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 08/19/2024
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)
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** 40913 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 1 and Resident 3), were free from abuse (deliberately aggressive or violent behavior with the intention to cause harm) in accordance with the facility's policy and procedure (P&P) titled Physical Assault and the facility's lesson plan titled, Elder and Dependent Adult Abuse, Prevention and Policy when, a. On 8/16/2024, Resident 2 inappropriately touched Resident 1's vaginal area (female private area). b. On 8/16/2024, Resident 4 pushed Resident 3 on the back. This deficient practice resulted in Resident 1 feeling uncomfortable and Resident 3 feeling scared and unsafe at the facility. Additionally, the deficient practice had the potential to result in psychosocial declines to Residents 1 and 3. Findings: a. During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 11/8/2023 with diagnoses that included schizophrenia (a serious mental health condition that affects how people think, feel, and behave) and syphilis (a bacterial infection spread through sexual contact). During a review of Resident 1's Minimum Data Set (MDS - a standardized assessment and care planning tool) dated 8/6/2024, the MDS indicated Resident 1 was cognitively intact and was independent with all activities of daily living. During a review of Resident 2's Progress Notes dated 8/16/2024, timed at 3:59 pm, the progress notes indicated Resident 1 reported Resident 2 touched Resident 1's vaginal area when Resident 1 asked Resident 2 for money. The notes indicated this incident occurred in the hallway in front of Resident 2's room door. The notes indicated Resident 2 answered Yes when asked if Resident 2 touched Resident 1 inappropriately. During a review of Resident 1's Progress Notes, dated 8/16/2024, timed at 4:29 pm, the notes indicated Resident 1 was withdrawn, isolated form others, and lacked motivation to attend groups. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes dated 8/16/2024, timed at 4:56 pm, the progress notes indicated Resident 1 reported Resident 2 touched her private area in front of Resident 2's room. During an interview on 8/17/2024 at 12:13 pm, Resident 1 stated Resident 1 walked toward Resident 2's room who was sitting in front of Resident 2's room door. Resident 1 stated Resident 1 asked Resident 2 for a dollar and Resident 2 touched Resident 1's private area over Resident 1's clothes. Resident 1 stated Resident 1 immediately left and told Resident 2 Resident 1 would report the incident to the counselor. Resident 1 stated the touch made Resident 1 feel uncomfortable. During an interview on 8/17/2024 at 12:35 pm, the Registered Nurse (RN) stated when facility staff heard residents asking for money, staff needed to stop the activity. During an interview on 8/17/2024 at 1:30 pm, Resident 2 stated Resident 2 was sitting outside Resident 2's room when Resident 1 came and stood in front of Resident 2 and Resident 2 reached over and touched Resident 1's crotch. Resident 2 stated Resident 2 reached out and touched Resident 1's private area because the stimuli was there in front of him. During an interview on 8/17/2024 at 3:28 pm with Certified Nursing Assistant 3 (CNA 3). CNA 3 stated staff needed to constantly monitor the residents to ensure the residents maintained a distance of 6 feet from each other. During a review of the facility's Policy and Procedure (P&P) titled Facility Management Abuse Reporting dated 5/9/2018, the P&P indicated sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault. During a review of the facility's in-service lesson plan, dated 6/27/2024, titled, Class Title: Elder and Dependent Adult Abuse, Prevention and Policy, the lesson plan indicated the resident has the right to privacy and dignity; right to his/her care. Abuse is an intentional act, or failure to act, by any care giver or another person in relationship involving an expectation of trust that creates a risk of harm to a person. The in-service indicated sexual abuse as a forced or unwanted sexual interaction (touching or non-touching) of any kind to the residents. 42307 b. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that combines symptoms of schizophrenia, bipolar type (a mental health condition that affects your moods, which can swing from one extreme to another), major depressive disorder (a serious mental disorder that affects how a person feels, thinks, and acts characterized by a depressed mood, loss of interest in activities, causing significant impairment in daily life), recurrent, unspecified and mild intellectual disabilities. During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Resident 3's cognition was moderately impaired. The MDS indicated Resident 3 had behavior of hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality) and Resident 3 was independent with activities of daily living (ADL, term used in healthcare that refers to self-care activities). (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 3's History and Physical (H&P), dated 8/14/2024, timed at 4:08 p.m. the H&P indicated Resident 3 was calm, cooperative, and in no distress. During a review of Resident 3's Progress Notes-Interdisciplinary (IDT, a team of health care professions who work together to establish plans of care for residents) Notes, dated 8/16/2024, timed at 12:05 pm., the IDT indicated, Resident 4 suddenly pushed Resident 3 on the right shoulder in the [NAME] Unit hallway at approximately 11:50 am. During a review of Resident 3's 'Pain Evaluation (PE), dated 8/16/2024, timed at 1:19 pm., the PE indicated Resident 3 was pushed by female peer [Resident 4] on the right shoulder. During a review of Resident 3's Progress Notes (PN), dated 8/16/2024, timed at 2:45 pm., the PN indicated, the Program Counselor (PC) met with Resident 3 to discuss feelings of safety due to an incident that occurred with Resident 4. The PN indicated, Resident 3 stated, Resident 4 pushed Resident 3 and Resident 3 did not feel safe around Resident 4. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, other psychoactive substance (mind-altering drugs) abuse, and insomnia (a common sleep disorder that makes it difficult to fall asleep, stay asleep, or get quality sleep), unspecified. During a review of Resident 4's Care Plan (CP), titled, Physically Assaultive Behavior (Related to Diagnosis of Schizoaffective Disorder, Unspecified), date initiated 3/14/2024, one of the CP's interventions indicated to place Resident 4 on 1:1 (one staff for one resident for a period of time) monitoring for safety. During a review of Resident 4's MDS, dated [DATE], the MDS indicated, Resident 4's cognitive status was intact. The MDS indicated, Resident 4 had a behavior of hallucinations and delusions and was independent with ADLs. During a review of Resident 4's H&P, dated 8/14/2024, timed at 4:41 pm. the H&P indicated, Resident 4 was calm, cooperative, and in no distress. During a review of Resident 4's IDT, dated 8/16/2024, timed at 1:41 pm., the IDT indicated, Resident 4 suddenly pushed Resident 3 on the right shoulder at approximately 11:50 am. During a review of Resident 4's PN, dated 8/16/2024, timed at 2:40 p.m., the PN indicated, the Primary Counselor (PC) met with Resident 4 to discuss Resident 4's behavior due to an incident that occurred with Resident 3. Resident 4 stated, Resident 4 did not even hit her hard, I tapped her. The PN indicated, the PC reminded Resident 4 was not allowed to tap others, as someone could find it as assault, (the act of causing fear of physical harm or unwanted physical contact to another person). During an interview on 8/19/2024 at 1:35 pm. with Resident 3, Resident 3 stated, Resident 4 pushed Resident 3 in the back a couple of days ago, in the Nurse's Station. Resident 3 stated, Resident 3 did not get hurt but almost fell , was scared, and did not feel safe around Resident 4. Resident 3 stated, Resident 3 did not want to be in the same room with Resident 4. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/2024 at 2:16 pm. with Certified Nursing Assistant (CNA), CNA 2 stated, CNA 2 was providing 1:1 monitoring to Resident 4 for suicidal (abstract thoughts about ending your life or feeling that people would be better off without you) reasons. CNA 2 stated, Resident 4 got up from a chair and walked toward the direction of Resident 3 and just out of the blue, just pushed her [Resident 3]. CNA 2 stated, the incident happened right before lunch time while the residents (in general) were hanging out in Area 1 next to the Nurse's Station across from the phone booth and were waiting to be called for lunch. CNA 2 stated, there were no words or gestures exchanged between Resident 3 and Resident 4 prior to the incident. During a concurrent observation and interview on 8/19/2024 at 3:01 pm. with Resident 4, Resident 4 was observed to have a flat affect (severely restricted or nonexistent expression of emotion) and appeared slightly anxious. Resident 4 stated, Resident 4 did not push Resident 3 and Resident 4 only tapped Resident 3's right shoulder. Resident 4 was not cooperative for the rest of the interview and walked out of the interview cussing at the surveyor. During a concurrent record review on 8/19/2024 at 3:53 pm. with the Program Director (PD), the facility's Surveillance Video (SV), of the incident was reviewed. The SV indicated Resident 4 was sitting by herself at the doorway of a room looking out toward the Nursing Station. The SV indicated Resident 3 was standing outside by the Nursing Station's corner. The Nursing Station had multiple staff inside including CNA 2. The SV indicated, Resident 3 and Resident 4 started to exchange words, gestures, and looked upset with a male staff (unidentified) standing close by the Nursing Station door. The SV indicated, Resident 3 started to walk away toward the south hallway in front of the Nursing Station and Resident 4 got up from Resident 4's chair, followed, and pushed Resident 3 on Resident 3's back. During a concurrent interview and record review on 8/19/2024 at 4:33 pm. with the Licensed Vocation Nurse (LVN), the facility's SV of the incident was reviewed. The LVN stated, Resident 4 was supposed to be on 1:1 monitoring, and CNA 2 should have been [positioned] next to Resident 4 at all times for Resident 4's and residents' safety. The LVN stated, Resident 3 and Resident 4 appeared to be exchanging words while CNA 2 was inside the Nursing Station. The LVN stated, the male staff (unnamed) at the Nursing Station's door should have recognized Resident 3 and Resident 4 were exchanging words and should have separated Resident 3 and Resident 4 immediately to prevent the situation from escalating and avoided the pushing. During a concurrent interview and record review on 8/19/2024 at 4:45 pm., with the Director of Nursing (DON), the facility's SV of the incident was reviewed. The DON stated, as a 1:1 sitter (monitoring), CNA 2 should have been [positioned] next to Resident 4 and at arm's length and not inside the Nursing Station. The DON stated, Resident 3 and Resident 4 had a verbal exchange and the staff didn't pay attention. The DON stated, the CNA (unnamed) should have stopped the verbal exchange to prevent the next incident, [Resident 4] pushed. During a review of the facility's P&P titled, Policy and Procedure - Physical Assault, revised date 2/23/2021, the P&P indicated, the facility is to provide a safe and secure environment. The P&P indicated, some examples of physical assault were, but not limited to: punches, kicks, spitting, throwing objects, pushing, grabbing of clothes or person to cause personal harm, etc.