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	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penn Mar Healthcare Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision to one of eight sampled residents (Resident 1) in accordance with Resident 1's Care Plan. This failure resulted in Resident 1 hitting Resident 2 in the face on [DATE] at 3 pm. Resident 2 sustained a laceration (tear or cut in the skin) under Resident 2's left eye, a skin tear (traumatic wound caused by friction when the upper layer of the skin becomes torn from the underlying layers) on the left eyelid, and was transferred to the General Acute Care Hospital 1's (GACH 1's) Emergency Department (ED). Resident 2's Computed Tomography (CT scan - a detailed picture of the inside of the body using specialized imaging techniques and computer technology) results from GACH 1's ED, dated [DATE] and timed at 1:07 pm, indicated Resident 2 sustained a displaced fracture (a broken bone where the pieces have shifted out of their normal alignment, often breaking into two or more fragments) of the left nasal (relating to the nose) bone. Findings: 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 (severe mental disorder causing loss of touch with reality) and anxiety (persistent worries that disrupt daily life). During a review of Resident 1's History & Physical (H&P) dated [DATE], the H&P indicated Resident 1 did not have the capacity to make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated [DATE], the MDS indicated Resident 1's was inattentive (not paying attention to something) and had disorganized thinking (thoughts do not have logical flow). During a review of Resident 1's untitled Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 1 had schizophrenia which placed Resident 1 at risk (increased possibility of happening) for aggression, anxiety, and unsafe behaviors. The CPR indicated Resident 1 attempted to strike a male peer on [DATE] due to belief that the peer was talking about Resident 1. The CPR indicated Resident 1 struck a male peer [Resident 2] without provocation (action or speech that makes someone angry) due to paranoid ideation (persistent feelings of distrust and suspicion) on [DATE]. The CPR indicated on [DATE], while out on the patio, Resident 1 accused a male staff member (unknown) of talking about Resident 1 and wanted to engage in a physical fight with the male staff member. The CPR indicated on [DATE], while out on the patio, Resident 1 struck another resident [Resident 2] without provocation due to paranoid ideations. The CPR interventions initiated on [DATE] indicated Resident 1 will have Resident 1's meals in the dining room with assigned 1:1 supervision (providing dedicated, constant supervision for individual) while [Resident 2] will have [Resident 2's] meals in the patio area or the TV room; Resident 1 will be permitted in the patio area when Resident 1 was deemed psychiatrically stable (person is no longer an immediate danger to themselves or others), accompanied by Resident 1's 1:1 staff and only when the patio is not in use by others. The CPR also indicated Resident 1, and [Resident 2] have been informed of the [DATE] safety plan interventions and both residents understood the supervision protocols. The CPR did not indicate how long the [DATE] safety plan interventions were going to be in effect. The CPR safety plan interventions were updated on [DATE] and indicated Resident 1 will be closely monitored while on the patio, by assigned Certified Nursing Assistant (CNA); Resident 1 will have Resident 1's meals on a table alone until Resident 1 presents with further behavioral stability with no incidents of aggression for 2 weeks. The CPR did not indicate any changes to the safety plan interventions initiated on [DATE]. During a review of Resident 1's Interdisciplinary Team (IDT, a team of professionals from various disciplines who work in collaboration to address the resident's care) Note, dated [DATE] and timed 6:38 pm, the IDT Note indicated at 4 pm (on [DATE]), Resident 1 was observed by facility staff (unknown) struck another male peer [Resident 2] once to the back of [Resident 2's] head while [Resident 2] was getting water out of the water jug while out on the patio. The staff (unknown) separated Resident 1 and Resident 2 immediately, notified the Nurse Practitioner (NP- a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor), and received a Telephone Order (T.O.) to give Resident 1 an emergency intramuscular (IM- injecting directly into the muscle) of Haldol 10 milligrams (mg)/milliliter (ml) and Benadryl 50 mg/ml x1 STAT (immediately) and for Resident 1 to be placed in the Seclusion Room (room within facility used to decrease stimulation to calm resident) due to (d/t) delusional thoughts (false beliefs) and aggression as ordered. During a review of Resident 1's Change of Condition (COC, a sudden clinically important deviation in the resident's health or functioning that requires further assessments and interventions) Evaluation, dated [DATE] and time 4 pm, the COC indicated Resident 1 showed verbal and physical aggression towards another male peer [Resident