resident 4 stated Resident 2 wore a red shirt when Resident 2 came into Resident 4'sroom at night and stated Resident 4 saw Resident 2 in the same red shirt in the morning of 3/18/2024. Resident 4 stated he wanted to punch Resident 2 on the teeth, so he tried to turn Resident 2 to face him and hit Resident 2 in the face. During an interview on 3/19/2024 at 12:02 PM with LVN 1, LVN 1 stated Resident 4 was upset and Resident 4 visually identified Resident 2 as the resident who went into Resident 4's room at night (on 3/17/2024) and asked to perform oral sex. LVN 1 stated Resident 2 was wearing a red crew neck on 3/18/2024. During a concurrent interview and record review on 3/19/2024 at 2:11 PM with the DON, Resident 2 and Resident 4's untitled CPs were reviewed. The DON stated Resident 4's CP did not indicate any aggressive behaviors. The DON stated Resident 4's CP needed to be revised to assess Resident 4's psychosocial behaviors from Resident 2's alleged sexual behavior. The DON stated the risk of not revising Resident 4'sCP was not being able to assess Resident 4's mental or physical trauma from the physical attack and alleged sexual abuse. The DON stated Resident 2's CP was not revised to address his inappropriate sexual behaviors after Resident 2 had two incidents of alleged sexual abuse on 2/14/2024 and 2/28/2024. The DON stated resident CPs needed to be revised based on the individual needs of each resident. During an interview on 3/20/2024 at 8:55 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she saw Resident 4 hit Resident 2 on the right side of the face during medication pass. CNA 1 stated Resident 4 said Resident 2 came into his room in the night and asked him for oral sex. 3. During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 to the facility on [DATE] with diagnoses including but not limited to psychosis (people see or hear things that other people cannot see or hear and believe in things that are not actually true. It may also involve confused thinking and speaking). During a review of the facility's Resident Altercation Log (RAL) dated 8/29/2023 to 3/28/2024, the RAL indicated Resident 6 and Resident 7 have had physical altercations on 11/13/2023, 2/23/2024, 3/1/2024, and 3/13/2024. During a review of Resident 7's untitled CP, dated 11/13/2023, the CP indicated Resident 7 had resident to resident conflict incidences in which residents may endure verbal or physical abuse, as well as property theft from their roommates or other residents. The CP interventions indicated for staff to identify triggers and or factors that lead up to conflict. During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7's cognitive abilities were moderately impaired. During a review of Resident 7's untitled CP, initiated on 2/23/2024, the CP indicated on 2/23/2024 Resident 7 struck a male peer on the back of the neck, on 3/1/2024 Resident 7 struck a male peer on the right ear with a closed fist, and on 3/18/2024 Resident 7 slapped a male peer on the face. The CP interventions indicated on staff to monitor and modify the environment for external contributors to behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 7's OSR dated 3/18/2024, the OSR indicated Resident 7 had an active MD order dated 10/30/2023 for Assaultive Precautions. During an interview on 3/18/2024 at 9:25 AM with Resident 6, Resident 6 stated Resident 7 came out of nowhere and hit Resident 6 on the face. Resident 6 stated he did not say anything to Resident 7 and was minding his own business. During an interview on 3/18/2024 at 10:01 AM with CNA 3, CNA 3 stated Resident 7 had a history of hitting other residents when Resident 7 was upset. During an interview on 3/18/2024 at 11:24 AM with LVN 2, LVN 2 stated Resident 7 had outburst, got upset at times, and can hit someone. LVN 2 stated it occurred at least once a month. During a concurrent interview and record review on 3/18/2024 at 1:57 PM with the DON, Resident 7's IDT meeting dated 2/14/2024 and CP dated 2/23/2024 were reviewed. The IDT note did not indicate the physical altercation that occurred on 2/14/2024 between Resident 6 and Resident 7. The DON stated IDT was not completed for both Resident 6 and Resident 7 on 2/14/2024, 3/1/2024, and 3/13/2024. The DON stated IDT needs to be completed within 72 hours of the incident and stated there was no excuse why it was not completed. The DON stated the risk of not completing an IDT meeting for both residents was being unable to identify triggers in residents' behaviors to prevent serious injury to residents. The DON stated interventions on the CP were reviewed and determined if interventions were completed or appropriate for the resident during IDT meetings. The DON stated if interventions on the CP were not effective, then it was addressed in the IDT meeting. The DON stated there had not been any IDT meetings to address the physical altercations between Resident 6 and Resident 7, therefore the CP was not revised for both residents. During an interview on 3/19/2024 at 10:30 AM with CNA 5, CNA 5 stated on 3/13/2024 CNA 5 heard a loud clap and stated Resident 6 said Resident 7 hit Resident 6. CNA 5 stated he saw Resident 7 pointing his finger at Resident 6 mumbling to himself. CNA 5 stated Resident 7 sometimes got agitated and would focus on a single person and would start yelling and point his finger at residents. CNA 5 stated she was unsure of what triggered Resident 7's aggressive behavior. During a review of the facility's policy and procedure (P&P) titled, Care Planning dated 10/1/2023, the P&P indicated a comprehensive care plan (CCP) will be developed for each resident. The P&P stated the CP will include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. The P&P indicated the CCP to be prepared by the IDT team and the IDT team will revise the CPP as needed at the following intervals: A. Per RAI schedules; B. As dictated by changes in the resident's condition; C. In preparation for discharge; D. To address changes in behavior and care; and E. Other times as appropriate or necessary. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Management of Assaultive Behavior, undated, the P&P indicated the IDT developed objectives and plans. The P&P indicated staff were to make an entry of observed antecedent (what was happening or who was present right before the behavior occurred) behaviors that preceded aggression. The P&P indicated treatment plans should indicate the antecedent behaviors.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide adequate supervision and monitoring for three of eight sampled residents (Resident 1, 2, and 4) as indicated in the facility's policies and procedures (P&P) titled, Hallway Monitor and Rounds/Headcount. 1. Resident 1 reported to the Recreational Activities Assistant (RAA) that Resident 2 pulled down Resident 2's pants and asked Resident 1 to perform oral sex on Resident 2 in Resident 2's room. 2. Resident 4 reported to staff that Resident 2 came into Resident 4's room in the middle of the night, pulled down Resident 4's blanket, tried to grab Resident 4's genitals, and asked Resident 4 for oral sex. As a result of these failures, Resident 2 experienced feelings of mental and emotional distress and felt unsafe until Resident 1 was moved to another room. Resident 4 hit Resident 2 on the back of Resident 2's head due to feeling upset about the incident with Resident 2. Cross reference F609 and F657 Findings: 1. During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 to the facility on [DATE] with diagnoses including but not limited to schizoaffective disorder (mental health disorder that involves psychosis [loss of contact with reality] as well as mood symptoms), suicidal behavior, and insomnia (difficulties with falling and or staying asleep). During a review of Resident 1's Minimum Data Set (MDS, a standardized comprehensive assessment and care planning tool) dated 2/8/2024, the MDS indicated Resident 1's cognitive abilities (ability to think, learn, and process information) were intact. The MDS indicated Resident 1 had feelings of being down, depressed, or hopeless for one day. During a review of Resident 1's Nursing Note (NN) dated 2/14/2024, timed at 8:03 PM, the NN indicated Resident 1 notified the RAA of Resident 2 allegedly pulling down his pants and asking Resident 1 for oral sex three or four days ago. The NN indicated Resident 2 denied the allegations. The NN indicated Licensed Vocational Nurse (LVN) 1 notified the previous Director of Nursing through the phone and the Social Worker (SW) through voicemail. 2. During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 to the facility on [DATE] with diagnoses including but not limited to schizoaffective disorder. During a review of Resident 2's Psychiatric Evaluation (PE), dated 3/23/2023, the PE indicated Resident 2 was alert and oriented to person, place, and time. (continued on next page)

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	05A360	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penn Mar Healthcare Center	3938 Cogswell Road El Monte, CA 91732

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's untitled CP, initiated on 9/5/2023, the CP indicated Resident 2 had socially inappropriate behavior such as stealing items, going into other residents' rooms, being intrusive with others, removing clothing in front of others, and dressing inappropriate in situations. The CP interventions indicated for staff to ask Resident 2 to identify triggers one time weekly, discuss and evaluate the effectiveness and side effects of current medication treatment, and for Resident 2 to attend Anger Management, Coping Skills, and Dual Diagnosis group once weekly. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive abilities were intact. 3. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 to the facility on [DATE] with diagnoses including but not limited to schizophrenia (severe mental disorder that affects how a person thinks, acts, expresses emotions, perceives reality, and relates to others), hyperlipidemia (high levels of fats in the blood), and tobacco use. During a review of Resident 4's History and Physical (H&P) dated 10/7/2023 at 2:25 PM, the H&P indicated Resident 4 was alert and oriented to person. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognitive abilities were intact. During a review of Resident 4's Nursing Notes (NN) dated 3/18/2024, timed at 8:50 AM, the NN indicated Resident 4 hit Resident 2 on the back of the head during medication pass in the hallway at around 8:45 AM on 3/18/2024. The NN indicated Resident 4 stated Resident 2 came into his room last night and wanted oral sex. The NN indicated Resident 4 denied physical contact. The NN indicated Resident 4 did not notify the staff when the incident occurred. During a review of Resident 4's Social Services Noted (SSN) dated 3/18/2024, timed at 4:58 PM, the SSN indicated Resident 4 stated on the previous night (3/17/2024) Resident 2 went to Resident 4's room, took Resident 4's blanket, and tried to grab Resident 4's genitals. The SSN indicated Resident 4 told Resident 2 to get out and Resident 2 did. The SSN indicated Resident 4 did not report the incident to anyone. The SSN indicated Resident 4 stated Resident 4 hit Resident 2 (on 3/18/2024) because Resident 4 was upset. During an interview on 3/19/2024 at 10:02 AM with Resident 4, Resident 4 stated Resident 2 came into his room in the middle of the night on 3/17/2024, pulled down Resident 4's blanket, and grabbed Resident 4's genitals. Resident 4 stated Resident 2 wore a red shirt when Resident 2 came into Resident 4's room at night and stated Resident 4 saw Resident 2 in the same red shirt in the morning of 3/18/2024. Resident 4 stated he wanted to punch Resident 2 on the teeth, so he tried to turn Resident 2 to face him and hit Resident 2 in the face. During an interview on 3/19/2024 at 12:02 PM with LVN 1, LVN 1 stated Resident 4 was upset and Resident 4 visually identified Resident 2 as the resident who went into Resident 4's room at night (on 3/17/2024) and asked to perform oral sex. LVN 1 stated Resident 2 was wearing a red crew neck on 3/18/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/19/2024 at 1:52 PM with Resident 1, Resident 1 stated Resident 2's room shared a bathroom with Resident 1's room. Resident 1 stated Resident 2 came to the doorway of Resident 1's room through the shared bathroom and asked Resident 1 a question but was unsure of what Resident 2 wanted. Resident 1 stated he followed Resident 2 through the shared bathroom to Resident 2's room. Resident 1 stated Resident 2 then pulled down his pants and asked Resident 1 for oral sex. Resident 1 stated, What are you doing? Stop! Resident 1 stated he walked away and reported the incident to a staff member (unidentified). Resident 1 stated it was stuck in his mind the whole day, and stated, I felt so upset. Resident 1 stated after the incident, he did not feel safe with Resident 2 in the next room, until Resident 2 was moved to a different room on 2/17/2024. During an interview on 3/19/2024 at 3:06 PM with Resident 2, Resident 2 stated he asked Resident 1 to come to Resident 2's room then Resident 1 sat on Resident 2's bed. Resident 2 stated he sat next to Resident 1 on the bed. Resident 2 stated he pulled out his genitals out of his pants to show Resident 1. Resident 2 stated Resident 1 said, No, what are you doing? Resident 2 stated he thought Resident 1 wanted to play with him since Resident 1 followed Resident 2 to Resident 2's room. During an interview on 3/19/2024 at 3:52 PM with the RAA, the RAA stated Resident 1 reported to her that Resident 2 pulled down his pants and asked Resident 1 for oral sex. The RAA stated Resident 1 looked visibly upset and shaken up after the incident stating Resident 1 felt uncomfortable. The RAA stated Resident 1 said that Resident 1 could not get it off his mind. and stated Resident 1 followed up with RAA at the end of the day to ask if she reported the incident. The RAA stated it was not typical behavior for Resident 1 to follow up with the RAA and stated, it really bothered Resident 1. During an interview on 3/20/2024 at 8:55 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated she saw Resident 4 hit Resident 2 on the right side of the face during medication pass. CNA 1 stated Resident 4 said Resident 2 came into his room in the night and asked him for oral sex. CNA 1 stated residents were not allowed to engage in sexual activities or have physical contact. CNA 1 stated staff encouraged residents to not go into other resident's rooms. CNA 1 stated she had never seen Resident 2 with sexually inappropriate behavior. CNA 1 stated Resident 2 would pace on and off a lot in the hallway but most of the time stayed in Resident 2's room. During an interview on 3/20/2024 at 10:39 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated staff needed to monitor the residents every 15 minutes and do a headcount. LVN 2 stated staff needed to monitor residents with inappropriate behaviors closer and ensure residents were not going into other residents' rooms and not acting inappropriately with others. LVN 2 stated if those interventions did not work, staff needed to place the resident with inappropriate behavior within the line of sight. During an interview on 3/20/2024 at 11:00 AM with the Director of Nursing (DON), the DON stated residents with inappropriate sexual behavior required closer monitoring. The DON stated in addition to the 15-minute rounds/headcount, staff will provide additional visual checks/monitoring every 30 minutes or hour. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Rounds/Headcount, undated, the P&P indicated rounds/headcount duty was where assigned staff members made visual contact of every resident at the very least every 15 minutes to insure resident's whereabouts and safety. The P&P indicated rounds/headcount was done continuously. The P&P indicated all residents shall be placed on 15-minute rounds unless resident is on 1:1 (constant observation). The P&P indicated nursing staff observed each resident at 15-minute interval. The P&P indicated rounds were continuous; the staff assigned to rounds/headcount should not be sitting nor doing any other duty. During a review of the facility's P&P titled, Hallway Monitor, undated, the P&P indicated to provide guidelines for staff regarding appropriate method to conduct hallway monitoring and to help provide a safe and secure environment for residents. The P&P indicated staff were to make rounds, observe the residents' rooms continuously and record at 10-minute intervals. The P&P indicated check room and room hallways and check bathrooms. The P&P indicated residents were to be entering their own rooms only.