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	11/26/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide supervision every hour for two of six sampled residents (Resident 3 and Resident 6) in accordance with the facility's policy and procedure (P&P) titled, Policy for Hourly Monitoring, by failing to ensure Certified Nurse Assistant (CNA) 1, CNA 2, CNA 3, and CNA 6 had visually seen and identified Resident 3 and Resident 6 between the hours of 12 am and 4 am on 10/18/2025, 10/19/2025, and 10/20/2025. This failure resulted in Resident 3 and Resident 6 not being visually checked during hourly monitoring on 10/18/2025 at 12 am and from 2 am to 4 am, on 10/19/2025 at 1 am, and from 3 am to 4 am, and on 10/20/2025 from 12 am to 4 am, and had the potential to result in Resident 3 and Resident 6 harming themselves, harming each other, and being susceptible to abuse. Cross Reference: F842Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 6/20/2025 with diagnoses that included schizophrenia (serious mental illness in which people interpret reality abnormally), insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 3's Follow Up Question Report (FUQR - used by facility to document hourly visual monitoring of residents), dated 10/17/2025 to 10/20/2025, the FUQR indicated Resident 3 was monitored hourly. The FUQR indicated during the night shift (11 pm to 7 am) on 10/17/2025, Resident 3 was monitored hourly by CNA 1 between the hours of 12 am and 1 am, and 3 am on 10/18/2025. The FUQR indicated CNA 6 monitored Resident 3 on 10/17/2025 at 11 pm, and 10/18/2025 at 2 am and 4 am. The FUQR indicated during the night shift on 10/18/2025, CNA 1 monitored Resident 3 hourly between the hours of 11 pm and 4 am (on 10/19/2025). The FUQR indicated during the night shift on 10/19/2025, CNA 1 monitored Resident 3 hourly between the hours of 11 pm and 4 am (on 10/20/2025). b. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6, to the facility on 5/4/2021 and was readmitted on [DATE], with diagnoses that included paranoid schizophrenia, major depressive disorder, and anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of Resident 6's FUQR dated 10/17/2025 to 10/20/2025, the FUQR indicated Resident 6 was monitored hourly. The FUQR indicated during the night shift on 10/17/2025, Resident 6 was monitored hourly by CNA 1 between the hours of 11 pm and 4 am (on 10/18/2025). The FUQR indicated during the night shift on 10/18/2025, CNA 1 monitored Resident 6 hourly between the hours of 11 pm and 2 am (on 10/19/2025). The FUQR indicated CNA 6 monitored Resident 3 and Resident 6 at 3 am and 4 am. The FQUR indicated during the night shift on 10/19/2025, CNA 3 monitored Resident 3 hourly between the hours of 11 pm and 4 am (on 10/20/2025). During a concurrent observation and interview on 10/21/2025 at 12:31 pm with the Program Director (PD), the facility's video surveillance from 10/17/2025 at 11 pm to 10/18/2025 at 4 am was reviewed. The PD stated the video surveillance started on 10/17/2025 from 11:00:01 pm. The PD stated the camera was positioned in the west wing hallway by the back door. The PD stated there were three doors on right side of the hall in the camera frame that were visible, and Resident 3 and Resident 6's room door was second/middle door. The PD (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	stated CNA 1 was the only staff who was observed entering and exiting Resident 3 and Resident 6's room. The PD stated no other staff were observed entering or exiting Resident 3 and Resident 6's room. The PD stated CNA 1 entered the room on 10/17/2025 at 11pm, and again on 10/18/2025 at 1 am. The PD stated CNA 1 did not enter Resident 3 and Resident 6's room on 10/18/2025 from 12 am to 1 am, from 2 am to 3 am, and from 3 am to 4 am. PD stated no other staff member entered the room on 10/18/2025 from 12 am to 1 am, from 2 am to 3 am, and from 3 am to 4 am. During a concurrent observation and interview on 10/21/2025 at 3:12 pm with the PD, the facility's video surveillance from 10/18/2025 at 11 pm to 10/19/2025 at 4 am was reviewed. The PD stated the video surveillance started on 10/18/2025 from 11:00:04 pm. The PD stated the camera was positioned in the west wing hallway by the back door. The PD stated there were three doors on right side of the hall in the camera frame that were visible, and Resident 3 and Resident 6's room door was second/middle door. The PD stated CNA 2 was observed entering Resident 3 and Resident 6's room on 10/18/2025 at 11 pm. The PD stated CNA 2 was observed standing in the doorway of Resident 3 and Resident 6's room on 10/19/2025 at 12 am and again at 2 am. The PD stated no other staff member entered the room on 10/19/2025 from 1 am to 2 am, and from 3 am to 4 am. During a concurrent observation and interview on 10/22/2025 at 9:16 am with the PD, the facility's video surveillance from 10/19/2025 at 11 pm to 10/20/2025 at 4 am was reviewed. The PD stated the video surveillance started on 10/19/2025 from 11:00:04 pm. The PD stated the camera was positioned in the west wing hallway by the back door. The PD stated there were three doors on right side of the hall in the camera frame that were visible, and Resident 3 and Resident 6's room door was second/middle door. The PD stated CNA 3 was observed entering and exiting Resident 3 and Resident 6's room on 10/19/2025 at 11pm. The PD stated no staff member, or residents were observed entering or exiting the room on 10/20/2025 from 12 am to 4 am. The PD stated CNA 3 was observed on CNA 3's phone most of the video. During a telephone interview on 10/22/2025 at 12:12 pm with CNA 3, CNA 3 stated CNA 3 went into Resident 3 and Resident 6's room on 10/19/2025 not long after CNA 3's shift started. CNA 3 stated both Resident 3 and Resident 6 were sleeping. CNA 3 stated CNA 3 sat in a chair by the room next door to Resident 3 and Resident 6. CNA 3 stated, I usually check my residents every hour, but I didn't check them every hour that night I guess, but I documented I did. CNA 3 stated CNA 3 could not see into Resident 3 and Resident 6's room if CNA 3 was on CNA 3's phone. CNA 3 stated when CNA 3 did hourly checks on residents, CNA 3 must go inside the residents' room to check on them. CNA 3 stated, It's really hard to see both residents from the doorway. When you're in the doorway, you can't visualize both residents. During a telephone interview on 10/22/2025 at 1:12 pm with CNA 1, CNA 1 stated CNA 1 worked the night shift of 10/17/2025. CNA 1 stated, I was supposed to check on [Resident 3 and Resident 6] every hour, but I was very tired that night. CNA 1 stated, I documented I checked on [Resident 3 and Resident 6] every hour or something like that. CNA 1 stated it was important to actually check on the residents to make sure they were safe. CNA 1 stated if CNA 1 did not check on the residents to make sure they were safe they could get sick, fall out of bed, get hurt, and that it was possible for the roommates to hurt each other. CNA 1 stated, I'm supposed to look at them. During an interview on 10/22/2025 at 2:09 pm with the Director of Staff Development (DSD), the DSD stated that unless otherwise indicated, all residents were monitored hourly. The DSD stated that staff were supposed to visualize each resident for their safety and to ensure they were alive, well, and breathing. The DSD stated this was done 24 hours a day, seven days a week. The DSD stated if staff were not checking on the residents, Anything could happen. The DSD stated residents could be choking, or not breathing, and that hourly checks ensured their safety to prevent them from harm. The DSD stated it was possible a resident could abuse their roommate if staff were not checking on the residents every hour. During an interview on 10/22/2025 at 2:47 pm with Licensed Psychiatric Technician (LPT) 1, LPT 1 stated CNAs were supposed to do hourly visual checks on residents. LPT 1 stated it was important for CNAs to do hourly visual checks because incidents like suicide could happen. LPT 1 stated, We need to make sure they're (residents) alive and assess their behavior. LPT (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 stated incidents like resident-to-resident abuse could occur if staff were not checking on the residents hourly. During an interview on 10/22/2025 at 2:56 pm with the Director of Nursing (DON), the DON stated the facility's standard was to check on residents every hour. The DON stated whoever documented the monitoring must lay eyes (to see or look at the resident) on the resident or visualize the resident, To make sure they (residents) were okay. The DON stated if CNAs or staff were not visualizing the residents every hour it posed a safety risk to the residents. The DON stated if not visualized hourly residents could fall and be unable to ask for help, residents could go into another resident's room, and it could put the residents at risk for resident-to-resident abuse. During a review of the facility's P&P titled, Policy for Hourly Monitoring of Residents, dated 5/2024, the P&P indicated it was the policy of the facility to provide an atmosphere that was safe and secure for all residents and staff. The P&P indicated that each CNA was assigned a zone or area in the unit and would observe the location of resident assigned in their section, each hour, and document the location in the facility's electronic medical record (EHR). The P&P indicated in documenting resident location in the EHR, staff were making an honest and accurate entry that they visually saw and identified the resident. The P&P indicated the monitoring allowed the staff to account for each resident and ensured that each resident was free from distress.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure accurate documentation of the Follow Up Question Report (FUQR - used by facility to document hourly visual monitoring of residents) for two of six sampled residents (Resident 3 and Resident 6) according to the facility's policy and procedure (P&P) titled, Policy for Hourly Monitoring of Residents, by failing to ensure CNA 1, CNA 2, CNA 3, and CNA 6 did not falsify (change something in order to deceive people) Resident 3's and Resident 6's FUQR. CNA 1, CNA 2, CNA 3, and CNA 6 documented on Resident 3's and Resident 6's FUQR they had visually seen and identified Resident 3 and Resident 6 between the hours of 12 am and 4 am on 10/18/2025, 10/19/2025, and 10/20/2025. Resident 3 and Resident 6 were not visually checked during hourly monitoring on 10/18/2025 at 12 am and from 2 am to 4 am, on 10/19/2025 at 1 am, and from 3 am to 4 am, and on 10/20/2025 from 12 am to 4 am. This failure had the potential for Resident 3 and Resident 6 not to receive adequate supervision, and for Resident 3's and Resident 6's care not to be accurately evaluated for procedural and guidelines compliance, and the need for staff education and training to be evaluated. Cross Reference: F689Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 6/20/2025 with diagnoses that included schizophrenia (serious mental illness in which people interpret reality abnormally), insomnia (a common sleep disorder that can make it hard to fall asleep or stay asleep), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 3's Follow Up Question Report (FUQR - used by facility to document hourly visual monitoring of residents), dated 10/17/2025 to 10/20/2025, the FUQR indicated Resident 3 was monitored hourly. The FUQR indicated during the night shift (11 pm to 7 am) on 10/17/2025, Resident 3 was monitored hourly by CNA 1 between the hours of 12 am and 1 am, and 3 am on 10/18/2025. The FUQR indicated CNA 6 monitored Resident 3 on 10/17/2025 at 11 pm, and 10/18/2025 at 2 am and 4 am. The FUQR indicated during the night shift on 10/18/2025, CNA 1 monitored Resident 3 hourly between the hours of 11 pm and 4 am (on 10/19/2025). The FUQR indicated during the night shift on 10/19/2025, CNA 1 monitored Resident 3 hourly between the hours of 11 pm and 4 am (on 10/20/2025). b. During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6, to the facility on 5/4/2021 and was readmitted on [DATE], with diagnoses that included paranoid schizophrenia, major depressive disorder, and anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of Resident 6's FUQR dated 10/17/2025 to 10/20/2025, the FUQR indicated Resident 6 was monitored hourly. The FUQR indicated during the night shift on 10/17/2025, Resident 6 was monitored hourly by CNA 1 between the hours of 11 pm and 4 am (on 10/18/2025). The FUQR indicated during the night shift on 10/18/2025, CNA 1 monitored Resident 6 hourly between the hours of 11 pm and 2 am (on 10/19/2025). The FUQR indicated CNA 6 monitored Resident 3 and Resident 6 at 3 am and 4 am. The FQUR indicated during the night shift on 10/19/2025, CNA 3 monitored Resident 3 hourly between the hours of 11 pm and 4 am (on 10/20/2025). During a concurrent observation and interview on 10/21/2025 at 12:31 pm with the Program Director (PD), the facility's video surveillance from 10/17/2025 at 11 pm to 10/18/2025 at 4 am was reviewed. The PD stated the video surveillance started on 10/17/2025 from 11:00:01 pm. The PD stated the camera was positioned in the west wing hallway by the back door. The PD stated there were three doors on right side of the hall in the camera frame that were visible, and Resident 3 and Resident 6's room door was second/middle door. The PD stated CNA 1 was the only staff who was observed entering and exiting Resident 3 and Resident 6's room. The PD stated no other staff were observed entering or exiting Resident 3 and Resident 6's room. The PD stated CNA 1 entered the room on 10/17/2025 at 11pm, and again on 10/18/2025 at 1 am. The PD stated CNA 1 did not enter Resident 3 and Resident 6's room on 10/18/2025 from 12 am (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 1 am, from 2 am to 3 am, and from 3 am to 4 am. PD stated no other staff member entered the room on 10/18/2025 from 12 am to 1 am, from 2 am to 3 am, and from 3 am to 4 am. During a concurrent observation and interview on 10/21/2025 at 3:12 pm with the PD, the facility's video surveillance from 10/18/2025 at 11 pm to 10/19/2025 at 4 am was reviewed. The PD stated the video surveillance started on 10/18/2025 from 11:00:04 pm. The PD stated the camera was positioned in the west wing hallway by the back door. The PD stated there were three doors on right side of the hall in the camera frame that were visible, and Resident 3 and Resident 6's room door was second/middle door. The PD stated CNA 2 was observed entering Resident 3 and Resident 6's room on 10/18/2025 at 11 pm. The PD stated CNA 2 was observed standing in the doorway of Resident 3 and Resident 6's room on 10/19/2025 at 12 am and again at 2 am. The PD stated no other staff member entered the room on 10/19/2025 from 1 am to 2 am, and from 3 am to 4 am. During a concurrent observation and interview on 10/22/2025 at 9:16 am with the PD, the facility's video surveillance from 10/19/2025 at 11 pm to 10/20/2025 at 4 am was reviewed. The PD stated the video surveillance started on 10/19/2025 from 11:00:04 pm. The PD stated the camera was positioned in the west wing hallway by the back door. The PD stated there were three doors on right side of the hall in the camera frame that were visible, and Resident 3 and Resident 6's room door was second/middle door. The PD stated CNA 3 was observed entering and exiting Resident 3 and Resident 6's room on 10/19/2025 at 11pm. The PD stated no staff member, or residents were observed entering or exiting the room on 10/20/2025 from 12 am to 4 am. The PD stated CNA 3 was observed on CNA 3's phone most of the video. During a telephone interview on 10/22/2025 at 12:12 pm with CNA 3, CNA 3 stated CNA 3 went into Resident 3 and Resident 6's room on 10/19/2025 not long after CNA 3's shift started. CNA 3 stated both Resident 3 and Resident 6 were sleeping. CNA 3 stated CNA 3 sat in a chair by the room next door to Resident 3 and Resident 6. CNA 3 stated, I usually check my residents every hour, but I didn't check them every hour that night I guess, but I documented I did. CNA 3 stated CNA 3 could not see into Resident 3 and Resident 6's room if CNA 3 was on CNA 3's phone. CNA 3 stated when CNA 3 did hourly checks on residents, CNA 3 must go inside the residents' room to check on them. CNA 3 stated, It's really hard to see both residents from the doorway. When you're in the doorway, you can't visualize both residents. During a telephone interview on 10/22/2025 at 1:12 pm with CNA 1, CNA 1 stated CNA 1 worked the night shift of 10/17/2025. CNA 1 stated, I was supposed to check on [Resident 3 and Resident 6] every hour, but I was very tired that night. CNA 1 stated, I documented I checked on [Resident 3 and Resident 6] every hour or something like that. CNA 1 stated it was important to actually check on the residents to make sure they were safe. CNA 1 stated if CNA 1 did not check on the residents to make sure they were safe they could get sick, fall out of bed, get hurt, and that it was possible for the roommates to hurt each other. CNA 1 stated, I'm supposed to look at them. During an interview on 10/22/2025 at 2:09 pm with the Director of Staff Development (DSD), the DSD stated that unless otherwise indicated, all residents were monitored hourly. The DSD stated that staff were supposed to visualize each resident for their safety and to ensure they were alive, well, and breathing. The DSD stated this was done 24 hours a day, seven days a week. The DSD stated if staff were not checking on the residents, Anything could happen. The DSD stated residents could be choking, or not breathing, and that hourly checks ensured their safety to prevent them from harm. The DSD stated it was possible a resident could abuse their roommate if staff were not checking on the residents every hour. During an interview on 10/22/2025 at 2:47 pm with Licensed Psychiatric Technician (LPT) 1, LPT 1 stated CNAs were supposed to do hourly visual checks on residents. LPT 1 stated it was important for CNAs to do hourly visual checks because incidents like suicide could happen. LPT 1 stated, We need to make sure they're (residents) alive and assess their behavior. LPT 1 stated incidents like resident-to-resident abuse could occur if staff were not checking on the residents hourly. During an interview on 10/22/2025 at 2:56 pm with the Director of Nursing (DON), the DON stated the facility's standard was to check on residents every hour. The DON stated whoever documented the monitoring must lay eyes (to see or look at the resident) on the resident or visualize (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident, To make sure they (residents) were okay. The DON stated if CNAs or staff were not visualizing the residents every hour it posed a safety risk to the residents. The DON stated if not visualized hourly residents could fall and be unable to ask for help, residents could go into another resident's room, and it could put the residents at risk for resident-to-resident abuse. During a review of the facility's P&P titled, Policy for Hourly Monitoring of Residents, dated 5/2024, the P&P indicated it was the policy of the facility to provide an atmosphere that was safe and secure for all residents and staff. The P&P indicated that each CNA was assigned a zone or area in the unit and would observe the location of resident assigned in their section, each hour, and document the location in the facility's electronic medical record (EHR). The P&P indicated in documenting resident location in the EHR, staff were making an honest and accurate entry that they visually saw and identified the resident. The P&P indicated the monitoring allowed the staff to account for each resident and ensured that each resident was free from distress. During a review of the facility's P&P titled, [Facility] Policy on Documentation in Point Click Care (EHR), updated 1/2022, the P&P indicated all entries were to be made by the nurse who provided the nursing care or made the observation.