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	12/05/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services to prevent resident-to-resident abuse (intentional bodily injury that includes slapping, pinching, choking, kicking, shoving, grabbing, and punching) for two of five sampled residents (Resident 3 and Resident 5), according to the facility's policy and procedure (P&P) titled, Residents Right to Human Care, and the facility's five-day Follow-up Investigation Report (FUIR - mandatory follow-up report long-term care facilities must submit to the State Survey Agency within five working days of an abuse/neglect incident, detailing investigation results, corrective actions taken, and if the allegation was verified) dated 12/1/2025 by failing to: 1. Ensure Resident 4, who had a history of resident-to-resident abuse and was experiencing increasingly agitated behavior, did not hit Resident 3 over the head with a food tray on 11/23/2025 at approximately 7:30 am. 2. Ensure Resident 4, who had a history of resident-to-resident abuse on 11/23/2025, continued to be placed on one-to-one (1:1) monitoring (one trained staff provides continuous monitoring, close supervision to prevent harm, requiring constant vigilance even during sleep, and ensuring immediate intervention) until Resident 4 was transferred to a higher level of care due to ongoing impulsive (acting on sudden urges or desires without thinking through the consequences, often leading to risky, poorly conceived, or regrettable actions) and assaultive (actions or tendencies to physically attack or aggressively confront others, ranging from verbal threats and intimidation to physical violence like hitting, kicking, or biting, and involves intent to harm, damage, or intimidate) behaviors. 3. Ensure Resident 4 did not hit Resident 5 on the top of the head and pull Resident 5's hair on 11/29/2025 at approximately 8:50 pm. As a result of these failures, Resident 4 assaulted Resident 3 while Resident 3 was eating breakfast. Resident 4 assaulted Resident 5 while on the facility's patio during a smoke break. Resident 5's hair was pulled and hit on the back of the head by Resident 4. This failure caused Resident 5 experiencing pain to Resident 5's head, and made Resident 5 feel unsafe and afraid that another resident will assault Resident 5. This failure caused psychosocial (mental, emotional, social, and spiritual effects) discomfort to Resident 5. Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 10/30/2024 with diagnoses that included schizoaffective disorder (mental health disorder that is marked by a combination of schizophrenia symptoms like hallucinations or delusions, and mood disorder symptoms, such as depression or mania), bipolar (mental illness that causes unusual shifts in a resident's mood, energy, activity levels, and concentration) type, unspecified temporal mandibular joint (TMJ- refers to the jaw joint connecting your jawbone to your skull) disorder, and insomnia (common sleep disorder marked by difficulty falling asleep, staying asleep, or getting quality rest, leading to daytime fatigue, concentration issues, and irritability). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated 10/31/2025, the MDS indicated Resident 3 had intact cognition (ability to think, remember, and function). The MDS indicated Resident 3 experienced hallucinations (false perceptions of things that are not real, involving the senses of sight, sound, smell, taste, or touch) and delusions (fixed belief that persists despite evidence of the contrary). During a review of Resident 3's Progress Notes (PN) dated 11/23/2025, timed at 1:36 pm, the PN indicated at approximately 7:30 am, Resident 3 was hit over the head with a meal tray by peer (Resident 4) while eating breakfast in the dining room. The PN indicated Resident 3 experienced, A little bit of pain. During an interview on 12/5/2025 at 12:05 pm, with Resident 3, Resident 3 stated, I don't remember when it [incident with Resident 4] happened, but it was [another resident] that hit me. Resident 3 stated, I was just sitting, eating my breakfast when [Resident 4] came to me and just hit me on my head with the tray. Resident 3 stated Resident 4 did not say anything to Resident 3 before hitting Resident 3. Resident 3 stated, It hurt a little, but I was in shock more. I don't know why [Resident 4] did that to me. b. During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 10/10/2025 with diagnoses that included schizoaffective disorder, unspecified anxiety disorder (persistent feeling of dread or panic that can interfere with daily life), and recurrent, unspecified, major depressive disorder (common and serious illness that negatively affects how one feels, thinks and acts). During a review of Resident 4's MDS dated [DATE], the MDS indicated had moderately impaired cognition. The MDS indicated Resident 4 experienced hallucinations and delusions. During a review of Resident 4's untitled Care Plan (CP), initiated 11/16/2025, the CP indicated Resident 4 was resident-to-resident abuser (related to diagnosis of schizoaffective disorder, depressive type). The CP indicated on 11/23/2025, Resident 4 hit [Resident 3] with food tray on the head. The CP indicated on