

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 07/09/2025
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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one of three sampled residents (Resident 1) from physical abuse (aggressive or violent behavior with the intention to cause physical harm) as indicated in the facility's policy and procedure (P&P) titled, Abuse Prevention and Prohibition Program. This failure resulted in Resident 2 hitting Resident 1 on 3/1/25, 4/12/25, 5/7/25, and on 6/27/25 and resulted in Resident 1 feeling unsafe in the facility. 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 which included schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and was independent with activities of daily living (ADLs) and with walking. During a review of Resident 1's Change in Condition (CIC) Evaluation, dated 4/12/25 and timed at 1:10 pm, the CIC indicated Resident 1 was hit once in the face by another resident. During a review of Resident 1's Nurses Notes (NN), dated 4/12/25 and timed at 4:16 pm, the NN indicated Resident 1 informed the charge nurse (unknown) that another resident hit Resident 1 on the patio on 4/11/25. During a review of Resident 1's IDT note, dated 4/15/25 and timed at 10:39 am, the IDT note indicated Resident 2 hit Resident 1 in the face during supervised patio activities. During a review of Resident 1's CIC, dated 5/7/25 and timed at 12:35 pm, the CIC indicated Resident 1 came out of Resident 1's room and stated another resident came to Resident 1's room and hit Resident 1 once in the face. During a review of Resident 1's IDT note, dated 6/27/25 and timed at 9 pm, the IDT note indicated Resident 1 was struck by a male peer who was experiencing a psychotic break (a period where a person loses touch with reality). The IDT note indicated the incident was unprovoked by Resident 1. During a review of Resident 1's Physician's Progress Note (PPN), dated 6/27/25 and timed at 11:57 pm, the PPN indicated Nurse Practitioner (NP) 1 received a report from nursing staff (unknown) that Resident 2 hit Resident 1 while Resident 1 was in bed. During a review of Resident 1's Census List (CL), the CL indicated Resident 2 had been in room [ROOM NUMBER]-C since 3/18/25. B. During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was intact and was independent with activities of daily living (ADLs) and with walking. During a review of Resident 2's untitled Care Plan (CP) Report, initiated on 3/1/25 and revised on 4/12/25 and revised on 5/7/25, the CP indicated Resident 2 punched a male peer in the nose on 3/1/25, punched a male peer in the face on 4/1/25, and punched a peer on the face on 5/7/25. The CP indicated the CP interventions were not revised after Resident 2 punched a male peer in the face on 4/12/25. During a review of Resident 2's untitled CP Report, initiated on 5/7/25 and revised on 6/7/25, the CP indicated Resident 2 hears voices which contributes to Resident 2's physical aggression. The CP indicated Resident 2 heard voices that peer had urinated in Resident 2's food so Resident 2 went to male peer's room and struck male peer. The CP indicated Resident 2 heard voices which led to an unprovoked assault on a male peer on 6/27/25. The CP interventions indicated Resident 2 was placed on one-to-one supervision for 24 hours on 5/8/25. During a review of Resident 2's IDT note, dated 5/7/25 and timed at 4 pm, the IDT indicated, on 5/7/25, Resident 2 heard voices that peer had urinated in Resident 2's food so Resident 2 went to male peer's room and struck male peer. The IDT indicated Resident 2 was placed on one-to-one supervision for 24 hours. During a review of Resident 2's Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) note, dated 6/27/25 and timed at 9 pm, the IDT note indicated Resident 2 had an episode of physical aggression towards a male peer and Resident 2 was placed on one-to-one (1:1, one staff supervising 1 resident) supervision to ensure the safety of other residents. During a review of Resident 2's Change in Condition (CIC) Evaluation, dated 6/27/25 and timed at 11:45 pm, the CIC indicated Resident 2 was physically aggressive to Resident 1 while inside Resident 1's room. During a review of Resident 2's Nurses Notes (NN), dated 6/27/25 and timed at 11:57 pm, the NN indicated, on 6/27/25, Resident 2 was witnessed by Licensed Vocational Nurse (LVN) 2 inside Resident 1's room holding on to Resident 1's back while Resident 1 was in bed. The NN indicated Resident 2 was restraining Resident 1 and was not allowing (Resident 1) to move or get away. During a</p>