

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 05A134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Landmark Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 44027</p> <p>Based on observation, interview, and record review, the facility failed to protect a residents' right to remain free from physical abuse (willful infliction of injury, deliberate aggressive or violent behavior with the intention to cause harm) for three of eight sampled residents (Residents 1, 3, and 5) by failing to:</p> <p>a. Protect Resident 1 from being pushed by Resident 2. On 5/31/2024, Resident 2 pushed Resident 1 on Resident 1's left arm.</p> <p>b. Protect Resident 3 from being punched by Resident 4. On 6/1/2024, Resident 4 punched Resident 3 on Resident 3's right cheek.</p> <p>c. Protect Resident 5 from being punched by Resident 6. On 6/4/2024, Resident 6 punched Resident 5 repeatedly on Resident 5's face and forehead.</p> <p>This failure had the potential to result in Residents 1, 3, and 5 feeling afraid and not safe while under the care of the facility. Additionally, the failure resulted in bruising, swelling, and pain on Resident 5's forehead.</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a disorder that affects a person's ability to think, feel, and behave clearly), alcohol abuse, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/7/2024, the MDS indicated, Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was independent from staff for dressing, toileting, and eating.</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 - Some</p>	<p>During a review of Resident 1's care plan titled, Potential for Injury r/t [related to] Being Pushed ., initiated 5/31/2024, the care plan indicated on 5/31/2024, Resident 1 was pushed on Resident 1's left arm by a peer [Resident 2].</p> <p>During a review of Resident 1's Progress Notes, dated 5/31/2024, the Progress Notes indicated on 5/11/2024, At approximately 0801 (8:01 AM), the resident [Resident 1] was pushed on the left lower arm by a peer [Resident 2] in the [NAME] Unit hallway outside of room [ROOM NUMBER]. The assault was unprovoked per resident [Resident 1] and staff member (Certified Nursing Assistant [CNA] 1) who observed the incident.</p> <p>During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, hearing loss, and major depressive disorder.</p> <p>During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 was independent from staff for dressing, toileting, and eating.</p> <p>During a review of Resident 2's Progress Notes, dated 5/31/2024, the Progress Notes indicated on 5/31/2024, .at approximately 0801 (8:01 AM), the resident [Resident 2] was observed in the [NAME] Unit hallway near room [ROOM NUMBER] where he [Resident 2] became agitated and pushed peer [Resident 1]. Staff immediately intervened . The Progress Notes indicate, Resident was asked by writer why he [Resident 2] pushed his peer [Resident 1] and he [Resident 2] stated, 'I know he was talking shit about me and he has to know he can't get near me'.</p> <p>During a review of Resident 2's care plan titled, Physically Assaultive Behavior ., initiated 3/28/2024, the care plan indicated on 5/31/2024, Client [Resident 2] physically assaulted male peer by pushing his left lower arm.</p> <p>During an interview on 6/6/2024 at 3:43 PM with Resident 2, Resident 2 stated Resident 2 pushed Resident 1 because Resident 2 got mad. Resident 2 stated Resident 2 thought Resident 1 was making fun of Resident 2.</p> <p>During a telephone interview on 6/6/2024 at 4:20 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated on 5/31/2024, Resident 2 pushed Resident 1 with one hand. CNA 1 stated CNA 1 thought Resident 2 was trying to push Resident 1 away from Resident 2.</p> <p>b. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including psychosis (a mental disorder characterized by a disconnection from reality), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and insomnia (persistent problems falling and staying asleep).</p> <p>During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 had no impairment in cognitive skills. The MDS indicated Resident 3 was independent from staff for dressing, toileting, and eating.</p> <p>During a review of Resident 3's Progress Notes, dated 6/3/2024, the Progress Notes indicated on 6/1/2024, At 1910 (7:10) PM, [Resident 4] reported to staff that she [Resident 4] hit her roommate [Resident 3] .</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 - Some</p>	<p>During a review of Resident 3's care plan titled, Resident to Resident Abuse Victim, initiated 6/1/2024, the care plan indicated on 6/1/2024, Resident 3 was hit by female peer [Resident 4] on Resident 3's left cheek.</p> <p>During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, major depressive disorder, and insomnia.</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4 was moderately impaired in cognitive skills. The MDS indicated Resident 4 was independent from staff for dressing, toileting, and eating.</p> <p>During a review of Resident 4's care plan titled, Resident to Resident Abuser, initiated 6/1/2024, the care plan indicated on 6/1/2024, Resident 4 hit peer [Resident 3] on the cheek and staff (unidentified) on the chest.</p> <p>During an interview on 6/6/2024 at 3:10 PM with Resident 3, Resident 3 stated Resident 4 started going off out of nowhere. Resident 3 stated Resident 4 was blaming Resident 3 for all the bad things that were happening to Resident 4. Resident 3 stated Resident 4 came over to Resident 3's area of the room and pulled Resident 3's curtain open and around Resident 3's bed. Resident 3 stated Resident 4 hit Resident 3 on Resident 3's right cheek under the eye (Resident 3 did not know how or with what Resident 4 hit Resident 3). Resident 3 stated Resident 3 felt Resident 4 hit Resident 3 twice.</p> <p>During an interview on 6/6/2024 at 3:18 PM with Resident 4, Resident 4 stated Resident 4 was upset at Resident 3 because Resident 3 was asking Resident 4 to have Resident 4's shoes. Resident 4 stated Resident 4 wanted a room change. Resident 4 stated she started to yell at Resident 3 and told Resident 3, lets fight. Resident 4 stated Resident 3 did not want to fight. Resident 4 stated Resident 4 pulled Resident 3's curtain open and punched Resident 3 with a closed fist. Resident 4 stated Resident 4 hit Resident 3 with Resident 4's knuckle.</p> <p>c. During a review of Resident 5's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), insomnia, and nicotine dependence.</p> <p>During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had no impairment in cognitive skills. The MDS indicated Resident 5 was independent from staff for dressing, toileting, and eating.</p> <p>During a review of Resident 5's Progress Notes, dated 6/4/2024, the Progress Notes indicated on 6/4/2024, Resident 6 alerted the charge nurse that Resident 6 wanted a room change because Resident 6 beat up his roommate [Resident 5]. The Progress Notes indicated, Resident 5 was then evaluated and was noted with redness and slight swelling on Resident 5's forehead. The Progress Notes indicated, resident 5 stated that his roommate [Resident 6] hit him while in their room at approximately 6:30 AM.</p> <p>During a review of Resident 5's Pain Evaluation, dated 6/4/2024, the Pain Evaluation indicated Resident 5 experienced pain from being punched in the forehead by Resident 6. The Pain Evaluation indicated Resident 5 experienced moderate pain.</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 - Some</p>	<p>During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including paranoid (where a person feels distrustful and suspicious of other people) schizophrenia, major depressive disorder, and hyperlipidemia.</p> <p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated, Resident 6 had no impairment in cognitive skills. The MDS indicated Resident 5 was independent from staff for dressing, toileting, and eating.</p> <p>During a review of Resident 6's care plan titled, Resident to Resident Abuser, initiated 6/4/2024, the care plan indicated on 6/4/2024, Client [Resident 6] stated he [Resident 6] beat up roommate [Resident 5] due to [Resident 5] masturbating.</p> <p>During a review of Resident 6's Progress Notes, dated 6/4/2024, the Progress Notes indicated on 6/4/2024, At approximately 0920 (9:20 AM), the [Resident 6] approached writer at the [NAME] Unit nursing station window and requested a room change. Writer inquired as to the reason the room change was wanted or needed. [Resident 6] replied stating, 'I beat my roommate up this morning in the room.'</p> <p>During an interview on 6/6/2024 at 2:53 PM with Resident 6, Resident 6 stated Resident 6 punched Resident 5 because Resident 6 was pissed that Resident 5 was jacking off. Resident 6 stated he punched Resident 5 twelve times while Resident 5 was lying in Resident 5's bed, Resident 6 stated Resident 6 hitting Resident 5 was not an accident and Resident 6 meant to do it. Resident 6 stated Resident 5 punched Resident 6 a couple times.</p> <p>During a concurrent observation and interview on 6/6/2024 at 3:48 AM with Resident 5, Resident 5 had a nickel sized bruise on Resident 5's forehead. Resident 5 stated Resident 6 punched Resident 5 in Resident 5's face at least seven times. Resident 5 stated the bruise on Resident 5's forehead was from Resident 6's punches. Resident 5 stated Resident 5 experienced 1 out of 10 pain (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt) level because of the punches.</p> <p>During an interview on 6/7/2024 at 11:01 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 assessed Resident 5 after the altercation with Resident 6. LVN 1 stated Resident 5 had some redness and swelling on Resident 5's forehead. The redness and swelling were approximately the size of a quarter.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Elder/Dependent Adult Abuse, revised 1/19/2018, the P&P indicated, This facility will protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition), for whom we provide care and treatment against any and all forms of physical, verbal, sexual, mental abuse, neglect, financial abuse (including misappropriation of property).</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 44027</p> <p>Based on interview and record review, the facility failed to report allegations of abuse for one of four sampled residents (Resident 7) on 2/11/2023 and on 5/8/2023, to the California Department of Public Health (the Department), the Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and to the local law enforcement, within two hours, in accordance with the facility's policy and procedure (P&P), titled Elder/Dependent Adult Abuse, revised 1/19/2018.</p> <p>This failure resulted in the delay of notification to the Department and had the potential for Resident 7 to be subjected to further abuse.</p> <p>Findings:</p> <p>During a review of Resident 7's Admission Record (AR), the AR indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses including paranoid (where a person feels distrustful and suspicious of other people) schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and breast cancer. The AR indicated Resident 7 was discharged from the facility on 8/22/2023.</p> <p>During a review of Resident 7's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/22/2023, the MDS indicated, Resident 7 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated Resident 7 was independent from staff for dressing, toileting, and personal hygiene.</p> <p>During a review of Resident 7's Progress Notes, dated 6/6/2024, the Progress Notes indicated on 2/11/2023 and 5/8/2023, Resident 7 made allegations of Resident 7 experiencing sexual abuse while at the facility.</p> <p>During an interview on 6/7/2024 at 8:35 AM with the Administrator (ADM), the ADM stated Resident 7 was delusional. The ADM stated Resident 7's allegations of rape were a fixed delusion. The ADM stated Resident 7 alleged on 2/11/2023 that Resident 7 was sexually abused. The ADM stated on 5/8/2023, Resident 7 alleged she was raped. The ADM stated the ADM did not report the two allegations of sexual abuse reported by Resident 7 because the ADM was certain the allegations were delusions. The ADM stated the ADM should have reported the allegations to the department [to follow what was indicated in] the facility's P&P. The ADM stated the P&P indicated to report all allegations of abuse.</p> <p>During a review of the facility's P&P titled, Elder/Dependent Adult Abuse, revised 1/19/2018, the P&P indicated, This facility will protect the rights, safety and wellbeing of each resident (regardless of physical or mental condition), for whom we provide care and treatment against any and all forms of physical, verbal, sexual, mental abuse, neglect, financial abuse (including misappropriation of property) . The P&P indicated, All alleged violations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, the mandated reporter shall: F609 S483.12(c)</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 - Some</p>	<p>1) Make phone report or phone 911 immediately (no later than two hours) to the local law enforcement and licensing agencies of observing, obtaining knowledge of, or suspecting the physical abuse;</p> <p>2) Fax within two hours written report (SOC 341) to the local ombudsman, licensing agency, and local law enforcement.</p>		