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	08/15/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish) for two of four sampled residents (Residents 1 and 2) by failing to: a. Protect Resident 1 from being pushed by Resident 2. b. Protect Resident 2 from being pushed by Resident 1. As a result, on August 11, 2024, Residents 1 and 2 were involved in an altercation. Resident 2 pushed Resident 1 and Resident 1 pushed Resident 2 back, resulting in both residents falling to the floor. This failure resulted in Resident 1 to experience pain and to sustain an abrasion (a superficial rub or wearing off the skin) to Resident 1's right forearm. This failure resulted in Residents 1 and 2 being subjected to physical abuse while under the care of the facility. Findings: 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), pneumonia (infection that inflames air sacs in one or both lungs), 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). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/3/2024, the MDS indicated, Resident 1 was moderately impaired in cognitive skills (decisions poor; cues/supervision required). The MDS indicated, Resident 1 was independent from staff for dressing, toileting, and eating. (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: 05A134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER Landmark Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes (PN), dated 8/11/2024, timed at 3:45 p.m., the PN indicated on 8/11/2024, at approximately 3:45 p.m., there was commotion noted coming out of (Room A) occupied by (Resident 2) and (Resident 1). The PN indicated, upon entry into the room, both residents were standing on their respective sides of the bed arguing with each other. The PN indicated, Resident 1 stated he was standing next to the closet when Resident 2 became agitated and pushed him without provocation. The PN indicated, staff (unidentified) immediately responded to Room A and found Resident 1 and 2 laying on the floor. The PN indicated, upon inquiry, Resident 1 stated he was just standing there when Resident 2 pushed Resident 1 because he stood his ground and would not move away from the closet. The PN indicated, Resident 1 was noted with an abrasion on the lower side of his right forearm with minor bleeding. During a review of Resident 1's untitled Care Plan (CP), initiated on 8/11/2024, the CC indicated, Resident 1 had potential for injury status post (condition after) unwitnessed fall related to (r/t) an altercation with a male resident (unidentified). During a review of Resident 1's Pain Evaluation (PE), dated 8/11/2024, the PE indicated, Resident 1 experienced pain from altercation with peer and an unwitnessed fall. The PE indicated, Resident 5 experienced mild pain (hurts a little bit- hurts a little bit more) to Resident 1's right forearm abrasion. During a review of Resident 1's untitled CP, initiated on 8/12/2024, the CP indicated, Resident 1 was a victim of resident-to- resident abuse. The CP indicated, on 8/11/2024, Resident 1 was arguing with male peer (Resident 2) and peer (Resident 2) pushed him (Resident 1). During a review of Resident 1's untitled CP, initiated on 8/12/2024, the CP indicated, on 8/11/2024, Resident 1 was arguing with male peer (Resident 2) and pushed him (Resident 2). During a review of Resident 1's PN, dated 8/12/2024, timed at 12:35 p.m., the PN indicated, on 8/12/2024, Registered Nurse (RN) 1 assessed Resident 1's right arm and documented, Noted redness, superficial abrasion to right forearm; measurement of 10 cm (L) x 1 cm (W), no discharge/active bleeding & no swelling at this time. Noted redness with skin intact & no swelling to right elbow. b. 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 (a disorder that affects a person's ability to think, feel, and behave clearly), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), 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). During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2 was moderately impaired in cognitive skills (decisions poor; cues/supervision required). The MDS indicated, Resident 2 was independent from staff for dressing, toileting, and eating. During a review of Resident 2's untitled CP, initiated on 8/12/2024, the CP indicated, Resident 2 with physically assaultive behavior. The CP indicated, on 8/11/2024, Resident 2 argued with, and pushed Resident 1 out of way to get to Resident 2's closet. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's untitled CP, initiated on 8/12/2024, the CP indicated, Resident 2 was a victim of resident-to-resident abuse. The CP indicated, on 8/11/2024, Client (Resident 2) asked peer (Resident 1) to move, peer (Resident 1) refused, client (Resident 1) went to open closet door and peer (Resident 1) pushed client (Resident 2). During a review of Resident 2's untitled CP, initiated on 8/12/2024, the CP indicated on 8/11/2024, Resident 2 pushed male peer (Resident 1) and peer (Resident 1) fell to the ground. During a review of the facility's report, untitled, dated 8/13/2024, the report indicated, on August 11, 2024, Resident 2 and Resident 1 were involved in an altercation. Resident 2 was entering his room and walking in the direction of his closet. Resident 1 was standing in his way and refused to move (according to Resident 2). Resident 2 pushed Resident 1. The report indicated, Resident 1 pushed back and both residents fell to the floor. The report indicated, staff responded after hearing commotion coming from the room and found both residents on the floor. The report indicated, Resident 1 had an abrasion on his right forearm and received first aid for this as there was some bleeding. During an interview on 8/14/2024 at 3:31 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated on 8/11/2024 at 3:45 p.m., CNA 1 heard yelling and immediately went into Room A. CNA 1 stated Resident 1 was lying on the floor between the two beds in the room. CNA 1 stated Resident 1 was sitting on the floor next to the door. CNA 1 stated both Resident 1 and 2 claimed the other resident pushed them. CNA 1 stated Resident 1 had a scratch on Resident 1's right arm. CNA 1 stated Resident 1 had a small amount of blood on Resident 1's right arm. During a concurrent observation and interview on 8/15/2024 at 9:00 a.m. with Resident 1, Resident 1 had some redness on the bottom of Resident 1's right forearm. Resident 1 stated Resident 2 pushed Resident 1 and Resident 1 fell . Resident 1 stated Resident 1 hit his arm on the bed when he fell . During an interview on 8/15/2024 at 9:06 a.m. with Resident 2, Resident 2 stated Resident 2 fell . Resident 2 stated, he pushed me. Resident 2 did not indicate who pushed Resident 2. During a review of the facility's policy and procedure (P&P) titled, Physical Assault, undated, the P&P indicated, (The facility) is to provide a safe and secure environment. The P&P indicated, Some examples of physical assault are but not limited to: punches, kicks, spitting, throwing objects, pushing, grabbing of clothes or person to cause personal harm, etc.