

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 08/28/2024
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** 38108</p> <p>Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm) for four of seven sampled residents (Residents 2, 3, 6 and 7) as indicated in the facility's policy and procedure on Abuse Prevention and Prohibition Program, when:</p> <p>a. Resident 1 kicked and hit Resident 2 on the face and arms on 8/12/2024 at 11:15 pm and a few minutes later (undetermined time) hit Resident 2 again. Resident 2 sustained abrasion (scraping of skin) of the bridge of the nose, right side of jawline and right side of the neck and discoloration of Resident 2's right knuckle.</p> <p>b. Resident 1 stabbed Resident 3 with a broken plastic plate on 8/13/2024 at 7:20 am. Resident 3 sustained one wound to the left forearm (front of arm) measuring 1.8 centimeters (cm, a unit of measurement) in length, 0.5 cm in width and 0.2 cm in depth, one wound on the scalp measuring 9.6 cm in length, 5.9 cm in width and 0.2 cm in depth, one wound on the left posterior (back) neck wound measuring 8.0 cm in length, 3.1 cm in width and 0.2 cm in depth and one wound on the right forearm measuring 0.1 cm in length, 0.1 cm in width and 0.1 cm in depth. Resident 1 sustained a cut on Resident 1's right thumb and left palm. Resident 1 was sent to General Acute Care Hospital 1 (GACH 1) for suturing of the right thumb.</p> <p>c. Resident 5 hit Resident 7 on the right side of Resident 7's face on 8/22/2024 and punched Resident 6 on the head and face on 8/18/2024.</p> <p>These deficient practices resulted in Residents 2, 3, 6 and 7 subjected to physical abuse 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 the facility admitted Resident 1 on 7/16/2024 with diagnoses that included psychosis (severe mental disorder in which thought, and emotions were so impaired that contact was lost with external reality).</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 Minimum Data Set (MDS, a resident assessment and care-screening tool) dated 6/29/2024, the MDS indicated Resident 1 was cognitively intact (ability to make daily decisions) and was independent (no help or staff oversight at any time) for transfers, dressing, and toilet use.</p> <p>During review of Resident 1's Change in Condition (COC- when there is a sudden change in a resident's health) Evaluation Form, dated 8/13/2024 at 12:28 am, the COC Evaluation Form indicated Resident 1 had physical aggression (behavior causing or threatening physical harm towards others) with Resident 2. The COC Evaluation Form indicated Resident 1 physically assaulted (involving physical force or injury) Resident 2 by kicking and hitting on Resident 2's face and arms.</p> <p>During a review of Resident 1's Progress Notes (PN) dated 8/13/2024 at 12:10 am, the PN indicated on 8/12/2024 at around 11:15 pm, Resident 1 went into Resident 2's room and began kicking and hitting Resident 2 on the face and arms. A few minutes later (specific time not documented), Resident 1 hit Resident 2 again.</p> <p>During a review of Resident 2's AR, the AR indicated the facility admitted Resident 2 on 3/20/2024 with diagnoses that included anxiety (a feeling of worry, nervousness, or unease) and insomnia (inability to sleep).</p> <p>During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was cognitively intact and was independent (no help or staff oversight at any time) for transfers, dressing, and toilet use.</p> <p>During a review of Resident 2's COC Evaluation Form dated 8/13/2024 timed at 12:00 am, the COC Evaluation Form indicated on 8/12/2024 (untimed) Resident 2 was physically assaulted by Resident 1, hitting Resident 2 on the face and arms. The COC Evaluation Form indicated Resident 2 sustained abrasion of the bridge of the nose, abrasion of the right side of jawline and abrasion on the right side of the neck and discoloration of the right knuckle.</p> <p>During a review of Resident 2's Physician Order (PO) dated 8/13/2024, untimed, the PO indicated an order for an X-ray (image of the inside of the body) of Resident 2's skull due to being punched by Resident 1. The PO indicated for licensed staff to perform Neurochecks (mental status evaluation) to Resident 2 every four hours for two days after being punched by Resident 1.</p> <p>During a concurrent observation and interview with Resident 2 in the facility conference room, on 8/27/2024 at 3:12 pm, Resident 2 stated Resident 1 and Resident 2 had two altercations/fights. Resident 2 stated during the first fight, staff (unidentified) was present and yelled Stop! Stop! to Resident 1 but staff did not physically intervene the fight. Resident 2 stated, Resident 1 and Resident 2 got tired and ended the physical fight. Resident 2 stated the second fight was minutes after the first fight. Resident 2 stated Resident 2 was in front of the nurse station and Resident 1 came and started hitting Resident 2 again.</p> <p>During an interview on 8/28/2024 at 11:58 am with Resident 4 who was alert and oriented, Resident 4 stated on 8/13/2024 at night (unknown time) Resident 4 witnessed Resident 1 and Resident 2 fighting. Resident 4 stated The staff did not help. They (staff) were all around surrounding the fight like a circle. Nobody jumped in.</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 an interview on 8/28/2024 at 1:08 p.m., with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated on 8/13/2024 (unable to recall specific time) LVN 2 was in the nursing station and heard a commotion in the main hallway. LVN 2 stated LVN 2 saw Resident 1 and Resident 2 punching and scratching each other's arms and head. LVN 2 stated LVN 2 attempted to separate Resident 1 and Resident 2 but according to LVN 2 we can't stop them (Residents 1 and 2) because they were big men. All we (staff) can do was to yell stop to Residents 1 and 2. LVN 2 stated Resident 1 did not listen to anyone, and Resident 1 did what Resident 1 wanted. LVN 2 stated after the first fight, LVN 2 told Resident 1 to go to the unlocked seclusion (private) room but Resident 1 did not listen and walked down the hallway. LVN 2 stated LVN 2 asked a Certified Nursing Assistant (unidentified CNA) to place Resident 1 in the unlocked seclusion room but Resident 1 did not comply. LVN 2 stated there were CNAs in the hallway, but LVN 2 did not tell a CNA to stay with and monitor Resident 1. LVN 2 stated, 10 to 15 minutes after the first fight, LVN 2 witnessed Resident 1 hitting Resident 2 again in front of the nursing station. LVN 2 stated staff tried to stop Resident 1 from hitting Resident 2 yelling stop at Resident 1, but staff cannot stop Resident 1 from hitting Resident 2. LVN 2 stated staff were unable to physically stop Residents 1 and 2 from fighting.</p> <p>During a review of the facility's video recording with the facility's Administrator (ADM) on 8/28/2024 at 2:42 pm, the ADM stated the video was taken on 8/12/2024 of the facility's hallway at 11:12 pm. ADM identified Resident 1 and Resident 2 and stated Resident 1 punched Resident 2 multiple times causing Resident 2 to fall to the floor. The video recording indicated staff did not attempt to physically stop the fight between Residents 1 and 2. The video recording ended with Resident 1 walking towards the front of the facility, unescorted. The ADM stated there was no video surveillance of the second fight between Residents 1 and 2.</p> <p>During an interview with the Assistant Director of Nursing (ADON) on 8/28/2024 at 3:46 p.m., the ADON stated when two residents were in a physical altercation/fight, staff needed to attempt to physically separate the residents for the residents' safety. The ADON stated LVN 2 should have escorted Resident 1 to the unlocked seclusion room or place the resident on 1 to 1 monitoring (direct observation by staff) to prevent the second attack on Resident 2.</p> <p>b. During a review of Resident 3's AR, the AR indicated the facility admitted Resident 3 on 5/4/2023 with diagnoses that included bipolar disorder (mental disorder with periods of depression and periods of elevated mood), schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems), anxiety and insomnia.</p> <p>During a review of Resident 3's History and Physical dated 7/18/2024, the H&P indicated Resident 3 lacked decision-making capacity.</p> <p>During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 was cognitively intact and was independent with oral and toileting hygiene, dressing and transfers.</p> <p>During a review of Resident 3's COC Evaluation Form dated 8/13/24 at 7:20 am, the COC Evaluation Form indicated Resident 1 broke Resident 1's plastic plate while having breakfast and tried to stab resident Resident 3 with a piece of the plastic plate that had broken.</p> <p>During a review of Resident 3's PAS Wound Care (PASWC) Progress Note, dated 8/15/2024, the PASWC indicated Resident 3 sustained the following four wounds from the physical altercation/fight on 8/13/2024:</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>	<ol style="list-style-type: none"> 1. Left forearm wound measuring 1.8 cm in length, 0.5 cm in width and 0.2 cm in depth. 2. Scalp wound measuring 9.6 cm in length, 5.9 cm in width and 0.2 cm in depth. 3. Left posterior neck wound measuring 8.0 cm in length, 3.1 cm in width and 0.2 cm in depth. 4. Right forearm wound measuring 0.1 cm in length, 0.1 cm in width and 0.1 cm in depth. <p>During a review of Resident 3's PO dated 8/14/2024, the PO indicated for licensed staff to cleanse the cuts on Resident 3's forehead, left forearm and behind the right and left ears with Normal Saline Solution (NSS - a wound cleansing solution), pat dry (the wound), and leave the area open to air daily for 14 days.</p> <p>During a review of Resident 1's COC Evaluation Form dated 8/13/2024, timed at 7:20 am, the COC Evaluation Form indicated Resident 1 broke a plastic plate and attacked and tried to stab Resident 3 with it the broken plastic plate.</p> <p>During a review of Resident 1's PN dated 8/13/2024 at 7:20 am, the PN indicated, while in the dining room, Resident 1 broke Resident 1's plastic plate and grabbed a piece of the broken plastic plate and attempted to stab Resident 3 with the piece of the broken plastic plate. Resident 3 sustained a cut on the forehead, behind the ears and non the left arm. Resident 1 cut his Resident 1's right thumb and left palm. The PN indicated Resident 1 was transferred to GACH 1 for suturing of the right thumb.</p> <p>During a concurrent observation and interview in the facility conference room with Resident 3 on 8/27/2024 at 2:41 pm, Resident 3 stated on 8/13/2024, while eating breakfast in the dining room, Resident 1 attacked Resident 3. Resident 3 stated Resident 1 was on Resident 3's right side. Resident 3 stated Resident 3 was eating food and Resident 1 suddenly punched Resident 3 in the head, in the nose and in the ears, causing bleeding (unspecified amount).</p> <p>During an interview on 8/28/2024 at 1:08 pm with LVN 2, LVN 2 stated on 8/13/2024 during breakfast (unable to recall specific time) in the dining room, Resident 1 broke Resident 1's plastic plate and attacked/stabbed Resident 2 with a piece of the broken plastic plate. LVN 2 stated Resident 3 was bleeding but unable to remember where the bleeding came from. LVN 2 stated after hitting Resident 3, Resident 1 stated Resident 1 wanted to hurt Resident 3 because Resident 3 was helping Resident 2 during the fight between Resident 1 and Resident 2 on 8/12/2024.</p> <p>During a review of the facility's video recording with the ADM on 8/28/2024 at 2:42 pm, Resident 1 was observed on 8/13/2024 sitting in the dining room in one table and Resident 3 was sitting in another table next to Resident 1. The video recording indicated Resident 1 broke Resident 1's plastic plate by stepping on the plastic plate into pieces. Resident 1 picked up a piece of the broken plastic plate and walked towards Resident 3. Resident 1 stabbed and jabbed (quick sharp blow with a fist) Resident 3 three times on the head, three times to the right flank, three times to the head and then five times to the right flank. The ADM did not narrate or made a comment what happened in the video when asked by the surveyor.</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 an interview on 8/28/2024 at 4:13 pm. with the ADON, the ADON stated based on the video recording, ADON stated Resident 1 intentionally hit and stabbed Resident 3 because Resident 3 helped Resident 2 during the altercation/fight between Residents 1 and 2 on 8/12/2024. The ADON stated any form of abuse should be prevented and should not happen to the residents.</p> <p>36924</p> <p>c. During a review of Resident 5's AR, the AR indicated the facility admitted Resident 5 on 10/26/23 with diagnoses that included schizophrenia (serious mental health condition affecting how a person thinks, feels, and behaves).</p> <p>During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 was cognitively intact.</p> <p>During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on 1/3/24 with diagnoses that included schizophrenia and type 2 diabetes mellitus (elevated blood sugar level).</p> <p>During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had moderately impaired cognition.</p> <p>During a review of Resident 7's AR, the AR indicated the facility admitted Resident 7 on 7/3/24 with diagnoses that included schizophrenia.</p> <p>During a review of Resident 7's MDS dated [DATE], the MDS indicated Resident 7 was cognitively intact.</p> <p>During an interview on 8/27/24, at 3:06 p.m., with Resident 7, Resident 7 stated on 8/22/24, Resident 7 was walking on the patio and suddenly Resident 7 felt something behind Resident 7, and Resident 7 got punched by Resident 5. Resident 7 stated Resident 7 saw the punch and stated Resident 5 hit Resident 7 with a closed fist. Resident 7 stated Resident 5 was coming out of the building, and Resident 5 hit Resident 7 on the right side of Resident 7's face as Resident 5 walked out.</p> <p>During an interview on 8/27/24, at 3:25 p.m., with Resident 2 who was alert and coherent, Resident 2 stated Resident 2 was outside the patio, and Resident 2 witnessed Resident 5 throw a punch at Resident 7 on 8/22/24.</p> <p>During a review of the facility's video recording on 8/27/24, at 3:30 p.m., with the ADM, the video recording indicated on 8/22/24, Resident 7 was observed walking towards the outside patio. Resident 5 was observed walking up to Resident 7 from behind and Resident 5 hit Resident 7 on the right side of Resident 7's face from behind.</p> <p>During an interview on 8/27/24 at 3:50 p.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated CNA 2 was in the patio and Resident 7 was in the patio. CNA 2 stated Resident 5 was standing behind Resident 7 and CNA 2 saw Resident 7's head move forward. CNA 2 stated Resident 7 stated b_ _ _ _ (derogatory statement) after Resident 5 hit Resident 7.</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 an interview on 8/28/24 at 12:44 p.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated CNA 3 reported that on 8/18/24 Resident 5 was first in the medication line (resident line up to be given medication) and Resident 6 cut (to go ahead of other people) Resident 5 in the medication line. CNA 3 redirected Resident 6 to go to the end of the line but Resident 6 was not redirectable (change in direction or course). CNA 3 stated Resident 6 stated b _ _ _ _ (derogatory statement) and Resident 5 punched Resident 6 on the left side of Resident 6's face. LVN 1 stated Resident 5 hit Resident 6 because Resident 6 cut the line and Resident 5 thought Resident 6 called Resident 5 a b _ _ _ _ (derogatory statement)</p> <p>During a review of a video recording on 8/28/24 at 2:58 p.m., with the ADM, the video recording indicated on 8/18/24, Resident 5 was observed waiting in line for medications to be given by licensed staff. Resident 5 was observed sitting on the floor and Resident 6 walked in front of Resident 5 while Resident 5 was seated on the floor waiting in the medication line. Resident 5 stood up from a sitting position and walked in front of Resident 6. Resident 5 was observed lunging (sudden forward thrust) toward Resident 6 and punched Resident 6 on the head and face.</p> <p>During a review of the facility's Policy and Procedure (P&P) titled Abuse Prevention and Prohibition Program, dated 7/9/2024, the P&P indicated the facility's residents have the right to be free from abuse .The facility has zero-tolerance for abuse and staff must not permit anyone to engage in verbal, mental, sexual or physical abuse. The facility is committed to protecting residents from abuse by anyone, including but not limited to .other residents.</p> <p>During a review of the facility's P&P titled Resident Rights, dated 10/1/2023, the P&P indicated the facility was to promote and protect the right of all residents at the facility.</p>		