STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555825	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
San Marino Healthcare Center	6812 N. Oak Avenue San Gabriel, CA 91775

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Cross reference with F610 Based on interview and record review the facility failed to report to the state agency (CDPH, California Department of Public Health), the state ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement of an allegation of physical abuse (intentional bodily injury) for one of two sampled residents (Resident 1). This failure had the potential to place Resident 1 and other residents at risk for physical abuse, which could result to harm/injury. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (any disease, damage, or disorder that affects the brain structure or function) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out daily tasks). During a review of Resident 1's History and Physical Examination (H&P), dated 8/23/24, the H&P indicated the resident has fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 8/5/24, the MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with walking 10 feet, transfers (how resident moves to and from bed, chair, wheelchair, standing position), personal hygiene and lower body dressing (the ability to dress and undress below the waist, including fasteners). Resident 1 needed partial/moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist, including fasteners) and eating. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/5/24 at 2:57 PM with the Director of Nursing (DON), a facility form titled, Investigation Statement, dated 8/22/24, indicated according to Licensed Vocational Nurse 1 (LVN 1) Resident 1's family representative (FR) had stated that Resident 1 informed her that he was hit by a male nurse. The DON stated that the physical abuse allegation was not and should have been reported to CDPH, the state ombudsman or local law enforcement as indicated on the facility's policy. During an interview on 9/5/24 at 3:09 PM with LVN 1, LVN 1 stated that on 8/22/24 Resident 1's FR brought it to their attention that Resident 1 stated that he was hit by a male nurse. LVN 1 also stated that the incident was then reported to the DON but was not sure whether it was reported to CDPH, the state ombudsman or local law enforcement. During an interview on 9/5/24 at 3:29 PM with the DON, the DON stated that Resident 1 stated that someone hit him on a Thursday but could not recall who and could not give a specific time or date. The DON also stated that when the facility receives any allegation of abuse, the abuse coordinator would conduct an investigation, report the allegation to CDPH, the state ombudsman and the police immediately within 2 hours, and conduct an abuse in-service for staff. During an interview on 9/5/24 at 3:53 PM with LVN 2, LVN 2 stated that any allegation of abuse needs to be reported to CDPH, the state ombudsman and the police within 2 hours. During an interview on 9/5/24 at 3:57 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that on 8/22/24 Resident 1 told his FR that a male nurse hit him and that she reported the allegation to LVN 1. CNA 1 also stated that all allegations of abuse must be reported to the police, the state ombudsman & CDPH. During an interview on 9/5/24 at 4:10 PM with the DON, the DON stated that the facility's nursing staff should have reported it to the Administrator who is the facility's abuse coordinator, start the SOC 341 (a California Department of Social Services [CDSS] form that is used to report suspected abuse or neglect of an elder or dependent adult) and report it to the state ombudsman, the police and CDPH. The DON further stated that all allegations of abuse need to be reported regardless of the resident's cognitive status and stated that the allegation of Resident 1 stating a male nurse hit him should have been reported. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised July 2017, the P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The P&P further indicated under Reporting: 1. All alleged violations involving abuse, neglect, exploitation, or mistreatment including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: a. The State licensing/certification agency responsible for surveying/licensing the facility; b. The local/State Ombudsman. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. The Resident's Representative (Sponsor) of Record; d. Adult Protective Services (where state law provides jurisdiction in long term care); e. Law enforcement officials; f. The resident's Attending Physician; and g. The facility Medical Director 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but no later than: a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48395 Based on interview and record review, the facility failed to implement its policy for abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for one (1) of two (2) sampled residents (Resident 1) by failing to: 1. Conduct a thorough investigation of an allegation of physical abuse (intentional bodily injury) reported by Resident 1's family representative (FR) on 8/22/24. 2. Provide a written report to the State Survey Agency of the findings of the physical abuse allegation investigation within five (5) working days of the incident. This failure had the potential to place Resident 1 and other residents at risk for physical abuse, which could result to harm/injury. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated the resident was initially admitted to the facility on [DATE] with diagnoses of encephalopathy (any disease, damage, or disorder that affects the brain structure or function) and Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out daily tasks). During a review of Resident 1's History and Physical Examination (H&P), dated 8/23/24, the H&P indicated the resident has fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a standardized resident assessment care screening tool), dated 8/5/24, the MDS indicated the resident was severely impaired (difficulty with or unable to make decisions, learn, remember things) with cognitive (ability to think, remember, and reason) skills for daily decision making. Resident 1 needed substantial/maximal assistance (helper does more than half the effort) with walking 10 feet, transfers (how resident moves to and from bed, chair, wheelchair, standing position), personal hygiene and lower body dressing (the ability to dress and undress below the waist, including fasteners). Resident 1 needed partial/moderate assistance (helper does less than half the effort) with upper body dressing (the ability to dress and undress above the waist, including fasteners) and eating. During a concurrent interview and record review on 9/5/24 at 2:57 PM with the Director of Nursing (DON), a facility form titled, Investigation Statement, dated 8/22/24, indicated according to Licensed Vocational Nurse 1 (LVN 1) Resident 1's FR had stated that Resident 1 informed her that he was hit by a male nurse. During an interview on 9/5/24 at 3:09 PM with LVN 1, LVN 1 stated that on 8/22/24 Resident 1's FR brought it to their attention that Resident 1 stated that he was hit by a male nurse. LVN 1 stated that when she asked Resident 1 what happened, he had said that a male nurse had hit him but could not remember the specific time or date. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/24 at 3:29 PM with DON, DON stated that Resident 1 stated that someone hit him on a Thursday but could not recall who and could not give the specific time or date. During an interview on 9/5/24 at 3:57 PM with CNA 1, CNA 1 stated that on 8/22/24 Resident 1 told his FR that a male nurse hit him and that she reported the allegation to LVN 1. During an interview on 9/5/24 at 4:10 PM with the DON, the DON stated that there was no interdisciplinary team (IDT, a group of professionals with various areas of expertise who work together towards the goal of their clients) meeting done for the alleged physical abuse incident with Resident 1. The DON further stated that an IDT meeting should have been done. During an interview on 9/5/24 at 5:06 PM with the Administrator (ADM), the ADM stated that an investigative report was not and should have been done for Resident 1's allegation of abuse. The ADM also stated there should have been a documentation indicating that the facility had looked into any possible male staff members in relation to Resident 1's physical abuse allegation. During an interview on 9/5/24 at 5:51 PM with the DON, the DON stated that there was no documentation that the male staff working on 8/22/24 was investigated regarding Resident 1's physical abuse allegation. The DON stated that it should have been documented and followed up. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, revised July 2017, the P&P indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. The P&P also indicated: Role of the Administrator o If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. Role of the Investigator o Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator. Reporting o The administrator or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. During a review of the facility's P&P titled, Abuse Prevention Program, revised August 2006, the P&P indicated: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policies and procedures that govern , as a minimum: o Timely and thorough investigations of all reports and allegations of abuse. o The reporting and filing of accurate documents relative to incidents of abuse.