

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 05/07/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for two of 12 sampled residents (Residents 1 and 3) by failing to:</p> <p>a. Protect Resident 1 from being slapped by Resident 2. On 4/21/2024, Resident 2 slapped Resident 1 on the back of Resident 1's head. This failure resulted in Resident 1 feeling afraid and not feel safe while under the care of the facility.</p> <p>b. Protect Resident 3 from being kicked by Resident 4. On 5/1/2024, Resident 4 kicked Resident 3 on Resident 3's left elbow. This failure resulted in Resident 3 to not feel safe while under the care of the facility.</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood).</p> <p>During a review of Resident 1's care plan titled, Post Trauma Response ., initiated 1/15/2024, the care plan indicated on 4/21/2024, Resident (Resident 1) was hit on the back of the head by a male peer in the patio.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/17/2024, the MDS indicated, Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was independent from staff for dressing, toileting, and personal hygiene.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Progress Notes, dated 5/7/2024, the Progress Notes indicated on 4/21/2024, A male peer (Resident 2) hit Resident 1 on her head with his hand on the patio at 1625. The Progress Notes indicated on 4/22/2024, the SW (Social Worker) received a phone message from charge nurse [NAME] on Sunday 4-21-24, on the 3-11 shift, that resident (Resident 1) was hit on her head by a male peer out on the patio for no apparent reason .</p> <p>During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizophrenia, insomnia (persistent problems falling and staying asleep) due to mental disorder, and hyperlipidemia.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 1 had no impairment in cognitive skills. The MDS indicated Resident 2 was independent from staff for dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 2's Progress Notes, dated 5/7/2024, the Progress Notes indicated on 4/21/2024, Pt (Resident 2) hit a female peer on the head with his hand on the patio at 1625 . The Progress Notes indicated on 4/23/2024, the Psychiatric Nurse Practitioner indicated Pt (Resident 2) had 2 incidents of hitting female residents on back-to-back days .</p> <p>During an interview on 5/7/2024 at 10:25 AM with Resident 1, Resident 1 stated Resident 2 hit Resident 1 when she was sitting on the bench in the patio. Resident 1 stated it was a hard hit to Resident 1's head. Resident 1 stated she doesn't feel safe because Resident 2 could hit Resident 1 again. Resident 1 stated Resident 1 stayed away from Resident 2.</p> <p>During a telephone interview on 5/7/2024 at 10:25 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 4/21/2024, Resident 2 slapped Resident 1 on the back of Resident 1's head while CNA 1 was talking to Resident 1 in the patio. CNA 1 stated Resident 1 and CNA 1 were sitting at the table across from each other. CNA 1 stated Resident 2 walked up behind Resident 1 and slapped Resident 1 in the back of her head. CNA 1 stated Resident 1 came close to CNA 1 because the slap made Resident 1 afraid of Resident 2.</p> <p>b. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including schizophrenia, anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had no impairment in cognitive skills. The MDS indicated Resident 3 was independent from staff for dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 3's Progress Notes, dated 5/7/2024, the Progress Notes indicated on 5/1/2024, Resident 3 was kicked on the left elbow x1 while Resident 3 was lying on the hallway floor. Resident 3 and another peer (Resident 4) were immediately separated. When Resident 3 was asked what had happened, he explained he did not know why Resident 4 kicked him since he did not do anything wrong.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 3's care plan titled, Post Trauma Response ., initiated 11/15/2023, the care plan indicated on 5/1/2024, Resident 3 was kicked on the left elbow while lying on hallway floor for no apparent reason.</p> <p>During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including schizophrenia, type 2 diabetes mellitus and hyperlipidemia.</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 was moderately impaired in cognitive skills. The MDS indicated Resident 4 was independent from staff for dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 4's SBAR Communication Form (SBAR), dated 5/1/2024, the SBAR indicated on 5/1/2024, Resident 4 kicked a peer on the left elbow.</p> <p>During a review of Resident 4's care plan titled, Resident to Resident Altercation, initiated 5/1/2024, the care plan indicated on 5/1/2024, Resident (Resident 4) kicked peer on elbow unprovoked.</p> <p>During a telephone interview on 5/7/2024 at 10:40 AM with CNA 2, CNA 2 stated on 1/1/2024 around 7:40 PM, CNA 2 was in the hallway by the shower room when CNA 2 saw Resident 4 kick Resident 3 on Resident 3's left elbow. CNA 2 stated Resident 3 was sitting on the hallway floor. CNA 2 stated Resident 4 walked up to Resident 3 and purposely kicked Resident 3. CNA 2 stated Resident 4 had a history of aggressive behaviors against staff and residents in the past. CNA 2 stated Resident 4 also hit CNA 2 a couple of months previously.</p> <p>During an interview on 5/7/2024 at 12:49 PM with Resident 4, Resident 4 stated he kicked a resident (did not say who the resident was). Resident 4 stated he could not explain why Resident 4 kicked the resident. When asked if the kick was an accident, Resident 4 stated No. When asked if Resident 4 meant to kick the resident, Resident 4 stated Yes.</p> <p>During a review of the facility's policy and Procedure (P&P) titled, Abuse Prevention and Prohibition Program, dated 10/1/2023, the P&P indicated, Each resident has the right to be free from abuse, neglect, mistreatment, and/or misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p>		