Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	12/11/2024

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36924 Based on observation, interview, and record review the facility failed to accurately document a one to one (1:1- continuous observation) monitoring for two hours after an altercation (physical aggression) for one of eight sampled residents (Resident 1). This failure resulted in inadequate documentation of Resident 1's one to one monitoring as ordered by the physician. Findings: A review of Resident 1's Admission Record (AR) indicated the resident was readmitted on [DATE] with diagnoses that included schizophrenia (disorder affecting person's ability to think, feel, and behave clearly) and major depressive disorder (persistently depressed mood or loss of interest in activities). A review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/10/24, indicated Resident 1 had moderate cognitive (ability to think, reason, and remember) impairment and mobility was independent. A review of Resident 2's AR indicated the resident was admitted on [DATE] with diagnoses that included paranoid schizophrenia (type of schizophrenia causing distrust of others) and major depressive disorder. A review of Resident 2's MDS, a resident assessment and care screening tool, dated 11/15/24, indicated Resident 2 was cognitively intact and mobility was independent. A review of Resident 1's Care Resident to Resident Abuser Care Plan, dated 11/30/24, indicated Resident 1 was assaultive to male per (Resident 2) during altercation. During a review of Resident 1's PO, dated 11/30/24, at 5:20 p.m., the PO indicated Resident 1 had a 1:1 order for two hours and then Q15 (every fifteen minutes) monitoring for two hours related to (r/t) altercation with peer one time only until 11/30/24 at 11:59 p.m. (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Progress Notes, dated 11/30/24, at 5:39 p.m., the Progress Notes indicated Resident 1 was to also be placed on 1:1 monitoring for two hours and then Q15 monitoring r/t Medical Doctor (MD 1) contacted and new order was given. During a concurrent interview, on 12/11/24, at 1:15 p.m., with the Administrator (ADM) and the Medical Records (MR), the ADM stated there was a Physician Order (PO) for a 1:1 monitoring for Resident 1, but the 1:1 monitoring was incorrectly entered in the Point Click Care (PCC- electronic documentation) documentation by staff and the facility was not able to provide documentation of the 1:1 monitoring for Resident 1. The MR stated there was no documentation that could be provided of the 1:1 monitoring for Resident 1. During an interview, on 12/11/24, at 5:54 p.m., the QA (Quality Assurance Nurse), the QA stated Licensed Vocational Nurse 2 (LVN 2) initiated the 1:1 monitoring in the task section of electronic documentation (the PCC) incorrectly. The QA stated the QA was not able to provide documentation of 1:1 monitoring for Resident 1. During a review of the facility's Policy & Procedure (P&P), titled Policy for Carrying Out Orders From Medical/Psychiatric Providers, dated August 2024, indicated the facility will carry out all orders prescribed by any Medical and/or Psychiatric Providers for all residents admitted to the facility. During a review of the facility's P&P, titled, Policy For Timely And Accurate 1:1 Monitoring And Q:15 MIN Monitoring Documentation In Point Click Care, dated, August 2022, indicated an order for 1:1 Monitoring and Q:15 Min. Monitoring will be obtained by ordering provider, noted, carried out for, but not limited to the following reasons: assaultive behavior, self-harm, suicidal ideations, severe agitation, safety, and new admission. The Licensed Nurse will then initiate the 1: 1 or Q: 15 Min. Monitoring in Point Click Care in the Tasks section of the EHR, and the CNA assigned to the Resident will do the required documentation every 15 mins and will have direct line of sight for the Resident receiving the monitoring. Once the order for the 1:1 or Q:15 Min. Monitoring is obtained the Licensed Nurse will go to the Resident's chart in PCC and click on the Tasks the Nurse will then click New Task' and choose 1:1 Monitoring or Q: 15 Min. Monitoring from the menu, 2. The Licensed Nurse will then specify the reason for the monitoring and then select the time the monitoring is to begin, 3. The documentation must be triggered immediately but no longer than 15 mins following the incident, 4. The CNA assigned to the Resident ordered the monitoring will then do the documentation every 15 minutes in the Point of Care Portal in PCC.