PRINTED: 12/20/2024 FORM APPROVED OMB NO. 0938-0391

K 000 INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1985 K7 SURVEY UNDER: 2012 EXSISTING STRUCTURE TYPE: ONE STORY, FULLY SPRINKLED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(f), National Fire Protection Association (NFPA) 101- Life Safety Code, 2012 Edition, and NFPA 99- Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 45 Census: 45 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced K 000 What corrective action will be accomplished for the residents found to have been affected by the deficient practice. The facility determined that no residents were directly adversely affected by the deficient practice. The facility obtained a contract with aftire alarm monitoring compony on who will maintain, service and inspect the fire panel and smoke detectors are inoperative. The facility will replace them once approval is obtained from the called by the deficient practice. The facility obtained a contract with aftire alarm monitoring compony conducted a smoke sensitivity test on 12/18 and determined two smoke detectors are inoperative. The facility will replace them once approval is obtained from the volume of the protection of 01/17/2024.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ECONSTRUCTION 11 - MAIN BUILDING 01		E SURVEY IPLETED
PENN MAR HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL TAGE) TOTAL COMPRETE PLAN OF CORRECTION (EACH OFFICENCY MUST BE PRECEDED BY FULL TAGE)			05A360	B. WING			12	2/05/2024
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) K 000 INITIAL COMMENTS K 3 BUILDING: 01 K 9 PLAN APPROVAL: 1985 K7 SURVEY UNDER: 2012 EXSISTING STRUCTURE TYPE: ONE STORY, FULLY SPRINKLED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101- Life Safety Code, 2012 Edition, The facilities Code, 2012 Edition, The facility as not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities Resident Certified Beds: 45 Cansus: 45 Fire Alarm System - Testing and Maintenance A fire alarm system - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Electric Code, and NFPA 77, National Electric Code, and NFPA	PENN MA	R HEALTHCARE CENTE			3	938 COGSWELL ROAD EL MONTE, CA 91732		
K3 BUILDING: 01 K6 PLAN APPROVAL: 1985 K7 SURVEY UNDER: 2012 EXSISTING STRUCTURE TYPE: ONE STORY, FULLY SPRINKLED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(f), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 45 Census: 45 K 345 Fire Alarm System - Testing and Maintenance A fire alarm system - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Electric Code, and NFPA 72, National Electric Code, and NFPA 72, National Electric Code, mand NFPA 72, National Electric Code, mand NFPA 72, National Electric Code, mand NFPA 72, National Electric Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70 This RECUIREMENT is not met as evidenced	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Based on an observation, interview and record review, the facility failed to: 1) provide ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE A TITLE (X6) DATE	K 345 SS=F	K3 BUILDING: 01 K6 PLAN APPROVAL K7 SURVEY UNDER: STRUCTURE TYPE: SPRINKLED The following reflects Department of Public Life Safety Code rece findings are in accord. Federal Regulations (National Fire Protectic Life Safety Code; 201 Health Care Facilities The facility is not in su 42 CFR 483.90 for Lo Facilities. Resident Certified Bec Census: 45 Fire Alarm System - To A fire alarm System - To A fire alarm system is accordance with an ap with the requirements Electric Code, and NF and Signaling Code. F acceptance, maintena available. 9.6.1.3, 9.6.1.5, NFPA This REQUIREMENT by: Based on an observa review, the facility faile	the findings of the California Health during an annual rtification survey. The ance with 42 Code of CFR) 483.90(a)(b)(c)(j), on Association (NFPA) 101 - 2 Edition, and NFPA 99 - Code, 2012 Edition. Abstantial compliance with ng Term Care (LTC) ds: 45 esting and Maintenance esting and Maintenance tested and maintained in approved program complying of NFPA 70, National PA 72, National Fire Alarm Records of system ance and testing are readily 170, NFPA 72 is not met as evidenced at to: 1) provide	K3		accomplished for the residents found to have been affected by the deficient practice. The facility determined that no residents were directly adversely affected by the deficient practice. However, all residents had the potential to be adversely affected by the deficient practice. The facility obtained a contract with a fire alarm monitoring compony who will maintain, service and inspect the fire panel and smoke detectors annually and as needed. The monitoring compony conducted a smoke sensitivity test on 12/18 and determined two smoke detectors are inoperative. The facility will replace them once approval is obtained from HCAI in writing. The fire alarm monitoring compony will conduct an annual fire alarm inspection on 01/17/2024.		

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION - MAIN BUILDING 01		E SURVEY (PLETED
		05A360	B. WING			12/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
.v				39	38 COGSWELL ROAD		
PENN MA	R HEALTHCARE CENTE	R		EI	MONTE, CA 91732		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N RE	(X5) COMPLETION
PREFIX TAG	FACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
		. 4	K	345	How will we identify other		
K 345			'`	J-3	residents having the potential		
	documentation that t	he facility's fire alarm system			to be affected by the deficient		
	was inspected, teste	d, and maintained annually		1	practice and what corrective		
	(Within the last 12 mg	onths) in accordance with ire Alarm and Signaling					•
	NEPA /2, National F	Sections 14.4.5, 14.6.2.1,			actions were taken		
	and 14 6 3 2 and 2)	provide documentation of a	:		the facility determined that		
	passing smoke deter	ctors calibration and		1	no residents were		
	sensitivity testing (te	sting and adjustments done	:		directly adversely affected by		
	to the smoke detector	ors to ensure that each			the deficient practice.		
	smoke detector or sr	moke alarm is within its listed			However, all residents had the		
	and marked sensitivi	ity range) conducted within			potential to be adversely affected		
	the last five years in	accordance with NFPA 72,			by the deficient practice.		
	2010 Edition, Section	ns 14.6.2.1, 14.6.3.2,			by the delictent practice.		
	14.4.5.3.1, 14.4.5.3.	2, and 14.4.5.3.3. These			What measures will be put in		1
	deficiencies have the	e potential to result in the		ı	place in a		
	failure of the fire alar	rm system which in case of a sential notification to building			systematic change will be made to	0	
	tire, would delay ess	y notification to emergency			ensure that the deficient practice		
	services, affecting th	ne safety of 45 of 45	;		does not re-occur.		
	residents, staff, and	visitors.			does not re-occar.		
	residents, start, and				The maintenance supervisor		
	Findings:				will inspect all smoke		
İ					detectors monthly and document		
	During an interview	on 12/5/2024 at 9:40 a.m.			his findings and		
	with the Administrate	or (ADM) and Maintenance			report his findings at the QA		
	Supervisor (MS), a	written request for the annual	1		monthly meeting. MS will report		
	sprinkler service and	d the smoke sensitivity			any irregularities to the administra	tor	
	calibration service re	eport was made.			and monitoring company immediat	ely.	
	4) During a consum	ent interview and record			and monitoring company	-	
	T) During a concurre	at 1:15 p.m. with the MS, the			į		
	facility's "Fire Alarm	Inspection Report", dated					
	9/21/2023 was revi	ewed. The report indicated	i				
Í	that the facility's fire	alarm system service was					1
	last serviced on 9/2	1/2023. The surveyor					
İ	requested for docum	nentation indicating that the		1	1		
	facility's fire alarm s	ystem had been inspected					
1	and tested within the	e last 12 months. The MS was	:				
1	not able to provide	evidence of the requested					

	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			1		TE SURVEY APLETED
		05A360	B. W	NG		<u></u>	12	2/05/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRES	S, CITY, STATE, ZIP CODE		-
		_	1		3938 COGSWEI	L ROAD	:	
PENNMA	R HEALTHCARE CENTE	ĸ			EL MONTE, CA	91732	;	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1	(D		ROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		REFIX TAG	(EA	CH CORRECTIVE ACTION SHOULD BI S-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
K 345	Continued From page	2		K 34	5			
	documentation and st					and administrator will		
		fire alarm service but did				ately after		
	not issue a report to the					oke sensitivity test,	•	
		•				the report		
		ion on 12/5/2024 between			fromthe	company and file those		
		with the MS, the surveyor			reports.			
i		ke detectors throughout the	-		reports a	re not generated		ľ
	facility.				properly	theMS		
	Durley of an end and and		}		and adm	nistrator will immediately		
		n. with the MS, the facility's			inform th	e company.		
		sitivity Test Report", dated			How doe	s the facility plan to monitor	-	
		ved. The report Indicated	-		its perfor	mance to ensure that the		
	•	e detector sensitivity testing	ĺ			are sustained.		
İ	was conducted more t					1		
	1/26/2018. The survey	ing that the facility's smoke	١,		The VP of	Clinical Services		
		s conducted within the last	1 1			quarterly all reports		
ĺ		ited that the vendor had not	i i			compliance.		
		ivity report to the facility						
		detectors sensitivity had			i .			1
ļ	passed or failed.	•	i			ł ·		
	•							
	During a review of the				1			
	procedures titled, "Poll	•			Complian	e Date: 12/30/2024		
		ent", undated, indicated,			1			j
	"The Maintenance Sur							
!	responsible for mainta	ining records or the ent and submitting reports	1 1			i ·		
İ		required. Recordkeeping						·]
I	includes the following:	•			1			
	a. Monthly inspection r				!]
	equipment.	•		i				1
	b. Work order reports.							
ĺ	c. Maintenance Repair			:	1			
	d. List of Repairman to	make repairs on		:				
	equipment,				İ			1 1
		rantees of supplies and		i				ļ !
	equipment."		!	ı				<u> </u>

		WEDICAID OF WOLG			OIMD I	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7 1 1	E CONSTRUCTION 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		05A360	B. WING		1:	2/05/2024
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	:
		_		3938 COGSWELL ROAD		:
PENN MAI	R HEALTHCARE CENTE	K		EL MONTE, CA 91732		
(X4) iD PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(XS) COMPLETIO DATE
K 346 SS=F	Fire Alarm System - C CFR(s): NFPA 101	Out of Service	К 346	What conjective ac		
İ	Fire Alarm - Out of Se	ervice	1 1	found to have been		
	Where required fire a					
	•	4 hours in a 24-hour	.]	by the deficient pra	cuce.	1:
		aving jurisdiction shall be		The facility determin	ed that	
		ing shall be evacuated or an		no residents were	1	
		hali be provided for all		directly adversely af	fected by	
		d by the shutdown until the		the deficient practice		:
ļ	-	been returned to service.		However, all residen	· ·	
i	9.6.1.6	!		potential to be adver		:
	_	is not met as evidenced		the deficient practice		1
	by:	nd record review, the facility		" I TO GOLICIO I I I I I I I I I I I I I I I I I I	' 1	
		ility's fire watch policy (a		The administrator no	tified the	
		person or persons assigned		department on Dec 9	^{ph} of the	
	to an area for the pur	oose of notifying the fire		replacement taking p	place that	· :
	department, the buildi	ng occupants, or both of an g a fire from occurring;		day to ensure the fire		
ĺ	extinguishing small fir			How will we identify	other residents	
		similar emergencies in the		having the potential	to be affected	
}		etic sprinkler system and/or		by the deficient pred	tice	1.
	fire alarm system) by having jurisdiction (Al-	not notifying the authority 1J, the local health facilities		and what corrective	actions were taken	,
İ		ice) of the fire watch in		The facility determine		
I		A 101, 2012 Edition, Section		residents were direct	ly adversely	:
		Standard for the Inspection,		affected by the deficie	ent practice.	
		ince of Water-Based Fire 2011 Edition, Section 15.5.2.		However, all resident	s had the potential	1
	This failure resulted in			to be adversely affect	ed by the	
		(the local health facilities		deficient practice.	1 :	
		ice), affecting the safety of		i I		
	46 of 46 residents, sta				2.4	
				·· ,	· ·	1:
	Findings:			1.1	[]	
1						1:
	During a review of the	facility's "Fire Watch Log",				
-	dated from 10/18/202	4 to 12/5/2024, the log	[
i	indicated that the facil	ity initiated their fire watch				

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDII	E .	CONSTRUCT		OMB (X3) D.	TED: 12/20/20/20/20/20/20/20/20/20/20/20/20/20
NAME OF P	ROVIDER OR SUPPLIER		 1			li	SS, CITY, STATE, ZIP CODE		12/05/2024
PENN MA	R HEALTHCARE CENTE	R			1	938 COGSWE MONTE, C			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PR	D EFIX AG			PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROPR DEFICIENCY)	91≘ [i	(X5) COMPLETION DATE
K 346	procedures on 10/18/2 During an interview or with the ADM, the ADI notified the local healt division office that the The ADM stated that the working for a little ove During a review of the procedures titled, "Fire indicated, in the event designated staff membra. Notifying the local fifacilities inspection div of the Facility of the incestimated time of reparation with the state of the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the state of the ADI notificated in the	2024. In 12/5/2024 at 10:45 a.m. If stated that he had not he facilities inspection facility was on Fire Watch. The fire panel was not rear a month. If acility's policy and the watch, "dated 10/1/2023, of a fire watch, "The over will be responsible for: re department, local health islon office, and occupants operable systems (s), the irr, and an additional system (s) are repaired."				isystematic ensure that not re-occular the administration of Clinical State need to on unusual reviewed the fire alarm How does its perform solutions. The facility takin place monthly Quall incident reported and the second of	Inservice by the VP ervices on 12/24/24 on report to the department occurrences. The administrate p&p for fore watch, and goi inform the department when inoperative for more than 4 the facility plan to monitor mance to ensure that the are sustained. Will review all incidents in the fac facility during the meetings to ensure that sneeding to be reported wer to that the facility is in complete. Date: 12/30/2024 Admin	in to the state of	Feet Page 5 of 5

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		05A380	B. WING			12/	05/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 038 COGSWELL ROAD		
PENN MA	R HEALTHCARE CENTE	R	EL MONTE, CA 91732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENT:FYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRU DEFICIENCY)		(X5) COMPLETION DATE
E 030	Continued From page		E	030	Howwill we identify other		
	§485.625(c)] The con include all of the follow	nmunication plan must			residents having the potential to be effected by the	į	
	(1) Names and contact following:				deficient practice and what corrective actions		
		services under arrangement.			were taken		
	(⊞) Patients' physiciai (iv) Other [hospitais a				The facility determined that no residents were		
	(v) Volunteers.	N=404 N175			directly adversely affected by the deficient		
	*[For RNHCls at §403 communication plan r				practice. However, all residents had the potential		
	following: (1) Names and contact following:	ct information for the			to be adversely affected by the deficient practice.		
		services under arrangement.			What measures will be put in place in a systematic change		
	(iii) Next of kin, guard (iv) Other RNHCls. (v) Volunteers.	ian, or custocian.			will be made to ensure that the deficient practice does		
	, •	5(c):] The communication			not re-occur.		
	plan must include all (1) Names and contact following:	of the following:			The administrator will review the list of department heads and replace as needed at		
	(i) Staff.	services under arrangement. ns.			our monthly QA meetings.	•	
	*[Fo: Hospices at §41 communication plan r following: (1) Names and contact following: (i) Hospice employee	nust include all of the					
1 1			1	1		1	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		05A360	B. WING			12	2/05/2024
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 3938 COGSWELL ROAD EL MONTE, CA 91732			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
€ 030	(iii) Patients' physici (iv) Other hospices. *[For HHAs at §484 plan must include a (1) Names and conf following: (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Volunteers. *[For OPOs at §486 plan must include a (2) Names and conf following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPCs. (v) Transplant and of Donation Service A This RECUIREMEN by: Sased on intervew falled to maintain at information within ti preparedness compractice could delay provision of care in This deficiency has affect 45 out of 45 if Findings: During an interview with the Administra	g services under arrangement. ans. .102(c):) The communication ii of the following: tact information for the g services under arrangement. ians. 6.360(c):) The communication II of the following: tact information for the g services under arrangement. donor hospitals in the OPO's	E	030	How does the fecility plan to monitits performance to ensure that the solutions are sustained. The VP of Clinical Services will review and approve the EOP's list of staff quarterly. Compliance date: 12/30/2024	or.	

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		95A360	B. WING_		12/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		_	ţ	3938 COGSWELL ROAD		
PENN MA	R HEALTHCARE CENTE	*	Í	EL MONTE, CA 91732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL MOTAMMORNI DNIYTITHED SC	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
	on 12/5/2024 at 2 p.m Emergency Operation Manual (EOP), undate facility's most recently Preparedness Programot include the curren names and phone nurthe list of current staff updated on the EOP. EP Testing Requireme CFR(s): 483.73(d)(2) §416.54(d)(2), §448.1 §460.64(d)(2), §482.1 §483.475(d)(2), §484.1 §485.542(d)(2), §485.3485.920(d)(2), §491. *[For ASCs at §416.54 at §485.727, CMHCs at §495.727, CMHCs at §491.12, and ESRD F (2) Testing. The [facility to test the emergency must do ail of the folio (i) Participate in a full-community-bused eve (A) When a communicaccessible, conduct a exercise every 2 years (B) If the [facility]	ested. Interview and record review In with the ADM, the Is Program and Plan Index was provided as the Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Emergency Impediated Impediate	E 03	What corrective action will be accomplished for the residents found to have been affected by the deficient practice. The facility determined that no resider directly adversely affected by the deficient practice. However, all residents had to be adversely affected by the deficient of the facility will conducted full-scale earthquake exercise for all dept heads on 12/30/20205.	cient ne potential nt practice. e scenario, having the ient practice ken ial ent practice. in a	
	exercise every 2 years (B) If the [facility] natural or man-made e	; or		facility remains in		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		• •	PLE CONSTRUCTION IG		E SURVEY PLETED	
		05A360	B. WING_		12	2/05/2024
	ROV:DER OR SUPPLIER R HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE, ZIP COL 3938 COGSWELL ROAD EL MONTE, CA 91732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECT:VE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 039	exempt from engaging community-based or if functional exercise for actual event. (ii) Conduct an addition years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the years, opposite the follow (A) A second full-scale community-based or if functional exercise; or (B) A mock disaster d (C) A tabletop exercise a facilitator and include a narrated, clinically-rescenario, and a set of directed messages, or designed to challenge (iii) Analyze the [facilit maintain documentative exercises, and emergifacility's] emergency (For Hospices at 418 (2) Testing for hospic patient's home. The hexercises to test the eannually. The hospice structurally based eve (A) When a community based eve (B) If the hospice experimen-made emergency	g in its next required ndividual, facility-based lowing the onset of the small exercise at least every 2 part the full-scale or der paragraph (d)(2)(i) of sed, that may include, but is swing: a exercise that is ndividual, facility-based of the exercise that is ndividual, facility-based of the exercise that is led by ses a group discussion using plevant emergency problem statements, an emergency plan. The exercise that is the property events, and revise the plan, as needed. 113(d): as that provide care in the exercise must do the following: ascale exercise that is ry 2 years; or y based exercise is not in individual facility based exy 2 years; or y that requires activation of the hospital is exempt from	EO	How does the facility plan to monits performance to ensure that the solutions are sustained. The VP of Clinical Services will quarterly review all of the facility safety exercises conducted the previous ensure that the facility remines in Compliance date: 12/30/2024 David Slavin, Administrator Date: 12/31/2024	's ious quarter	•

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(3) DATE SURVEY COMPLETED
		05A360	B. WING_			12/05/2024
j	ROVIDER OR SUPPLIER R HEALTHCARE CENTS	R		STREET ADDRESS, CITY, STATE, Zii 3938 COGSWELL ROAD EL MONTE, CA 91732	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
€ 039	community-based exe facility-based function onset of the emergence (ii) Conduct an addition opposite the year the exercise under paragis conducted, that may to the following: (A) A second full-scal community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise a facilitator and Include a narrated, clinicality-in scenario, and a set of directed messages, or designed to challenge (3) Testing for hospice care directly. The hospice must be community-based; of (A) When a community accessible, conduct at facility-based functions (B) If the hospice experimental emergency plan, the emergency plan, the emergency plan, the conduct an additional include, but is not (A) A second full-scal	ercise or individual sal exercise following the cy event. onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section by include, but is not limited as exercise that is a facility based functional drill; or see or workshop that is led by les a group discussion using elevant emergency problem statements, an emergency plan. The sthat provide inpatient spice must conduct emergency plan twice per ust do the following: Include full-scale exercise that for exercise; or eriences a natural or or that requires activation of the hospice is exempt from equired full-scale community if functional exercise that the immunity is functional exercise that the immunity is functional exercise that the immunity is functional exercise that the immunity of the following:	EC	039		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		05A36 0	B. WING		12/05/2024	
	PROVIDER OR SUPPLIER AR HEALTH CARE CENT	rek	STREET ADDRESS, CITY, STATE, ZIP CODE 3938 COGSWELL ROAD EL MONTE, CA 91732			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
E 039	exercise; or (B) A mock disaste (C) A tabletop exerticalitator that include narrated, clinically-rand a set of problem messages, or preparent challenge an emerging (iii) Analyze the host maintain documents exercises, and emercises, and emercises, and emercises, and emercises, and emercises, and emercises are serviced; and exercises to the service per year. The dothe following: (i) Participate in an is community-based (A) When a community-based (A) When a community-based function (B) if the [PRTF, Host actual natural or man requires activation of facility] is exempt for required full-scale of facility-based functions of the emergence (ii) Conduct an and that may include following: (A) A second full-scale (C)	r drill; or clse or workshop led by a les a group discussion using a elevant emergency scenario, in statements, directed red questions designed to ency pian. Spice's response to and stich of all drills, tabletop regncy events and revise the ty plan, as needed. 1.184(d), Hospitals at the \$485.625(d):] TF, Hospital, CAH; must be test the emergency plan [PRTF, Hospital, CAH] must cannual full-scale exercise that the emergency plan and exercise; or spital, CAH; experiences an emade emergency plan, the own engaging in its next the emergency plan, the own engaging in its next emmunity based or individual, nai exercise following the ency event. [additional] annual exercise or to, but is not limited to the laie exercise that is individual, a facility-based	E 039		the state of the s	

PRINTED: 12/20/2024

OMB NO. 0938-0391

FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER.CLIA SEBIMUN NOITACITITATION PROVIDER:	(X2) MUL A. BUILDI		LE CONSTRUCTION		E SURVEY IPLETED
		05A360	B. WING			12	2/05/2024
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		
					3938 COGSWELL ROAD		
PENN MA	R HEALTHCARE CENTE	R			EL MONTE, CA 91732		
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	(B) A mock of (C) A tabletop exited by a facilitator and discussion, using a natemergency scenario, statements, directed in questions designed to plan. (III) Analyze the [filmaintain documentatic exercises, and emergifacility's] emergency [facility's]	disaster drill; or percise or workshop that is includes a group percent of the problem and a set of problem persages, or prepared challenge an emergency acility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. ((c):] corganization must conduct mergency plan at least reganization must do the innual full-scale exercise that or y-based exercise is not a annual individual, all exercise: or ences an actual natural or that requires activation of the PACE is exempt from quired full-scale community	E	3038	9		The state of the s
į	(A) A second full-scale community-based or in functional exercise; or	e exercise that is idividual, a facility based					

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		05A360	B, WING		1:	12/05/2024	
NAME OF PROVIDER OR SUPPLIER PENN MAR HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3938 COGSWELL ROAD EL MONTE, CA 91732			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
€ 039	SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		, c			The state of the s	

		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		05A360	B. WING			12	2/05/2024
NAME OF PROVIDER OR SUPPLIER PENN MAR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3938 COGSWELL ROAD EL MONTE, CA 91732				
(X4', ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	narrated, clinically-reand a set of problem messages, or prepare challenge an emerge (iii) Analyze the [LT and maintain docum exercises, and emergence [LTC facility] facility's "[For ICF/IIDs at §48 (2) Testing. The ICF to test the emergence The ICF/IID must do (i) Participate in an a is community-based (A) When a community-based function (B) If the ICF/IID examan-made emergency plantengaging in its next community-based or functional exercise from the emergency event. (ii) Conduct an addit may include, but is in (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exercise facilitator and including a narrater, clinical exercise; (B) A mock disaster (C) A tabletop exercise facilitator and including a narrater, clinical exercises, and a set of directed messages, designed to challenge	elevant emergency scenario, in statements, directed red questions designed to ency plan. C facility] facility's response to tentation of all drills, tabletop gency events, and revise the semergency plan, as needed. 33.475(d): //ID must conduct exercises by plan at least twice per year. If the following: annual full-scale exercise that an annual individual, and exercise; or, periences an actual natural or by that requires activation of a the ICF/ID is exempt from required full-scale individual, facility-based plowing the enset of the ional annual exercise that not limited to the following: an individual, facility-based produced full-scale individual, facility-based plowing the conset of the ional annual exercise that is an individual, facility-based produced full-scale individual, facility-based produced full-scale individual, facility-based produced full-scale exercise that is an individual, facility-based produced full-scale exercise that is an individual, facility-based produced full-scale exercise that is an individual, facility-based produced full-scale exercise that is an individual, facility-based produced full-scale exercise that is	E	039			

STATEMENT OF DEFICITIONS AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		05A30J	8. WING		12/05/2024	
NAME OF PROVIDER OR SUPPLIER PENN MAR HEALTHCARE CENTER			393	REET ADDRESS, CITY, STATE, ZIP CODE 18 COGSWELL ROAD MONTE, CA 91732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DE COMPLETION	
E 039	maintain documentati exercises, and emerging in the control of the	ion of all drills, tableton lency events, and revise the plan, as needed. C21 HA must conduct exercises oplan at HA must do the following: scale exercise that is	E 039			
	cr. (B) If the HHA export man-made emerge of the emergency plarengaging in its next recommunity-based or if functional exercise for emergency event. (ii) Conduct an addition opposite the year the exercise under paragris conducted, that illustrated to the following (A) A second full-community-based or a functional exercise; or (B) A mock disastic) (C) A tabletop exceed by a facilitator and discussion, using a nate mergency scenario, a statements, directed in questions designed to plan.	czi exercise every 2 years: speriences an actual natural ncy that requires activation n, the HHA is exempt from equired full-scale individual, facility based lowing the onset of the smal exercise every 2 years, full-scale or functional eaph (d)(2)(i) of this section may include, but is not is scale exercise that is an individual, facility-based fier drill; or ercise or workshop that is includes a group irrated, clinically-relevant			A SAN A SAN ASAN AND A COMPANY AND AND AND AND AND AND AND AND AND AND	

PRINTED: 12/20/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 05A369 B WING 12/05/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3938 COGSWELL ROAD PENN MAR HEALTHCARE CENTER EL MONTE, CA 91732 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY E 039 | Continued From page 11 E 039 documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from: engaging in its next required testing exercise following the enset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCi must conduct exercises to test the entergency plan. The RNHC! must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCl's response to and

maintain documentation of all tabletop exercises,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		05A360	B. WING			12/05/2024	
NAME OF PROVIDER OR SUPPLIER PENN MAR HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3938 COGSWELL ROAD EL MONTE, CA 91732				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
E 039	emergency plan, as rathis REQUIREMENT by: Based on interview a failed to test its emergency passed extractional exercise, of experiences an actual emergency that requiremergency plan) with deficient practice has be prepared during a the activation of the enegatively affect the last test and secondary exercise. During an interview of with the ADM, a requirements and secondary exercise the last test and secondary exercise. During a concurrent on 12/5/2024 at 2:30 Emergency Operation Manual (EOP), under facility's most recent Preparedness Progrand include records of participation in a full-after-action report fro occurred within the last stated that the facility is stated that the facility is stated that the facility is most recent in the facility occurred within the last stated that the facility is most recent in the facility occurred within the last stated that the facility is most recent in the facility occurred within the last stated that the facility is most recent in the facility occurred within the last stated that the facility is most recent in the facility occurred within the last stated that the facility is most recent in the facility occurred within the last stated that the facility is most recent in the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility occurred within the last stated that the facility oc	ts, and revise the RNHCl's seeded. The is not met as evidenced and record review, the facility gency plan by not be exercise (a sercise, facility-based or if the LTC facility at natural or man-made of the last 12 months. This is the potential for staff to not an emergency plan which could be mealth and safety of 45 out of in the facility. The facility written nergency preparedness of the facility's written nergency preparedness of the both full scale exercise is exact made. Interview and record review p.m. with the ADM, the ns Program and Plan ted, was provided as the yupdated Emergency are record. The binder did of written evidence of	E	039			