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	09/15/2025

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Residents 1), who had a history of major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest, and other symptoms that significantly interfere with daily life) was properly and adequately monitored in accordance with the facility's policies and procedures (P&P).This failure potentially resulted in Resident 1 gaining the opportunity to hang himself to attempt suicide (the act of intentionally causing one's own death) while inside Resident 1's room (Area 2) and resulted in Resident 1 to be resuscitated (to revive from apparent death or from unconsciousness) and transferred to the General Acute Care Hospital (GACH) where Resident 1 was declared brain dead two days later.During a review of Resident 1's admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood and behavior), bipolar (extreme mood swings between periods of mania [elevated mood] and depression) type, other psychoactive substance abuse (the harmful or hazardous use of drugs that alter brain function, affecting mood, perception, cognition, and behavior), uncomplicated, and major depressive disorder, recurrent, unspecified.During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated, Resident 1 had a flat affect (lack of emotional expression), was confused, and with tangential thought process (a pattern of thinking where a person's thoughts frequently stray from the main topic of conversation or question).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was intact. The MDS indicated, Resident 1 had potential indicators of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) behavior such as hallucinations (perceptual experiences in the absence of real external sensory stimuli) and delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated, Resident 1 was independent in activities of daily living and was taking antipsychotic and antidepressant drugs and had one day of psychological therapy (any licensed mental health professional).During a review of Resident 1's Order Summary Report (OSR), active orders as of [DATE], the OSR indicated, an order on [DATE] for Q (every) 15 (fifteen) min (minute) monitoring UFO (until further order) d/t (due to) AWOL (away without leave- when a patient leaves the facility without permission) attempt. The OSR indicated, an order on [DATE] to transfer Resident 1 via 911 (emergency response system) ambulance with bed hold (a resident's right to keep a bed vacant and available for seven days after their transfer to the hospital in anticipation of their return to the facility) to the GACH ER (Emergency Department) r/t (related to) being found unresponsive m/b (manifested by) resident attempting suicide by hanging.During a review of the GACH's ED Note Physician (EDN), dated [DATE], timed at 7:56 AM, the EDN indicated, Resident 1 was found in cardiac arrest (the heart suddenly and unexpectedly stops beating) at the facility, LKW (last known well) between 6:30 AM and 6:40 AM, found at 6:59 AM hanging from a sprinkler head and had ligature marks (a type of pressure mark or abrasion on the neck caused by a ligature [the act of binding or tying up with a cord or other material in cases of hanging or strangulation around neck]). EMS (Emergency Medical Services) reported that Resident 1 was cyanotic (a bluish discoloration of the skin caused by a shortage of oxygen in the blood) and unresponsive in full cardiac arrest on EMS's arrival at the facility and Resident 1's initial heart rhythm was asystole (flatline - when the heart's electrical system fails entirely causing the heart to stop pumping). EMS was able to obtain ROSC (Return of Spontaneous Circulation - the moment when a patient in cardiac arrest regains their own heartbeat and blood flow) in the field but Resident 1 had another cardiac arrest. During a review of Resident 1's Progress Notes (PN), dated [DATE], timed at 8:38 AM, the PN indicated, at approximately 7 AM the Licensed Psychiatric Technician (LPT) was called on the radio (walkie-talkie device) by a staff (unnamed) to Area 2. The PN indicated, the LPT entered Area 2 and observed Resident 1 hanging from the water sprinkler by a sheet and a code blue (an emergency code for a patient needing resuscitation) was called.During a review of the GACH's Discharge Summary (DS), dated [DATE], timed at 18:48 PM, the DS indicated, Resident 1's multiple discharge diagnoses included strangulation via asphyxiation (when you don't get enough oxygen in your body) resulting in cardiac arrest. The DS indicated, Resident 1's prolonged downtime (an extended period during which a patient experiences cardiac arrest) and evidence of cerebral edema