

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 07/16/2025
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)
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 observation, interview, and record review, the facility failed to protect one of two residents (Resident 1) from physical abuse (intentional bodily injury such as pinching, slapping and hitting) when Resident 2 hit, slapped, and scratched Resident 1 on 7/1/2025 in accordance with the facility's policy and procedure (P&P) titled, Abuse Prevention Program,. This deficient practice resulted in, abrasions (wound where skin rubs off due to friction) on Resident 1's left face, left upper cheek and left side of the forehead; abrasion on the middle left outer forearm; bruising on the distal (location on the body farther away from the center of the body) left outer wrist; and an abrasion on the right Achilles (back of the lower leg connecting the calf muscles to the heel bone) and placed the resident at risk for psychosocial (combined influence of psychological factors and the surrounding social environment on physical, emotional, and/or mental wellness) harm. Findings: 1. During a review of Resident 1's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE], with the diagnoses including but not limited to metabolic encephalopathy (abnormalities of water, electrolytes, vitamins, and other chemicals that adversely affect the brain function), dementia (progressive brain disorder that slowly destroys memory and thinking skills), and difficulty in walking. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2025, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. The MDS indicated Resident 1 was dependent (helper does all of the effort, resident [NAME] none of the effort to complete the activity) for sitting to lying, lying to sitting on side of bed, sitting to standing, and chair-bed-to-chair transferring. During a record review of Resident 1's SBAR (an acronym for Situation-Background-Assessment-Recommendation is a technique used to provide a framework for communication between members of the health care team), dated 7/1/2025, the SBAR indicated Resident 1 was involved in an altercation with her roommate. The SBAR indicated at approximately 4 AM, after staff reported the altercation, noted Resident 1 sitting on the floor and Resident 2 attempting to hit Resident 1. Residents 1 and 2 were separated and noted scratches on Resident 1's left upper cheek, left side of the forehead, left forearm, and anterior aspect of the right heel. During a record review of Resident 1's Nursing Note, dated 7/1/2025, the note indicated Resident 1 had four new wounds acquired in-house as follows: - Skin issue #1: left face, left upper cheek and left side of the forehead abrasions.- Skin issue #2: Middle left outer forearm abrasion.- Skin issue #3: Distal left outer wrist bruising.- Skin issue #4: Right Achilles abrasion. During a record review of Resident 1's care plan, dated 7/1/2025, the care plan indicated physical altercation with resident's roommate (Resident 2), Resident 1 is the victim, and Resident 1 sustained scratch marks on the left arm, left cheek, left side of the forehead and right anterior aspect of the ankle and right anterior aspect of the ankle. During a record review of Resident 1's Interdisciplinary Team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident) Conference Record, dated 7/2/2025, the IDT record indicated Resident 1 was seen by staff being attacked by the resident's roommate (Resident 2). The IDT also indicated when charge nurse arrived both residents (Resident 1 and 2) were on the floor and Resident 2 was attempting to continue to hit/scratch/slap Resident 1. The IDT also indicated upon assessment Resident 1 was noted with scratch marks on the left arm, left cheek, left side of the forehead, and right anterior aspect of the ankle. During a record review of Resident 1's Physician Order Summary Report, dated 7/3/2025, the orders indicated as follows:- Cleanse left cheek scratch with normal saline (NS, mixture of salt and water used to replenish fluid and electrolyte), pat dry, apply triple antibiotic (used to reduce the risk of infections following minor skin injuries) and leave open to air every day shift for 30 days.- Cleanse left forearm scratch with normal saline, pat dry, apply triple antibiotic and leave open to air every day shift for 30 days.- Cleanse right heel abrasion with normal saline, pat dry, apply triple antibiotic and leave open to air every day shift for 30 days. 2. During a record review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE], with the diagnoses including but not limited to metabolic encephalopathy, schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), and personal history of other mental and behavioral disorders. During a record review of Resident 2's Physician Order Summary Report, dated 3/3/2025, the order indicated Risperidone (an antipsychotic [drugs that work by altering brain chemistry to help reduce psychotic symptoms like hallucinations, delusions, and disordered thinking] medication that alters the effects of chemicals in the brain)</p>		