

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  06/04/2024
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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49900</p> <p>Based on interview and record review, the facility failed to protect residents' rights to be free from emotional abuse (non-physical behaviors that were meant to control, isolate, or frighten) and physical abuse (any intentional act causing injury or trauma to another person) for three of seven sampled residents (Residents 3, 4 and 7) when:</p> <p>a. Resident 3 punched Resident 4 in the face on 5/29/2024 in the patio. Resident 4 punched Resident 3 in the mouth on 5/29/2024 in the patio. This deficient practice resulted in Resident 3 and Resident 4 being subjected to emotional and physical abuse. Resident 4 became upset and punched Resident 3 on the mouth. Resident 3 sustained superficial cut (cuts that do not involve fat or muscle tissue and not bleeding heavily) measured approximately 0.5 centimeter (cm-unit of measurement) to right lower lip with slight bleeding.</p> <p>b. Resident 8 punched Resident 7 in the face on 6/3/2024 and Resident 8's care plan was not updated and/or revised after hitting another resident on 3/1/2024, 3/23/2024, 4/8/2024, 4/29/2024, and 6/3/2024. These failures had the potential for Resident 8 to hit other residents.</p> <p>Findings:</p> <p>a. During an interview on 6/3/2024 at 9:22 AM with Resident 3, in the activity room, Resident 3 stated Resident 4 called him (Resident 3) a name (to address a person with a name that is intended to be offensive) while they (Resident 3 and Resident 4) were at the patio (unable to recall date). Resident 3 stated in consequence, he messed (to deal with someone in a way that may cause anger or violence) with Resident 4. Resident 3 stated he tried to punch Resident 4, then Resident 4 punched him on the mouth, and he (Resident 3) sustained a cut on his right lower lip.</p> <p>During an interview on 6/3/2024 at 3:08 PM, Registered Nurse (RN 1) stated on 5/29/2024, he was in the patio and saw Resident 4 asking Resident 3 for chips. RN 1 stated Resident 3 refused to give away chips and told Resident 4 to leave him (Resident 3) alone. RN 1 stated he saw both residents (Resident 3 and Resident 4) walked away from each other. RN 1 stated he (RN 1) turned his back and went to the restroom, then when he returned, he heard a chant, Fight, fight, fight from the patio. RN 1 stated the residents (Resident 3 and Resident 4) were separated when he (RN 1) arrived in the patio.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the interview on 6/3/2024 at 3:08 PM, RN 1 stated he saw Resident 3 and Resident 4 in the patio with both arms up in the air (indicated to stop an activity or effort and admit that one cannot do anything to make a situation better). RN 1 stated he saw blood coming from Resident 3's lip, and RN 1 provided Neosporin (a first aid antibiotic to prevent infections caused by bacteria in minor cuts, scrapes, or burns on the skin) to Resident 3's right lower lip. RN 1 stated there was no other staff present in the patio when Resident 3 and 4 started fighting.</p> <p>During a concurrent interview and video review on 6/3/2024 at 3:30 PM with the Administrator (ADM), a video recording taken at the patio on 5/29/2024 at 5:02 PM was reviewed. The ADM stated the residents fighting on the video were Resident 3 and Resident 4. The video showed Resident 4 approached Resident 3 then Resident 3 hit Resident 4 on the face. Resident 4 punched Resident 3 in the mouth. No staff was seen in the video footage when Resident 3 and Resident 4 started fighting. The video showed RN 1 ran to Resident 3 and Resident 4 after Resident 3 and Resident 4 were separated.</p> <p>During the interview on 6/3/2024 at 3:30 PM, the ADM stated on 5/29/2024, he heard a scream, Fight coming from the courtyard (patio). The ADM stated he ran to the courtyard (patio) and witnessed RN 1 separating Resident 3 and Resident 4. The ADM stated RN 1 informed him that Resident 4 asked Resident 3 for chips, and he (Resident 4) stepped back and started being verbally aggressive towards Resident 3. The ADM stated Resident 3 had a cut and blood in the lip after Resident 3 and Resident 4 had physical fight.</p> <p>A review of Resident 3's Admission Record, indicated the facility admitted Resident 3 to the facility on [DATE], with diagnoses including anxiety (feelings of fear, dread, and uneasiness that might occur as a reaction to stress), insomnia (trouble falling or staying asleep), major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves).</p> <p>A review of Resident 3's Practitioner (any individual licensed to practice medicine) Progress Note (a written record that captures the details of a patient's health status, treatment progress, and any changes in their condition over time), dated 8/4/2023, indicated Resident 3 was alert and oriented (person's level of awareness) to person.</p> <p>A review of Resident 3's care plan for post trauma response (the state of an individual experiencing a sustained painful response to an overwhelming traumatic event), date initiated 11/15/2023 indicated Resident 3's care plan goal included Resident 3 will recognize and verbalized increased feelings of safety and will seek out support from staff members.</p> <p>A review of Resident 3's Minimum Data Set ([MDS]- a standardized resident assessment and care screening tool), dated 4/12/2024, indicated Resident 3's cognitive (the ability to think and process information) skills for daily decisions making was intact. The MDS indicated Resident 3 had serious mental illness (health conditions involving changes in emotion, thinking or behavior) and had put others at significant (serious) risk of physical injury. The MDS indicated Resident 3 had no impairment on all extremities, was independent with mobility, and does not require assistance from a helper in walking.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 3's progress note, dated 5/29/2024 at 6:31 PM, indicated Resident 10 reported to RN 1 that Resident 4 punched Resident 3 in the mouth at the patio around 5 PM (on 5/29/2024). The progress note indicated Resident 3 got up from his seat and fought Resident 4 because Resident 4 was talking trash (to talk in an insulting way) to Resident 3. The progress note indicated Resident 3 sustained superficial cut to right lower lip with slight bleeding.</p> <p>A review of Resident 3's Skin Observation Checks, dated 5/29/2024 at 8:06 P.M., indicated Resident 3 had right lower lip superficial laceration (cut) approximately 0.5 centimeter (cm-unit of measurement) with no active bleeding.</p> <p>A review of Resident 3's Order Summary Report, dated 6/3/2024 indicated the following active orders:</p> <ul style="list-style-type: none"> <li>- Assaultive (violent physical actions which were likely to cause immediate physical harm or danger to an individual or others) precautions for Resident 3, ordered on 4/4/2023.</li> <li>- Suicidal precautions (placing the client in the least restrictive, safe, and monitored environment that allowed for the necessary level of observation) for Resident 3, ordered on 4/4/2023.</li> <li>- Behavioral monitoring (a proactive approach used to detect threats by establishing a system behavior baseline and checking for abnormalities) for episodes of aggressive behaviors for Resident 3, ordered on 3/13/2024.</li> <li>- Apply Neosporin to Resident 3's right lower lip topically (applied directly to the skin) one time a day for five (5) days, ordered on 5/29/2024.</li> </ul> <p>A review of Resident 4's Admission Record, indicated the facility admitted Resident 4 to the facility on [DATE], with diagnoses including anxiety, insomnia, and stimulant (a drug that increases bodily activity) abuse.</p> <p>A review of Resident 4's physician order, date ordered 3/20/2024, indicated an order for behavioral monitoring for aggressive behaviors.</p> <p>A review of Resident 4's MDS, dated [DATE], indicated Resident 4's cognitive skills for daily decisions making was intact. The MDS indicated Resident 4 had a serious mental illness. The MDS indicated Resident 4 had no impairment on all extremities, was independent with mobility and does not require assistance from a helper in walking.</p> <p>A review of Resident 4's Practitioner Progress Note, dated 4/14/2024, indicated Resident 4 was alert and oriented (person's level of awareness) to person.</p> <p>A review of Resident 4's progress note, dated 5/26/2024 at 7:19 PM, indicated Resident 4 was gesturing with his (Resident 4) fists towards a peer (unidentified) at the patio.</p> <p>A review of Resident 4's progress note, dated 5/28/2024, indicated Resident 4 has been provoking peers (unidentified) and being a bully (a person who habitually seeks to harm or intimidate those whom they perceive as vulnerable) with other residents.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 4's progress note, dated 5/29/2024 at 2:16 PM, indicated Resident 4 had been trying to annoy (irritate, disturb, or bother) and provoke (to anger, enrage, exasperate) other (unidentified) residents.</p> <p>A review of Resident 4's progress note, dated 5/29/2024 at 5:45 PM, indicated Resident 4 was talking Crap (nonsense or lie) to Resident 3 in the patio around 5 PM, and Resident 3 got up from his chair to fight Resident 4. The progress note indicated Resident 4 punched Resident 3 on his (Resident 3) mouth at the patio.</p> <p>A review of Resident 4's Social Service progress note, dated 5/30/2024 at 1:52 PM, indicated Resident 4 informed Social Service (SS) 1 that Resident 3 tried to hit him (Resident 4) first.</p> <p>A review of Resident 4's care plan, titled Resident to Resident Altercation, created on 5/29/2024, indicated an intervention for staffs to intervene as needed to protect the rights and safety of others.</p> <p>A review of Resident 4's progress note, dated 6/2/2024 at 3:58 PM, indicated Resident 4 had been threatening peers on the patio.</p> <p>A review of facility's policy and procedure (P&amp;P) titled Abuse Prevention and Prohibition Program, revised on 10/1/2023, indicated each resident has the right to be free from abuse. The facility has zero-tolerance (a policy of not allowing any violations of a rule or law) for abuse. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse. The P&amp;P indicated signs and symptoms of physical abuse included abrasions or lacerations.</p> <p>34273</p> <p>b. During a review of Resident 7's Admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others) and depression (persistent feelings of sadness and loss of interest).</p> <p>During a review of Resident 7's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/15/2024, the MDS indicated Resident 7's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and Resident 7 walked independently with steady gait. The MDS indicated Resident 7 was independent with oral hygiene, toileting hygiene, personal hygiene, and with upper and lower body dressing.</p> <p>During a review of Resident 7's Change in Condition Evaluation (CICE), dated 6/3/2024, the CIC indicated a Certified Nursing Assistant (CNA) reported to the charge nurse Resident 7 was punched in the face and Resident 7 had a nose bleed (blood vessels in the lining of the nose bursts). The CIC did not indicate who hit Resident 7.</p> <p>During a review of Resident 7's untitled care plan dated 6/3/2024, the care plan indicated Resident 7 was punched in the face by a male peer.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems).</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 had some difficulty with decision making in new situations only and walked independently with steady gait. The MDS indicated Resident 8 was independent with oral hygiene, toileting hygiene, personal hygiene, and with upper and lower body dressing.</p> <p>During a review of Resident 8's CICE, dated 6/3/2024, the CICE indicated a CNA reported to the charge nurse Resident 8 punched a male peer in the face.</p> <p>During a review of Resident 8's untitled care plan initiated on 11/13/2023, the care plan indicated Resident 8 was yelling in the patio, defiant towards staff, name calling, disruptive in the hallway and non-redirectable on 3/2/2024. The care indicated Resident 8 demanded breakfast, yelling and shouting in a fighting stance on 3/9/2024. The care indicated Resident 8 attempted to spit at male peer on 3/16/2024. The care plan indicated Resident 8 attempted to punch male peer behind the head on 3/27/2024. The care plan indicated Resident 8 hit staff member on the nose on 4/17/2024. The care plan indicated Resident 8 spit on a staff on 5/2/2024. The care plan indicated Resident 8 hit a resident in the face on 6/3/2024. The care plan interventions initiated on 11/13/2023 included to Assist the client in examining alternatives to acting out behavior, discuss and speak with patient the effectiveness and side effects of medications twice a week and encourage participation in community and coping skills groups twice a week. The care plan interventions also included the use of PRN (as needed) medications if he client's level of agitation is high, assess the client's behavior that indicates agitation is increasing and encourage verbalization of feelings rather than acting out and for staff to maintain a calm, nonthreatening manner for the Resident 8. The care plan was not revised and/or updated after Resident 8's behaviors on 3/2/2024, 3/9/2024, 3/16/2024, 3/27/2024, 4/17/2024, 5/2/2024, and 6/3/2024.</p> <p>During a review of Resident 8's untitled care plan initiated on 2/23/2024, the care plan indicated Resident 8 hit a male peer on the back of the neck on 2/23/2024. The care plan indicated Resident 8 hit a male peer on the right ear on 3/1/2024. The care plan indicated Resident 8 slapped a male peer on the face on 3/23/2024. The care plan indicated Resident 8 hit a male peer on the head on 4/8/2024. The care plan indicated Resident 8 slapped a male peer on the right side of the head on 4/11/2024. The care plan indicated Resident 8 hit a peer on the back of the head on 4/29/2024. The care plan indicated Resident 8 punched a peer in the face on 6/3/2024. The care plan interventions initiated on 2/23/2024 included to Administer and monitor the effectiveness of medications, evaluate for side effects of medications and intervene as needed to protect the rights and safety of others. The care plan interventions also included to approach in a calm manner, divert attention, remove from situation, and take to another location. The care plan interventions also included to monitor and modify environment for external contributors to behavior, monitor/document/report to the MD (medical doctor) of danger to self and others and Psychiatrist/psychologist consult as indicated. The care plan intervention initiated on 4/11/2024 included for the resident to check in with Activity Coordinator for activities inside the room and with Mental Health Worker for groups in the patio. The care plan was not revised and/or updated after Resident 7 hit another resident on 3/1/2024, 3/23/2024, 4/8/2024, 4/29/2024, and 6/3/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/4/2024 at 11:58 am with Resident 7, Resident 7 stated Resident 7 had seen Resident 8 fought with other residents and staff before.</p> <p>During an interview on 6/4/2024 at 12:15 pm with the Director of Staff Development (DSD), the DSD stated on 6/3/2024, CNA 5 reported Resident 8 hit Resident 7 in the face. The DSD stated Resident 7 had a nose bleed after Resident 8 hit Resident 7. The DSD stated Resident 7 was calm and did not get into fights with other residents. The DSD stated Resident 8 was unpredictable and would all of a sudden hit (other) people.</p> <p>During an interview on 6/4/2024 at 12:32 pm with Mental Health Worker 1 (MHW 1), MHW 1 stated Resident 7 was calm. MHW 1 stated Resident 7 has not had any arguments or fights with other residents or staff before. MHW 1 stated Resident 8 was unpredictable. Resident 8 could suddenly change from a good mood to being agitated, mad, and throwing punches. MHW 1 stated Resident 8 had been involved in multiple fights and arguments with other residents and staff.</p> <p>During an interview of 6/4/2024 at 12:43 pm with Social Worker 1 (SW 1), SW 1 stated Resident 8 was impulsive, and Resident 8's behavior made it challenging to find placement for Resident 8.</p> <p>During an interview on 6/4/2024 at 12:58 pm with CNA 5, CNA 5 stated he was doing a head count on 6/3/2024 and walked towards the patio door where Resident 8 was standing. Resident 7 was walking out to the patio to get coffee, and when Resident 7 passed Resident 8, Resident 8 turned around and hit Resident 7 in the face. CNA 5 stated Resident 7 sustained a nose bleed. CNA 5 stated Resident 8 fought with residents and staff all the time.</p> <p>During a concurrent interview and record review on 6/4/2024 at 1:55 pm with the Director of Nursing (DON), the DON reviewed Resident 8's care plans. The DON stated every time Resident 8 was involved in an altercation, Resident 8's care plan needed to be revised. The DON stated care plans needed to be revised for any change in condition (CIC). The DON stated any altercation and/or behavior was considered a CIC. The DON stated it was important to determine a specific and individualized plan of care appropriate for the resident.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled Abuse Prevention and Prohibition Program, dated 10/1/2023, the P&amp;P indicated, Each resident has the right to be free from abuse . The Facility has zero-tolerance for abuse .The Facility promptly and thoroughly investigates reports of resident abuse . The Facility will reassess the resident following the investigation to determine if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences have changed as a result of the incident and initiate or update the care plan .</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48905</p> <p>Based on interview and record review, the facility failed to follow its Policy and Procedure (P&amp;P) on Abuse Reporting and report an alleged physical abuse for one of nine sampled residents (Resident 5) to the California Department of Public Health (CDPH). Resident 9 hit Resident 5 on the left side of Resident 5's face on 5/21/2024.</p> <p>This failure had the potential for Resident 5 to be exposed to further abuse from Resident 9.</p> <p>Findings:</p> <p>During a review of Resident 9's Admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (serious mental disorder in which people interpret reality abnormally) and tobacco use.</p> <p>During a review of Resident 9's untitled care plan (CP), dated 2/28/2024, the CP indicated for staff to intervene as needed to protect the rights and safety of others and to remove the resident from the situation and take to another location.</p> <p>During a review of Resident 9's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 5/3/2024, the MDS indicated Resident 9's cognitive abilities (ability to think, learn, and process information) were intact.</p> <p>During a review of Resident 9's Nursing Notes (NN) dated 5/21/2024 at 10:42 PM, the NN indicated on 5/21/24 at around 6:00 PM Resident 9, hit another resident (unidentified) on the right shoulder.</p> <p>During an interview on 6/3/2024 at 10:02 AM with Resident 5, Resident 5 stated Resident 9 hit Resident 5 on the left side of the face a couple of weeks ago at around 6:00 PM to 7:00 PM. Resident 5 stated Resident 9 hit Resident 5 in the hallway when Resident 5 was coming out of Resident 5's room. Resident 5 stated Resident 5 reported the incident to the charge nurse. Resident 5 stated Resident 5 stated Resident 5 was concerned that Resident 5 would get into another altercation with Resident 9 because both residents share the same bathroom.</p> <p>During an interview on 6/3/2024 at 12:32 PM with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated CNA 3 was made aware of Resident 9 hitting Resident 5 two weeks ago. CNA 3 stated CNA 3 was unsure if the incident was reported to CDPH, Police, or Ombudsman.</p> <p>During an interview on 6/3/2024 at 2:57 PM with Resident 9, Resident 9 stated Resident 9 hit Resident 5 on the left side of Resident 5's face in the hallway two weeks ago at around 6:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/3/2024 at 3:09 PM with the RN Sup 1, RN Sup 1 stated Resident 5 and Resident 9's rooms are connected by a restroom. RN Sup 2 stated Resident 9 was in the hallway when the incident occurred. RN Sup 2 stated RN Sup 1 did not witness the alleged physical abuse. RN Sup 1 stated RN Sup 1 did not report the incident to the Administrator because RN Sup 1 did not see any physical injuries on Resident 5 or Resident 9. RN Sup 1 stated RN Sup 1 considered the incident as alleged physical abuse because Resident 5 said Resident 9 hit Resident 5. RN Sup 1 stated the risk of not reporting alleged abuse is that the incident would happen again, especially since both residents share the same bathroom.</p> <p>During an interview on 6/3/2024 at 4:05 PM with the Director of Nursing (DON), the DON stated the incident between Resident 5 and Resident 9 on 5/21/2024 was not reported to the DON nor the ADM. The DON stated the risk of not reporting alleged physical abuse was that it could happen again.</p> <p>During a review of the facility's P&amp;P titled Abuse Prevention and Prohibition Program dated 10/1/2023, the P&amp;P indicated the facility staff are mandated reporters and indicated staff are 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 dependent adults. The P&amp;P indicated facility staff will report known or suspected instances of abuse to the ADM.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48905</p> <p>Based on interview and record review, the facility failed to notify the Medical Doctor (MD) of a physical altercation on 5/24/2024 for two of nine sampled residents (Residents 5 and 6). Resident 6 punch Resident 5 in the left eye and forehead.</p> <p>This failure had the potential to result in serious injury to the residents.</p> <p>Findings:</p> <p>During a review of Resident 5's Admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (mental disorder that is characterized by abnormal thought processes and an unstable mood) and insomnia (inability to sleep).</p> <p>During a review of Resident 5's History and Physical (H&amp;P, formal document of a medical provider's examination of a patient) dated 11/29/2023 at 12:44 PM, the H&amp;P indicated Resident 5 was alert and oriented to name, place, date of birth, and situation.</p> <p>During a review of Resident 5's untitled care plan (CP), dated 5/24/2024, the CP indicated Resident 5 was pushed on the forehead with two hands by a male resident. The CP indicated for staff to assess the resident for the need of medical attention.</p> <p>During a review of Resident 5's Nursing Note (NN) dated 5/24/2024 at 8:07 PM, the NN indicated Resident 5 was pushed on the forehead with two hands by a male resident in the hallway by the nursing station. The NN indicated Resident 5 complained of a headache, five out of 10 pain level. (0= no pain, 10=worst pain). The NN indicated the incident was reported to the Administrator (ADM), the Director of Nursing (DON) and facility's Social Worker (SW).</p> <p>During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (serious mental disorder in which people interpret reality abnormally) and insomnia.</p> <p>During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 4/12/2024, the MDS indicated Resident 6's cognitive abilities (ability to think, learn, and process information) were intact.</p> <p>During a review of Resident 6's NN dated 5/24/2024 at 7:40 PM, the NN indicated Resident 6 pushed a female resident on the forehead in the hallway by the nursing station. The NN indicated the incident was reported to the ADM, DON, conservator, and facility's SW.</p> <p>During an interview on 6/3/2024 at 10:03 AM with Resident 5, Resident 5 stated a resident (Resident 6) bopped (blow with a fist) Resident 5 on the right eye and forehead on 5/24/2024 for no reason. Resident 5 stated the facility did not do an x-ray when Resident 6 hit Resident 5 on the forehead.</p> <p>(continued on next page)</p>		

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  06/04/2024
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.

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/3/2024 at 3:33 PM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated CNA 2 saw Resident 6 punch Resident 5 in the left eye and reported the incident to the Registered Nurse Supervisor (RN Sup 1).</p> <p>During an interview on 6/3/2024 at 4:05 PM with the DON, the DON stated the Medical Doctor (MD) was not notified of the physical altercation between Residents 5 and 6 and a change of condition (COC) was not completed for Resident's 5 and 6 on 5/24/2024. The DON stated the risks of not notifying the MD of the physical altercation was not receiving any orders to monitor the residents' condition (such as neurological checks or x-rays).</p> <p>During a review of the facility's undated Policy and Procedure (P&amp;P) titled, Change of Condition Notification, the P&amp;P indicated residents, family, legal representatives, and physicians are informed of changes in residents' condition in a timely manner. The P&amp;P indicated the licensed nurse will document the following but not limited to: i. The time the Attending physician was contacted, method which the MD was contacted, the response time, and whether or not orders were received.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48905</p> <p>Based on interview and record review, the facility failed to ensure residents were supervised and monitored in accordance with Medical Doctor's (MD) order for one of nine sampled residents (Resident 6) by failing to:</p> <ol style="list-style-type: none"> <li>1. Monitor Resident 6's behavior on 5/10/2024, 5/13/2024, and 5/27/2024 when Resident 6 was receiving Depakote (medication used to stabilize mood) for behavior problems of auditory hallucinations (hearing noises or voices that do not exist in reality).</li> <li>2. Provide one-to-one monitoring (continuous observation to protect a resident from harm) for Resident 6 for on 6/3/2024.</li> </ol> <p>These failures had the potential to result in serious injury to Resident 6 and/or others.</p> <p>Cross reference F684</p> <p>Findings:</p> <p>During a review of Resident 6's Admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (mental disorder that is characterized by abnormal thought processes and an unstable mood) and insomnia (inability to sleep).</p> <p>During a review of Resident 6's untitled care plan (CP), dated 3/18/2024, the CP indicated for staff to administer and monitor the effectiveness of medications per MD order.</p> <p>During a review of Resident 6's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 4/12/2024, the MDS indicated Resident 6's cognitive abilities (ability to think, learn, and process information) were intact.</p> <p>During a review of Resident 6's Order Summary Report (OSR) dated 6/3/2024, the OSR indicated Resident 6 had an MD order for staff to monitor Resident 6 for auditory hallucinations, every shift.</p> <p>During a review of Resident 6's Nursing Note (NN) indicated:</p> <ol style="list-style-type: none"> <li>a. On 5/24/2024 at 7:40 PM, the NN indicated Resident 6 pushed a female resident on the forehead in the hallway by the nursing station.</li> <li>b. On 5/31/2024 at 7:49 PM, the NN indicated Resident 6 punched Resident 5 in the face.</li> <li>c. On 5/31/2024 at 10:54 PM, the NN indicated new orders were received to place Resident 6 on one-to-one monitoring for three days.</li> </ol> <p>(continued on next page)</p>		

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  06/04/2024
NAME OF PROVIDER OR SUPPLIER  Penn Mar Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3938 Cogswell Road El Monte, CA 91732	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/3/2024 at 9:43 AM with Resident 6, Resident 6 stated Resident 6 was hearing voices telling Resident 6 to push Resident 5 on the forehead in the hallway on 5/24/2024. Resident 6 stated Resident 6 was hearing voices on 5/31/2024 telling Resident 6 to hurt people and hit Resident 5 on the left side of Resident 5's neck. Resident 6 stated Resident 6 reported hearing voices to staff on multiple occasions.</p> <p>During an interview on 6/3/2024 at 11:01 AM with the Registered Nurse Supervisor 2 (RN Sup 2), RN Sup 2 stated RN Sup 2 notified the MD of the physical altercation on 5/31/2024 between Residents 5 and 6 and stated RN Sup 2 received orders from MD to place Resident 6 on one-to-one monitoring for three days.</p> <p>During an observation and interview on 6/3/2024 at 2:25 PM with the Director of Nursing (DON) in the hallway, Resident 6 was observed in a room with no staff member present. The DON stated Resident 6 had orders for one-to-one monitoring for 72 hours. The DON stated there were no staff members present to monitor Resident 6. The DON stated the purpose of one-to-one monitoring was to continuously monitor the resident because of aggressive behavior towards others. The DON stated the risk of not monitoring the resident based on the MD order was that the resident would hit another resident because staff was not monitoring the resident.</p> <p>During an interview on 6/3/2024 at 3:33 PM with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated CNA 2 witnessed Resident 6 hit Resident 5 on 5/24/2024. CNA 2 stated CNA 2 saw Resident 6 and Resident 5 walking in the hallway and Resident 6 punched Resident 5 in the left eye. CNA 2 stated Resident 6 reported hearing voices telling Resident 6 to hurt people. CNA 2 stated on 5/31/2024, CNA 2 saw Resident 6 punch Resident 5 on the right side of the face in the hallway. CNA 2 stated Resident 6 reported hearing voices but was unsure of what the voices were saying. CNA 2 stated Resident 6 reported hearing voices every day. CNA 2 stated Resident 6 was unpredictable and would need one to one monitoring because of the behavior of hearing voices to hurt others.</p> <p>During an interview and record review on 6/3/2024 at 4:05 PM with the DON, Resident 6's Treatment Administration Record (TAR) dated 5/2025 was reviewed. The TAR indicated monitoring/assessment for Resident 6 on 5/10/2024 (3-11pm shift), 5/13/2024 (11pm-7am shift), and 5/27/2024(11pm-7am shift) were not completed. The TAR indicated zero episodes of auditory hallucination on 5/24/2024 and 5/27/2024. The DON stated the blank spaces on the TAR indicated the assessment was not completed. The DON stated Resident 6's behavior for auditory hallucinations was not monitored on those days (5/10/2024, 5/13/2024, and 5/27/2024). The DON stated the risk of not monitoring Resident 6's behavior was that the resident could develop more altercations with other residents and to assess if medications needed to be adjusted accordingly.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Psychotherapeutic Drug Management, dated 10/1/2023, the P&amp;P indicated that the facility will use nonpharmacological (therapies that do not involve medications) interventions when indicated, and staff to monitor psychotropic (medications that affect the mind or mental processes) drug use daily.</p>		