STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A134	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (PP) titled, Q:15 (every 15) Minute Monitoring, and provide supervision every 15 minutes per the physician's order to prevent elopement (leaving the facility without notice) from the locked (equipped with secured locks or other functioning security devices) facility for one of four sampled residents (Resident 1) who was assessed as at risk for elopement by failing to: 1. Ensure Certified Nurse Assistant (CNA) 1 and CNA 2 monitored and kept Resident 1 in a clear and direct line of sight (within someone's view) every 15 minutes. 2. Ensure CNA 1 and CNA 2 accurately monitored and documented Resident 1's whereabouts every 15 minutes. As a result of these failures, on 5/19/2024 at 10:15 am, Resident 1 entered the facility's unlocked Recreation Room without CNA 1 and CNA 2's supervision. On 5/19/2024 at 10:32 am, Resident 1 eloped from the facility through the patio from the Recreation Room. Resident 1 stacked chairs on top of a table in the patio, climbed onto the facility roof, walked to the southwest corner of the front of the facility building, climbed down using facility fencing, and walked southbound on the street and away from the facility. Resident 1 had not been found. These failures had the potential to put Resident 1 at risk for serious injury, harm, and/or death due to not receiving psychotropic medications (any drug that affected brain activities associated with mental processes and behavior), not having food and shelter, and being exposed to cold weather at night. On 5/21/2024 at 5:10 pm, while onsite at the facility, the surveyor identified an Immediate Jeopardy situation (IJ- a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The surveyor called an IJ in the presence of the Administrator (ADM), Director of Nursing (DON), Quality Assurance Nurse (QAN), Director of Staff Development (DSD), Medical Records Director (MRD), and the facility's [NAME] President (VPL) due to the facility's failure to monitor and supervise Resident 1, under 42 Code of Federal Regulations Section 483.25(d) Accidents, including providing adequate (acceptable in quality or quantity) supervision to prevent accidents to Resident 1 who was at risk for elopement, and was on every 15-minute monitoring by CNA 1 and CNA 2. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/22/2024 at 4:54 pm, the facility submitted an acceptable Plan of Action (POA- a list of steps taken to correct the deficient practices). While onsite at the facility, the surveyor verified the facility installed a new lock on the Recreation Room's door, other residents do not have access to the Recreation Room and confirmed the facility's implementations of the POA through observation, interview, and record review. The surveyor determined an IJ situation was no longer present and removed the IJ while onsite at the facility on 5/22/2024 at 5:06 pm, in the presence of the ADM, DON, QAN, DSD, and MRD. The IJ removal plan, dated 5/22/2024 included the following: 1. The facility made every effort to locate Resident 1 in the community by doing the following: a. CNA 2, Mental Health Aide (MHA) 1, and CNA 6 completed a 1-mile parameter search around the facility. b. Licensed Psychiatric Technician (LPT) 1 conducted a search of the roof to determine if Resident 1 had injured himself or was unable to get off roof. c. LPT 1 and LPT 2 contacted Local Police Department and filed a missing person's report. d. The DON called local hospitals daily and asked if Resident 1 had been admitted . e. The QAN and Social Services Designee (SSD) updated County Public Guardian (an individual or entity appointed by the court to make decisions with respect to the personal affairs of an individual) daily and inquired if the County Public Guardian had any new information regarding Resident 1. 2. The facility would provide an environment, safe from hazards and bodily injury to Resident 1 once found. Staff (assigned staff) would supervise Resident 1 every 15 minutes for safety. Staff must visually see Resident 1 upon these checks. The facility ' s updated PP titled, Q:15Minute Monitoring, on 5/22/2024 to reflect the following changes: a. Facility staff (assigned staff) must have a clear line of sight of Resident 1. b. Facility staff must visually identify Resident 1. c. If facility staff exercised the use of a Walkie Talkie device (a small radio held in the hand, used for both sending and receiving messages) to locate Resident 1's whereabout, the staff who visually saw Resident 1 must document Resident 1's location in Resident 1's electronic clinical record under the Plan of Care (POC) portal. d. In documenting Resident 1's location in Resident 1's electronic clinical record, staff were to make an honest and accurate entry that staff visually saw and identified Resident 1. 3. All 95 Residents admitted to the facility would be safe in the environment and safe from hazards and bodily injury. Facility staff would supervise all residents on an hourly basis unless otherwise noted, every 15 minutes for safety. Staff must visually see the residents upon these checks. As per the facility ' s PP titled, Q:15 Minute Monitoring, updated on 05/22/2024, staff assigned to conduct the Q:15-minute checks would do the following: (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Facility staff must have a clear line of sight of the residents. b. Facility staff must visually identify the residents. c. If facility staff exercised the use of a Walkie Talkie device to locate the residents, the staff who visually saw the residents must document the residents' location in the residents' electronic clinical record under the POC portal. d. In documenting the resident's location in the resident's electronic clinical record under the POC portal, staff were to make an honest and accurate entry that staff visually saw and identified the residents. 4. To prevent future incidents of elopement of this likeness, the facility implemented the following: a. On 5/20/2024, the Maintenance Staff (MS) installed a self-locking door hardware on the Recreation Room door. b. On 5/20/2024, facility staff replaced white plastic chairs in the Recreation Room with plastic back and seat. c. ON 5/20/2024, the two staff (CNA 1 and CNA 2) responsible for failing to follow resident care documentation for the Q:15-minute check for Resident 1 were suspended. c1. CNA 1 was terminated on 05/22/2024. Report to the CNA Certification Board to follow. c2. CNA 2 will be terminated on 05/23/2024. Report to the CNA Certification Board to follow. d. On 5/21/2024, the MS had a consultation to have motion sensor cameras installed on the patio to detect any motion. e. On 5/21/2024 and 5/22/2024, all staff (85 staff) were in-serviced on safety and Q:15-minute supervision requirements. f. On 5/22/2024, the MS checked all doors in the facility for self-locking door hardware and replaced any non-self-locking door hardware with self-locking door hardware. This check included the following with the following interventions: f1. On 5/22/2024, the MS replaced the traditional locking doorknob on the roof access with a self-locking doorknob. f2. On 5/22/2024, the MS removed the traditional locking doorknob from the Recreation Room Sliding Door and installed a case lock (a device that kept the door locked and secured). f3. On 5/22/2024, the MS removed the traditional doorknob from the Dining Room and installed a self-locking doorknob. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f4. On 5/22/2024, the MS removed the traditional doorknob from the Patio Access Door on [NAME] Unit and installed a self-locking doorknob. g. As of 05/22/2024, all staff would be required to unlock with key to exit onto the patio. h. As of 05/22/2024, all doors in the facility would be required to have a key to unlock for entry. 5. On 5/22/2024, the DSD carried out safety and Q:15-minute supervision in-service training to all staff. The DSD would conduct a safety and Q:15-minute supervision in-service training to all staff annually and upon hire. 6. On 5/22/2024, the Administrator carried out safety and Q:15-minute supervision in-service training to all social services staff (12 staff). Staff that were not able to attend the safety and Q:15-minute supervision in-service training due to being out on leave or being ill, would be in-serviced promptly upon return to work. 7. The QAN to review Q:15-minute documentation for accuracy. The Quality Assessment and Assurance (QAA- a continuous process based on identifying quality problems assessment of data collection and analysis) Committee to review compliance at Quarterly (every 3 months) QAA meeting. Cross Reference F842 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 to the facility on [DATE], with diagnoses that included schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), anxiety disorder (persistent feeling of dread or panic that can interfere with daily life), and major depressive disorder (common and serious illness that negatively affects how one feels, thinks and acts). During a review of Resident 1's Elopement Risk Assessment (ERA), dated 10/26/2023, the ERA indicated Resident 1 had a history of elopement from previous placements. The ERA indicated Resident 1 believed he did not need treatment for mental illness and shelter as he had been living in the streets. The ERA indicated staff were aware of Resident 1's wander (to move around or go to different places without having a particular purpose or direction) risk. During a review of Resident 1's untitled care plan (CP), initiated on 10/26/2023, the CP indicated Resident 1 had poor impulse control due to absent without official leave (AWOL- also known as elopement) related to schizoaffective disorder. The CP indicated Resident 1 had a history of AWOL from prior facilities. The CP indicated Resident 1 had an attempted AWOL on 1/1/2024 and had one AWOL episode on 1/26/2024. The CP interventions included to assist Resident 1 to identify/discuss feeling associated with impulsive behavior. During a review of Resident 1's Physician Order (PO), dated 1/8/2024, the PO indicated an order for staff to monitor Resident 1 Q:15 minutes, every shift related to safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 4/23/2024, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, remember, and reason). The MDS indicated Resident 1 was independent (no help or staff oversight at any time) with eating, oral hygiene, toileting hygiene, and walking 10 to 150 feet (ft- unit of measurement). The MDS indicated Resident 1 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity and may be provided throughout the activity or intermittently) with personal hygiene. During a concurrent interview and record review on 5/21/2024 at 10:42 am with the ADM, Resident 1's Location Monitoring Follow Up Question Report (LM Report) dated 5/19/2024 was reviewed. The ADM stated CNA 2 was the primary CNA assigned to monitor Resident 1 every 15 minutes on 5/19/2024. The ADM stated CNA 1 documented on the LM Report that Resident 1 was in Resident 1's room on 5/19/2024 at 10 am. The ADM stated CNA 1 documented on the LM Report that Resident 1 was in the hallway from 10:15 am to 10:30 am. The ADM stated CNA 2 documented on the LM Report that Resident 1 was in the hallway from 11:15 am to 11:45 am. The ADM stated facility staff (CNA 1 and/or CNA 2) did not document Resident 1's whereabouts at 10:45 am and 11 am. The ADM stated per the facility's investigation, Resident 1 entered the facility's Recreation Room at 10:15 am because the Recreation Room door was left unlocked. The ADM stated the Recreation Room's door opened to the patio. The ADM stated residents (all residents) were not allowed to be on the patio without staff supervision. The ADM stated Resident 1 was left unsupervised in the Recreation Room and on the patio (on 5/19/2024) from 10:15 am to 10:32 am. The ADM stated Resident 1 climbed onto the facility's roof from the patio and eloped from the facility. The ADM stated facility staff (CNA 1 and CNA 2) did not realize Resident 1 was missing until after lunch (1 pm), even though CNA 1 and CNA 2 were documenting Resident 1's whereabouts between 10:15 am to 11:45 pm. During a concurrent review of the facility's video surveillance and interview on 5/21/2024 at 11:57 am with the Program Director of Special Treatment Program (PD), the surveyor reviewed the facility's video surveillance, dated 5/19/2024 with the PD. The PD stated, the facility's video surveillance dated 5/19/2024, at 10:10:00 am, Resident 1 was in the hallway, standing adjacent to the facility's Beauty Parlor. The PD stated there were no staff visible in the (video surveillance's) frame. The PD stated at 10:15:22 am, Resident 1 was standing in the hallway across from the Recreation Room. The PD stated no staff were visible in the frame. The PD stated at 10:15:56 am, Resident 1 entered the Recreation Room. The PD stated at 10:30:32 am, Resident 1 climbed onto the roof from the patio using 5 stacked plastic chairs and plastic folding table that Resident 1 obtained from the Recreation Room and placed on the patio. The PD stated at 10:32:36 am, the video surveillance showed Resident 1 was outside of the facility fencing, walking south bound on the street and away from the facility. The PD stated no staff were visible in the frame. The PD stated there were no staff present to monitor and supervise Resident 1 while Resident 1 was in the Recreation Room and the patio. The PD stated the Recreation Room was supposed to remain locked for residents' safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 5/21/2024 at 1:28 pm with CNA 1, CNA 1 stated (in general) when a resident was on Q 15-minute monitoring, CNA 1 was supposed to supervise a resident by checking on him/her. CNA 1 stated (on 5/19/2024) CNA 1 went on break from 10:20 am to 10:30 am. CNA 1 stated CNA 1 documented Resident 1's whereabouts (at 10 am, 10:15 am and 10:30 am) without knowing Resident 1's accurate location because no other staff had documented in Resident 1's record. CNA 1 stated CNA 1 documented the whereabouts of Resident 1 because CNA 1 wanted to ensure the charting (medical record) was complete. CNA 1 stated CNA 1 changed the documentation to indicate Resident 1 was AWOL once facility staff realized Resident 1 was missing after lunch time. CNA 1 stated it was important to know Resident 1's whereabouts and accurate location for Resident 1's safety. CNA 1 stated when CNA 1 documented she knew Resident 1's location even though she did not, Resident 1 could get hurt. During a telephone interview on 5/21/2024 at 1:37 pm with CNA 2, CNA 2 stated CNA 2 was the primary CNA assigned to Resident 1 on 5/19/2024. CNA 2 stated Resident 1 was supposed to be monitored every 15 minutes to ensure Resident 1's safety. CNA 2 stated CNA 2 documented Resident 1's whereabouts as being in the hallway at 11:15 am, 11:30 am, and 11:45 am on 5/19/2024 even though CNA 2 did not know Resident 1's accurate location. CNA 2 stated because CNA 2 did not monitor Resident 1's accurate whereabouts as directed; Resident 1 was able to elope from the facility. CNA 2 stated Resident 1 could get really hurt and have an accident being out on the streets. During an interview on 5/21/2024 at 4 pm with the DSD, the DSD stated staff (CNA 1 and CNA 2) completing the Q 15-minute monitoring of Resident 1 must locate and visualize Resident 1's actual whereabouts every 15 minutes for Resident 1's safety. The DSD stated staff blindly documenting Resident 1's whereabouts when Resident 1's actual whereabouts were not visualized put Resident 1 at risk for elopement and serious injury, or even death. The DSD stated Resident 1 should not be out in the community unsupervised because Resident 1 had moderately impaired cognition and Resident 1 was a danger to himself and others. During a concurrent interview and record review on 5/21/2024 at 4:29 pm with the DON, Resident 1's Elopement Risk Assessment (ERA) dated 10/26/2023 was reviewed. The DON stated Resident 1 was at risk for elopement. The DON stated Resident 1 was on monitoring for poor impulse control and for AWOL/elopement risk because Resident 1 had attempted to leave the facility in the past (1/1/2024 and 1/26/2024). The DON stated the facility's protocol for Q 15-minute monitoring was to check a resident's (Resident 1's) location every 15 minutes. The DON stated that (Q 15-minute monitoring) meant staff needed to visualize Resident 1 every 15 minutes and document Resident 1's accurate location. The DON stated the staff (CNA 1 or CNA 2) who visualized Resident 1 was supposed to document Resident 1's location to ensure Resident 1's location was accurate, and that Resident 1 was being appropriately monitored and supervised. The DON stated (in general) when a resident was not appropriately monitored or supervised like Resident 1, then like Resident 1, that resident could also leave the facility without staff knowing. The DON stated because Resident 1 eloped from the facility, Resident 1 was a danger to himself and others. The DON stated CNA 1 and CNA 2 falsified Resident 1's Q 15-minute monitoring report by documenting they monitored/supervised and knew Resident 1's whereabouts even though they did not visually see Resident 1's whereabouts. The DON stated this (falsification of record) prevented staff from knowing Resident 1's accurate location and intervening the moment Resident 1 was missing. The DON stated the consequence of CNA 1 and CNA 2 not monitoring Resident 1's whereabouts accurately was that Resident 1 may not be found. The DON stated Resident 1 could become seriously injured or even die. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's PP titled, Q:15 Minute Monitoring, dated 4/2024, the PP indicated the facility provided an atmosphere that was safe and secure for all residents and staff. The PP indicated a tool to assist in providing a safe and secure environment was Q:15-minute checks. The PP indicated the CNA assigned to the resident placed on Q:15-minute checks sought, found, and documented location and condition of the resident every 15 minutes during their shift and must be done in a timely manner. The PP indicated staff who implemented the Q:15-minute checks must maintain a clear and direct line of sight at time of documentation of Q:15-minute checks and document their location.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview, and record review, the facility failed to ensure Certified Nurse Assistant (CNA) 1 and CNA 2 accurately documented the resident's location every 15 minutes for one of four sampled residents (Resident 1). This deficient practice resulted in inconsistencies and inaccurate in Resident 1's medical record. Cross Reference: F689 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 to the facility on [DATE], with diagnoses that included schizoaffective disorder (a mental disorder characterized by abnormal thought processes and an unstable mood), anxiety disorder (persistent feeling of dread or panic that can interfere with daily life), and major depressive disorder (common and serious illness that negatively affects how one feels, thinks and acts). During a review of Resident 1's Physician Order (PO), dated 1/8/2024, the PO indicated an order for staff to monitor Resident 1 Q:15 minutes (every 15 minutes), every shift related to safety. During a review of Resident 1's Minimum Data Set (MDS- a standardized resident assessment and care screening tool), dated 4/23/2024, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, remember, and reason). During a concurrent review of the facility's video surveillance and interview on 5/21/2024 at 11:57 am with the Program Director of Special Treatment Program (PD), the surveyor reviewed the facility ' s video surveillance, dated 5/19/2024 with the PD. The PD stated, the facility's video surveillance dated 5/19/2024, at 10:10:00 am, Resident 1 was in the hallway, standing adjacent to the facility's Beauty Parlor. The PD stated there were no staff visible in the (video surveillance's) frame. The PD stated at 10:15:22 am, Resident 1 was standing in the hallway across from the Recreation Room. The PD stated no staff were visible in the frame. The PD stated at 10:15:56 am, Resident 1 entered the Recreation Room. The PD stated at 10:30:32 am, Resident 1 climbed onto the roof from the patio using 5 stacked plastic chairs and plastic folding table that Resident 1 obtained from the Recreation Room and placed on the patio. The PD stated at 10:32:36 am, the video surveillance showed Resident 1 was outside of the facility fencing, walking south bound on the street and away from the facility. During a telephone interview on 5/21/2024 at 1:28 pm with CNA 1, CNA 1 stated (in general) when a resident was on Q 15-minute monitoring, CNA 1 was supposed to supervise a resident by checking on him/her. CNA 1 stated (on 5/19/2024) CNA 1 went on break from 10:20 am to 10:30 am. CNA 1 stated CNA 1 documented Resident 1's whereabouts (at 10 am, 10:15 am and 10:30 am) without knowing Resident 1's accurate location because no other staff had documented in Resident 1's record. CNA 1 stated CNA 1 documented the whereabouts of Resident 1 because CNA 1 wanted to ensure the charting (medical record) was complete. CNA 1 stated CNA 1 changed the documentation to indicate Resident 1 was AWOL once facility staff realized Resident 1 was missing after lunch time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 5/21/2024 at 1:37 pm with CNA 2, CNA 2 stated CNA 2 was the primary CNA assigned to Resident 1 on 5/19/2024. CNA 2 stated Resident 1 was supposed to be monitored every 15 minutes to ensure Resident 1's safety. CNA 2 stated CNA 2 documented Resident 1's whereabouts as being in the hallway at 11:15 am, 11:30 am, and 11:45 am on 5/19/2024 even though CNA 2 did not know Resident 1's accurate location. During a review of the facility's PP titled, Q:15 Minute Monitoring, dated 4/2024, the PP indicated the CNA assigned to the resident placed on Q:15-minute checks sought, found, and documented location and condition of the resident every 15 minutes during their shift and must be done in a timely manner. The PP indicated staff who implemented the Q:15-minute checks must maintain a clear and direct line of sight at time of documentation of Q:15-minute checks and document their location.