

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555825	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2025
NAME OF PROVIDER OR SUPPLIER San Marino Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on interview and record review, the facility failed to prevent a sexual abuse (when someone touches another person in a sexual manner, unwanted touching of a sexual nature, or makes that person take part in sexual activity with them without consent) for one of two sampled residents (Resident 1) when Resident 2 touched Resident 1's buttocks and exposed Resident 2's private parts in front of Resident 1 on 4/12/2025 at around 6:50 AM.</p> <p>This deficient practice violated Resident 1's rights to be free from abuse and has the potential to have negative psychosocial (the combined influence of thoughts, feelings, behaviors, relationships and environment on a person's wellbeing and how they function) outcomes to the resident.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included injury of unspecified body region (means that there is an injury, but the exact area of the body affected is not identified) open wound right knee, sequela (resulting from prior injury), anxiety disorder (a type of mental health condition that can cause excessive worry, restlessness, difficulty concentrating, sleep disturbances, and muscle tension), effusion right ankle (the result of excess fluids gathering in the soft tissues surrounding the joint).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 4/13/2025 indicated Resident 1 has the capacity to understand and make decisions.</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 - Few</p>	<p>During a review of the Resident 1's Progress Note dated 4/12/2025 at 12:01 PM, indicated, that around 8:25 AM the Director of Nursing (DON) called asking about the sexual abuse by Resident 2 to Resident 1 that happened on 4/12/2025 at 6:50 AM. The progress notes indicated according to the Case Manager (CM), Resident 1 emailed CM (did not specify when) and claimed that Resident 2 touched Resident 1 inappropriately on the buttocks and showed Resident 2's private parts in front of Resident 1. The progress notes indicated the night shift Charge Nurse (CN) stated resident was in station 1 waiting for Resident 1's morning medication when male resident (Resident 1) passed by and touched Resident 1 inappropriately and showed his private parts to Resident 1. The progress notes indicated Certified Assistant Nurse (CNA1) was present at the time of the sexual abuse incident and told Resident 2 that what Resident 2 did was not allowed. The progress notes also indicated, Resident 2 then turned around while in his wheelchair and pulled-down Resident 1's pants and underwear to show Resident 2's private part to Resident 1 and CNA 1. The progress notes indicated, on 4/12/2025 at around 9:15 AM RN Sup 1 left a voicemail at the local PD, at 9:17 AM called SSA left message and at 9:19 AM called Ombudsman left message.</p> <p>During a review of Resident 1's written statement undated, indicated on 4/12/2025 at 6:50 AM, Resident 1 was standing waiting for pain medication at the nursing station at around 6:50 AM, Resident 2 passed by while Resident 1 while sitting in the resident's wheelchair and slapped her (Resident 1) buttocks twice quickly. The written statement indicated at around 6:53 AM, Resident 2 taunted Resident 1 making a facial gesture of no regrets and CNA1 was present and witnessed the incident. The written statement also indicated, Resident 2 turned around while Resident 2 was in his wheelchair and pulled down his pants and underwear showing/ exposing Resident 2's penis.</p> <p>During a review of the facility Investigation Statement for Certified Nursing Assistant (CNA1) dated 4/13/2025, the investigation statement indicated CNA1 stated that on 4/12/2025 at around 6:50 AM, Resident 1 was standing at the hallway near the Nursing Station and Resident 2 passed by and touched Resident 1 on Resident 1's buttocks. The investigative statement indicated CNA1 reported it to the Charge Nurse (CN) and it did not indicate if it was reported to SSA, Ombudsman and/ or local PD.</p> <p>During a review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing), oral phase (problems with using the mouth, lips and tongue to control food or liquid), schizophrenia (a mental disorder with a range of symptoms that affect thoughts, behaviors, and perceptions of reality), acquired absence of left leg above the knee, and anxiety disorder.</p> <p>During a review of Resident 2's History and Physical (H&P) dated 8/09/2025 indicated Resident 2 has the mental capacity to understand and make medical decisions.</p> <p>During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2025, the MDS indicated Resident 2 needed supervision (helper provides verbal cues and resident completes activity) assistance from staff for toileting hygiene, showers and lower body dressing and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for oral and personal hygiene and putting on/taking off footwear.</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 - Few</p>	<p>During an interview with the Director of Nursing (DON) on 4/15/2025 at 7:37 AM, the DON stated CM called her on 4/12/2025 regarding an incident that happened on 4/12/2025 at around 6:50 AM, between Resident 1 and Resident 2. The DON stated that CM told the DON that according to Resident 1, Resident 1 was standing in the hallway near the nurse's station when Resident 2 passed by and touched Resident 1's buttocks and exposed Resident 2's private area to Resident 1 and CNA1.</p> <p>During a concurrent interview with Registered Nurse Supervisor (RN Sup 1) on 4/15/2025 8:33 AM, RN Sup 1 stated that Resident 1 told RN Sup 1 that on 4/12/2025 at around 6:50 AM, Resident 2 pulled Resident 2's pants down while in the wheelchair and showed Resident 2's private part to Resident 1. RN Sup 1 stated, Resident 1 told RN Sup 1 that CNA1 saw the sexual abuse by Resident 2 to Resident 1. RN Sup 1 stated Resident 2 showing his private area to Resident 1 was considered a sexual abuse and can cause Resident 1 psychosocial harm.</p> <p>During an interview with CM on 4/15/2025 at 10:49 AM, CM stated she received an email from Resident 1 on 4/12/2025 in the morning indicating Resident 2 touched Resident 1 inappropriately and then exposed Resident 2's private area to Resident 1 and CNA1.</p> <p>During an interview with CN on 4/15/2025 at 12:17 AM, CN stated, It is not acceptable for a resident to touch another resident's buttocks, it is inappropriate, and it is a type of abuse, especially if there was no consent. It is considered sexual abuse.</p> <p>During an interview with CNA1 on 4/17/2025 at 9:02 AM, CNA1 stated the incident between Resident 1 and 2 happened right before change of shift on date?? at around 6:50 AM. CNA1 stated she witnessed Resident 2 passing by the hallway near the nurse's station and touched Resident 1's buttocks. CNA1 stated she approached Resident 2 and told him it was inappropriate to touch another resident's buttocks and then Resident 2 then proceeded to pull down Resident 2's pants and exposed his penis to both Resident 1 and CNA1.</p> <p>During a review of the facility's policy revised 8/2006, titled Abuse Prevention Program indicated, Our residents have the right to be free from abuse. The policy indicated the facility is committed to protecting the residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents .or any other individual.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45523</p> <p>Based on observations, interview and record review, the facility failed to report a sexual abuse (when someone touches another person in a sexual manner, unwanted touching of a sexual nature, or makes that person take part in sexual activity with them without consent) for one of two sampled residents (Resident 1) to the State Survey Agency (SSA), the Ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities), and local law enforcement (Local PD) within two (2) hours from when Certified Nurse Assistant (CNA) 1 witnessed Resident 2 inappropriately touched Resident 1 buttocks and when Resident 2 exposed his private area in front of Resident 1 and CNA 1 on 4/12/2025 at 6:50 AM.</p> <p>This deficient practice had the potential to place Resident 1 and other residents for further abuse.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included injury of unspecified body region (means that there's an injury, but the exact area of the body affected is not identified) open wound right knee, sequela (resulting from prior injury), anxiety disorder (a type of mental health condition that can cause excessive worry, restlessness, difficulty concentrating, sleep disturbances, and muscle tension), effusion right ankle (the result of excess fluids gathering in the soft tissues surrounding the joint).</p> <p>During a review of Resident 1's History and Physical (H&P) dated 4/13/2025 indicated Resident 1 has the capacity to understand and make decisions.</p> <p>During a review of the Resident 1's Progress Note dated 4/12/2025 at 12:01 PM, indicated, that around 8:25 AM the Director of Nursing (DON) called asking about the sexual abuse by Resident 2 to Resident 1 that happened on 4/12/2025 at 6:50 AM. The progress notes indicated according to the Case Manager (CM), Resident 1 emailed CM (did not specify when) and claimed that Resident 2 touched Resident 1 inappropriately on the buttocks and showed Resident 2's private parts in front of Resident 1. The progress notes indicated the night shift Charge Nurse (CN) stated resident was in station 1 waiting for Resident 1's morning medication when male resident (Resident 1) passed by and touched Resident 1 inappropriately and showed his private parts to Resident 1. The progress notes indicated Certified Assistant Nurse (CNA1) was present at the time of the sexual abuse incident and told Resident 2 that what Resident 2 did was not allowed. The progress notes also indicated, Resident 2 then turned around while in his wheelchair and pulled-down Resident 1's pants and underwear to show Resident 2's private part to Resident 1 and CNA 1. The progress notes indicated, on 4/12/2025 at around 9:15 AM RN Sup 1 left a voicemail at the local PD, at 9:17 AM called SSA left message and at 9:19 AM called Ombudsman left message.</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 a review of Resident 1's written statement undated, indicated on 4/12/2025 at 6:50 AM, Resident 1 was standing waiting for pain medication at the nursing station at around 6:50 AM, Resident 2 passed by while Resident 1 while sitting in the resident's wheelchair and slapped her (Resident 1) buttocks twice quickly. The written statement indicated at around 6:53 AM, Resident 2 taunted Resident 1 making a facial gesture of no regrets and CNA1 was present and witnessed the incident. The written statement also indicated, Resident 2 turned around while Resident 2 was in his wheelchair and pulled down his pants and underwear showing/ exposing Resident 2's penis.</p> <p>During a review of the facility Investigation Statement for Certified Nursing Assistant (CNA1) dated 4/13/2025, the investigation statement indicated CNA1 stated that on 4/12/2025 at around 6:50 AM, Resident 1 was standing at the hallway near the Nursing Station and Resident 2 passed by and touched Resident 1 on Resident 1's buttocks. The investigative statement indicated CNA1 reported it to the Charge Nurse (CN) and it did not indicate if it was reported to SSA, Ombudsman and/ or local PD.</p> <p>During a review of Resident 2's Admission Record indicated Resident 2 was admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing), oral phase (problems with using the mouth, lips and tongue to control food or liquid), schizophrenia (a mental disorder with a range of symptoms that affect thoughts, behaviors, and perceptions of reality), acquired absence of left leg above the knee, and anxiety disorder.</p> <p>During a review of Resident 2's History and Physical (H&P) dated 8/09/2025 indicated Resident 2 has the mental capacity to understand and make medical decisions.</p> <p>During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2025, the MDS indicated Resident 2 needed supervision (helper provides verbal cues and resident completes activity) assistance from staff for toileting hygiene, showers and lower body dressing and setup or clean-up assistance (helper sets up or cleans up; resident completes activity) for oral and personal hygiene and putting on/taking off footwear.</p> <p>During an interview with the Director of Nursing (DON) on 4/15/2025 at 7:37 AM, the DON stated CM called her on 4/12/2025 regarding an incident that happened that same day (4/12/2025) at around 6:50 AM, between Resident 1 and Resident 2. The DON stated that CM told the DON that according to Resident 1, the resident was standing in the hallway near the nurse's station when Resident 2 passed by and touched Resident 1's buttocks and exposed Resident 2's private area in front of Resident 1 and CNA1.</p> <p>During an interview with Registered Nurse Supervisor (RN Sup 1) on 4/15/2025 at 8:10 AM, RN Sup 1 stated, when I interviewed the night shift nurses (that worked on 4/12/2025), they said the incident (Resident 2 inappropriately touching Resident 1's buttocks) happened at 6:50 AM, close to change of shift at 7 AM. RN Sup 1 stated the time frame to call and report an abuse to SSA, Ombudsman and local PD is within 2 hours from the allegation was made or when the abuse was witnessed which was on 4/12/2025 at 6:50 AM. RN Sup 1 stated, RN Sup 1 reported the abuse by Resident 2 to Resident 1 to SSA, Ombudsman and local PD on 4/12/2025 between 9:15 AM to 9:30 AM and it was passed the two-hour window to report.</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 a concurrent interview with RN Sup 1 on 4/15/2025 8:33 AM, RN Sup stated the abuse by Resident 2 to Resident 1 should have been reported to SSA within 2 hours from when it happened and if the facility did not report it, Resident 2 can do the inappropriate sexual behavior again to Resident 1 or other resident in the facility. RN Sup 1 stated, this can cause Resident 1 psychosocial harm (harm to a person's mental or emotional well-being, often caused by factors in their work or social environment).</p> <p>During an interview with the admin on 4/15/2025 at 11:18 AM, Admin stated he received a phone call from DON on Saturday (4/12/2025) morning around 8:30 AM to 9:30 AM. Admin stated, I am the abuse coordinator. Admin stated, the facility has to report but for a serious allegation such as abuse to SSA, Ombudsman and local PD within 2 hours from the incident of abuse or allegation. Admin stated the charge nurse during the abuse incident happened was the one responsible to start the process of the investigation and make the report to SSA, Ombudsman and local PD from when the CNA 1 witnessed the sexual abuse by Resident 2 to Resident 1. Admin stated, it is not acceptable that the abuse incident by Resident 2 to Resident 1 was not reported within 2 hours to the appropriate agencies to ensure the safety of all the residents regardless of any allegation. Admin stated, the sexual abuse by Resident 2 to Resident 1 happened on 4/12/2025 at around 6:50 AM and it was not reported to the appropriate agencies not until 9:15 AM (2 hours and 30 minutes) which was more than the 2 hours- time frame.</p> <p>During a concurrent interview with CN on 4/15/2025 at 12:17 AM, CN stated, When there is abuse reported, I must investigate and report to DON, Admin, local PD and Ombudsman within 2 hours. I did not endorse to RN Sup during change of shift. It's not acceptable for a resident to touch another resident's butt, it's inappropriate and it's a type of abuse, especially if there's no consent. It's considered sexual abuse.</p> <p>During an interview with CNA1 on 4/17/2025 at 9:02 AM, CNA1 stated the incident between Resident 1 and 2 happened right before change of shift on 4/12/2025 at around 6:50 AM. CNA1 stated CNA1 witnessed Resident 2 passing by in the hallway near the nurse's station and touching Resident 1's buttocks. CNA1 stated she approached Resident 2 and told him it was inappropriate to touch another resident's buttocks and Resident 2 then proceeded to pull down his pants and exposed Resident 2's penis to both Resident 1 and CNA1. CNA1 stated she let CN know about the incident with Resident 1 and 2. CNA1 stated, CNA1 was not aware the incident between Resident 1 and 2 was not reported by the CN to Admin, SSA, local PD and to ombudsman within 2 hours.</p> <p>During a review of the facility's policy revised on 9/2022, titled, Abuse, Neglect (failure to provide care), Exploitation (treating someone unfairly) or Misappropriation or Misappropriation (unauthorized use of someone else's belongings)-Reporting and Investigation, indicated, All reports of resident abuse (including injuries of unknow origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported.</p> <ol style="list-style-type: none"> 1. If resident abuse, neglect, exploitation is suspected, the suspicion must be reported immediately to the administrator and to tother officials according to state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: <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>a. The state licensing/certification agency responsible for surveying/licensing the facility (SSA)</p> <p>b. The local/state ombudsman</p> <p>e. Law enforcement</p> <p>3. Immediately is defined as:</p> <p>a. Within two hours of an allegation involving abuse</p> <p>4. Verbal/written notices to agencies are submitted via special carrier, facsimile (fax), electronic mail (email), or by telephone.</p>