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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36288 Based on interviews and record review, the facility failed to provide documented evidence for five of 18 sampled residents (Residents 24, 48, 89, 9, & 59) and/or their legal representative (RP) were informed and/or provided written information regarding Advance Directives (AD, legal document, which specifies the health-related actions in accordance with the resident's wishes, that is executed when the resident is no longer able to make decisions for himself/herself due to illness or incapacity). These failures had the potential to result in violation of the residents' right to formulate ADs and the potential for the residents to receive inappropriate or medically unnecessary care and/or treatment. Findings: a. During a review of Resident 24's Admission Record (AR), the AR indicated the facility initially admitted Resident 24 on 8/4/2022 with multiple diagnoses including schizoaffective disorder (mental illness marked by a mix of symptoms of hallucinations [perceptual experiences in the absence of real external sensory stimuli], delusions [misconceptions or beliefs firmly held, contrary to reality], depression [persistently depressed mood or loss of interest in activities that interfere with daily life], and mania [extremely elevated and excitable mood with excessive enthusiasm and overactivity]), type 2 diabetes mellitus (chronic [long standing] condition characterized by abnormal blood sugar elevation), nuclear cataracts (clouding of the center of the eye's lens, worsening vision) on both eyes, and open-angle glaucoma (chronic condition that could lead to vision loss due to increased eye pressure) on both eyes. The AR indicated RP 1 was Resident 24's conservator (person appointed by a judge to manage the financial and personal affairs of an individual deemed incompetent by the court). During a review of Resident 24's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 5/3/2024, The MDS indicated Resident 24 had moderate impairment in cognition (ability to think, process, and recall information). The MDS indicated Resident 24 had difficulty focusing attention and had disorganized or incoherent thinking (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). The MDS indicated Resident 24 performed most self-care activities independently and was independent with mobility. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the Medical Records Director (MRD) and a concurrent review of Resident 24's medical records on 8/6/2024 at 11:26 AM, The MRD stated there was no documented evidence that Resident 24 and RP 1 acknowledged receipt of AD information. The MRD stated the facility did not have a specific policy and procedure on AD but had an AD brochure provided to the residents/RP (in general) during admission. 42307 b. During a review of Resident 48's Admission Record (AR), the AR indicated, Resident 48 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that combines symptoms of schizophrenia [a serious mental health condition that affects how people think, feel and behave] and a mood disorder such as bipolar disorder [a mental health condition that affects your moods, which can swing from one extreme to another] or depression [a mood disorder that causes a persistent feeling of sadness and loss of interest]), unspecified, other psychoactive substance abuse, uncomplicated and insomnia (persistent problems falling and staying asleep), unspecified. During a review of Resident 48's Minimum Data Set (MDS, an assessment and screening tool), dated 11/21/2023, the MDS indicated, Resident 48's cognitive (ability to think and process information) skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). During a review of Resident 48's History of Present Illness (H&P), dated 7/24/2024 timed at 4:22 PM the H&P indicated, Resident 48 was cooperative, confused, and judgement and insight were impaired. c. During a review of Resident 89's AR, the AR indicated, Resident 89 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, bipolar type, other psychoactive substance abuse, uncomplicated and major depressive disorder, recurrent, unspecified. During a review of Resident 89's H&P, dated 3/20/2024 timed at 4:20 PM the H&P indicated, Resident 89 was able to make his/her own medical decisions and was calm and cooperative in no distress. During a review of Resident 89's MDS, dated [DATE], the MDS indicated, Resident 89's cognitive status was intact. During a concurrent interview with the Medical Records Director (MRD) and record review on 8/6/2024 at 11:22 AM, Resident 48 and Resident 89's medical records were reviewed. Resident 48's copy of the Acknowledgement of Advanced Directive AAD, form dated 11/9/2023 indicated, no signature from Resident 48 or Resident 48's Responsible Party (RP). The MRD stated, Resident 48 did not want to sign the AAD and the facility sent the AAD to Resident 48's RP. The MRD stated, the MRD could not find the admission packet that included Resident 89's AAD. The MRD stated, Resident 89 did not want to sign the AAD and the admission packet was sent to Resident 89's RP. The MRD stated, the facility preferred the AAD to be signed by both the resident and the RPs. The MRD stated, the timeframe for the facility to have the AAD signed from the RPs, I don't want to lie, should be short. The MRD stated, the MRD should have followed up with the RPs about Resident 48 and Resident 89's AAD. The MRD stated, it was important to have documented evidence of the AAD records where on file because it was the facility's policy and procedure (P&P) and resident's rights. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36924 d. During a review of Resident 59's Admission Record (AR), the AR indicated the facility admitted Resident 59 on 2/6/2024 with diagnoses that included schizophrenia (mental disorder characterized by abnormal social behavior and failure to understand what is real), obesity (excessive body fat), and acquired absence of right hand (amputation [loss or removal of a body part] of right hand). The AR indicated Resident 59's Responsible Party (RP) was a conservator (court appointed guardian). During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59 had intact cognition (ability to understand and process thoughts). The MDS indicated Resident 59's did not use mobility (ability to move) devices and was independent with Activities of Daily Living (ADLs). During a review of Resident 59's AAD dated 2/6/2024, the AAD was not signed by Resident 59's Public Guardian/Conservator and was incomplete. e. During a review of Resident 9's AR, the AR indicated the facility admitted Resident 9 on 12/1/2021 with diagnoses that included schizoaffective disorder (a mental condition that causes both a loss of contact with reality [psychosis] and mood problems) and cardiomegaly (enlarged heart). The AR indicated Resident 9's RP was a conservator. During a record review of Resident 9's AAD dated 12/1/2021, the AAD was not signed by the RP and was incomplete. During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9 had intact cognition. The MDS indicated Resident 9 did not use mobility devices and was independent with ADLs. During a concurrent record review and interview on 8/6/2024, at 11:31 AM with the Medical Records Director (MRD), the MRD stated the resident's AAD needed to be signed. The MRD stated Resident 59's AAD was not signed by Resident 59's Conservator. The MRD stated it was preferred to have the signature of both the resident and the resident's RP on the AAD. During a review of the facility's undated AD brochure, titled Your Right to Make Decisions about Medical Treatment, the AD brochure indicated the resident's rights to make health care decisions and explained how the resident could plan what should be done when the resident could no longer speak for oneself. The brochure indicated, a resident may, after appropriate instruction and with physician involvement, execute an AD while in the facility. During a review of the facility's undated P&P titled, Resident Rights, the P&P indicated, the resident had the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to notify the representative of one of one sampled resident (Resident 44) when Resident 44's physicians recommended cataract (clouding of the normally clear lens of the eye) surgery for Resident 44. This deficient practice resulted in a delay of informing Resident 44's representative of the needed eye treatment and/or services for Resident 44 and prevented Resident 44's representative from being included in decision making regarding Resident 44's plan of care. This deficient practice had the potential to negatively affect Resident 44's quality of life from Resident 44's untreated cataract. Findings: During a review of Resident 44's Administration Record (AR), the AR indicated, the facility admitted Resident 44 to the facility on [DATE], with a diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), cataract, tributary (branch) retinal (part of the eye that receives light) vein occlusion (blurry vision or vision loss), and legal blindness (unable to see). The AR indicated, Resident 44 was under conservatorship (a court appoints another person to act or make decisions for the person who needs help). During a review of Resident 44's untitled Care Plan (CP), dated 8/31/2023, the CP indicated Resident 44 had impaired visual function related to legal blindness and combined forms of age-related cataract on the left eye and right eye tributary retinal vein occlusion., The CP goal indicated, Resident 44 would maintain optimal quality of life within limitations imposed by visual function. During a review of Resident 44's Progress Notes (PN) under Monthly Medical Evaluation, by Resident 44's physician, dated 9/6/2023, the PN indicated, Resident 44 was confused, had tangential (something that goes off in one direction) thought process, and impaired judgement and insight. During a review of Resident 44's Ophthalmology (branch of medicine concerned with diagnosis and treatment of eye disorders) History and Physical (OH&P), dated 2/7/24, the OH&P indicated, Resident 44 had dense (thick) cataract on the left eye affecting daily activities. The OH&P indicated, glasses were not helping Resident 44. The OH&P indicated, the ophthalmologist's (a medical physician who specializes in eye and vision care) plan was to schedule a cataract surgery. The OH&P indicated, Resident 44 did not want surgery but did not appear fully capable of making decisions. During a review of Resident 44's OH&P, dated 3/29/24 and 4/26/24, the OH&P indicated, Resident 44's ophthalmologist highly recommended cataract surgery both for better visual function and to better evaluate Resident 44's retina (layer at the back of the eye). Both OH&P indicated, Resident 44 had refused multiple times. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 5/31/2024, the MDS indicated, Resident 44 had a behavior of continuously disorganized thinking (rambling, irrelevant, unclear, or illogical). The MDS indicated, Resident 44 had severely impaired vision (no vision or sees only light, colors, or shapes). (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/5/24 at 11:29 a.m. with Resident 44, in Resident 44's room, Resident 44 was observed sitting up in bed. Resident 44 stated, I can't see you. Come close to me so I can see you better. During an interview on 8/6/24 at 10:09 am with Licensed Psychiatric Technician 1 (LPT 1), LPT 1 stated Resident 44's vision had declined. LPT 1 stated Resident 44 relied heavily on the side rails to ambulate from Resident 44's bedroom to the dining room. LPT 1 stated during medication passes, Resident 44 would look from side to side and would place his pills up-close to his eyes to see. During a concurrent interview and record review on 8/7/24 at 3:36 pm with the Director of Nursing (DON), Resident 44's paper and electronic record was reviewed. The DON stated Resident 44 was legally blind and had poor vision upon admission to the facility. The DON stated the DON was unaware if the facility informed Resident 44's representative/conservator of the treatment recommendations of Resident 44's ophthalmologist regarding cataract surgery. The DON stated Resident 44's representative/conservator needed to be informed of Resident 44's option for cataract surgery because Resident 44 was not able to make decisions regarding Resident 44's own health. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, undated, the P&P indicated, the resident had a right to a dignified existence The P&P indicated, the facility protected and promoted the right of each resident, including each of the following rights: in the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the right of the resident were exercised by the person appointed under State law to act on the residents behalf. During a review of the facility's handbook titled, Rights for Individuals in Mental Health Facilities, undated, the handbook indicated, on conservatorship, the judge had granted the conservator power to make mental health treatment decisions, the individual no longer had the right to consent to or refuse treatment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure a safe and homelike environment for one of two sampled residents (Resident 48) when Resident 48's room bed light's pull-cord switch (pull chain) was not in working condition. This deficient practice had the potential to result in compromised safety to Resident 48 and made the resident feel depressed. Findings: During a review of Resident 48's Admission Record (AR), the AR indicated, Resident 48 was admitted to the facility on [DATE] with multiple diagnoses including other psychoactive substance abuse, uncomplicated and insomnia (persistent problems falling and staying asleep), unspecified. During a review of Resident 48's Minimum Data Set (MDS, an assessment and screening tool), dated 11/21/2023, the MDS indicated, Resident 48's cognitive (ability to think and process information) skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). During a review of Resident 48's History of Present Illness (H&P), dated 7/24/2024 timed at 4:22 PM the H&P indicated, Resident 48 was cooperative, confused, and judgement and insight were impaired. During an observation on 8/5/2024 at 11:38 AM with Licensed Psychiatric Technician (LPT) 1, Resident 48's bed light had a three-inch-long pull-cord switch (pull chain). During a concurrent observation and interview on 8/6/2024 at 8:20 AM with Resident 48 and Certified Nursing Assistant (CNA) 1, Resident 48's bed light's pull-cord was about three inches long. The bed light did not turn on when the cord was pulled. CNA 1 stated, looks like not working. CNA 1 stated, maintenance staff should be checking [the light's pull-cords] every day. Resident 48 stated, when Resident 48 was moved to the room, it [bed light] was already like that, it didn't work. Resident 48 stated, the bed light not working made Resident 48 feel depressed. I like [the] lights in my home. During a concurrent interview and record review on 8/7/2024 at 10:34 AM with the Maintenance Supervisor (MS) and the Maintenance Aide (MA), the facility's undated policy and procedure (P&P) titled, Maintenance Aide, was reviewed. The MA stated, the responsibilities of maintenance department included ensuring everything [was] in working condition, including the lighting. The MA stated, Resident 48's bed light was not working and [the concern] was reported by CNA 1 on 8/6/2024. The MA stated, it was important to have working bed lights for residents to see in case residents had to get up at night, to prevent safety hazards (a risk that can cause harm, damage, or adverse health effects) and for security [purposes]. The P&P indicated, one of the duties and responsibilities was assuring the facility's electrical system was in good working order. The MA stated, electrical systems included bed lights. During a review of the facility's undated P&P titled, Resident Rights, the P&P indicated, the residents had the right to a safe, clean, comfortable, and homelike environment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36288 Based on observation, interviews, and record review, the facility failed to prevent physical abuse (willful infliction of injury that includes, but is not limited to, hitting, slapping, punching, biting, and kicking) for three of six sampled residents (Residents 73, 87, & 57), who were involved in resident-to-resident altercations, when, A. For Resident 73, Resident 87 hit Resident 73's face on 7/29/2024. B. Resident 87, who was on 1:1 monitoring (continuous observation), got hit on the face when Resident 73 hit Resident 87 back with a closed fist on 7/29/2024. C. For Resident 57, the facility failed to provide an abuse-free environment on 8/6/2024. These failures had the potential to result in a decline in the residents' physical and/or psychosocial well-being. Findings: A. During a review of Resident 73's Admission Record (AR 1), AR 1 indicated the facility initially admitted Resident 73 on 6/18/2024 with multiple diagnoses including schizoaffective disorder (mental illness marked by a mix of symptoms of hallucinations [perceptual experiences in the absence of real external sensory stimuli], delusions [misconceptions or beliefs firmly held, contrary to reality], depression [persistently depressed mood or loss of interest in activities that interfere with daily life], and mania [extremely elevated and excitable mood with excessive enthusiasm and overactivity]) and hypothyroidism (abnormally low production of thyroid hormones). During a review of Resident 73's Initial Medical History and Physical (H&P), dated 6/19/2024, the H&P indicated Resident 73 had good eye contact, clear speech, and was calm and cooperative. During a review of Resident 73's Psychiatric Assessment (PA), date of service 6/25/2024, the PA indicated Resident 73 was oriented to person and place (awareness of one's name and location), had blunted affect (restricted emotional expression), loose thought process (lack of connection between ideas), delusional thought content (distorted personal beliefs that are not based on reality), auditory hallucinations (sensory perceptions of hearing in the absence of an external stimulus), and poor memory and concentration. During a review of Resident 73's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 6/28/2024, the MDS indicated Resident 73 had moderate impairment in cognition (ability to think, process, and recall information). The MDS indicated Resident 73 was independent with most self-care activities and mobility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 73's Care Plan (CP) for Response to Internal Stimuli, initiated on 7/29/2024, the CP indicated Resident 73 was observed by staff smiling, talking, and laughing to herself or unseen others. The CP indicated Resident 73 was in her bed responding to internal stimuli when roommate asked her to shut up. During a review of Resident 73's CP for Resident to Resident Abuser, initiated on 7/29/2024, the CP indicated Resident 73 was involved in an altercation with Resident 73's roommate. The CP indicated Resident 73's roommate lunged at Resident 73, and Resident 73 hit back. During a review of Resident 73's Nursing Interdisciplinary Team (IDT, a team of health care professions who work together to establish plans of care for residents) Notes (NIDTN), dated 7/29/2024, timed at 11:50 PM, the NIDTN indicated at 10 PM, Resident 73 was in Resident 73's bed responding to internal stimuli when Resident 87 asked her to shut up. The NIDTN indicated Resident 73 responded and stated, she [Resident 73] would not and what was she [Resident 87] going to do about it. The NIDTN indicated Resident 87 became agitated and lunged at Resident 73 and began punching and kicking her [Resident 73]. The NIDTN indicated Resident 73 retaliated and began fighting back. The NIDTN stated when staff first responded to the altercation incident in the residents' room, both residents were non-receptive to staff and continued fighting while on the floor between both beds. The NIDTN indicated staff immediately separated the residents, but Resident 87 continued to be non-receptive to staff direction. The NIDTN indicated Resident 73 had minor redness around the nose and on her [Resident 73's] right cheek but denied being in pain. During a concurrent observation and interview on 8/5/2024 at 12:03 PM, Resident 73 was in her room, sitting on Resident 73's bed. Resident 73 was calm and cooperative and did not have any bleeding or bruising on Resident 73's face. Resident 73 stated Resident 87 tried to tell Resident 73 about keeping the noise down. Resident 73 stated there was no noise but Resident 87 scratched Resident 73's face and punched Resident 73, so Resident 73 punched her (Resident 87) back. During an interview on 8/7/2024 at 3:02 PM, Counselor 1 (C1) stated Resident 73 was very social and would talk to peers and staff, but Resident 73 talked to herself a lot and made comments to herself. C1 stated before the incident occurred [between Resident 73 and Resident 87], Resident 73 stated, I just heard a joke. C1 stated Resident 73 then started laughing to herself. C1 stated Resident 87 then yelled at Resident 73 and told Resident 73 to shut up, because Resident 87 was trying to sleep. C1 stated Resident 73 stated Resident 73 was allowed to talk to herself and laugh and stated to Resident 87, You can't tell me what to do. C1 stated Resident 87 got up from Resident 87's bed and hit Resident 73's cheek with a closed fist. C1 stated Resident 73 tried to protect herself, so Resident 73 hit Resident 87 back with a closed fist and made contact before staff were able to separate them. B. During a review of Resident 87's Admission Record (AR), the AR indicated the facility initially admitted Resident 87 on 11/21/2023 with multiple diagnoses including schizoaffective disorder (mental illness marked by a mix of symptoms of hallucinations [perceptual experiences in the absence of real external sensory stimuli], delusions [misconceptions or beliefs firmly held, contrary to reality], depression [persistently depressed mood or loss of interest in activities that interfere with daily life], mania [extremely elevated and excitable mood with excessive enthusiasm and overactivity]), morbid obesity (severe obesity characterized by excessive body fat with increased risk of health problems), and asthma (chronic lung condition characterized by narrowed or swollen airways, causing difficulty breathing). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 87's MDS, dated [DATE], the MDS indicated Resident 87 had no impairment in cognition. The MDS indicated Resident 87 had difficulty focusing attention and had disorganized or incoherent thinking (rambling or irrelevant conversations, unclear or illogical flow of ideas, or unpredictable switching from subject to subject). The MDS indicated Resident 87 was independent with most self-care activities and mobility. During a review of Resident 87's Monthly Medical Evaluation (MME), effective date 7/24/2024, the MME indicated Resident 87 was able to make own medical decisions. During a review of Resident 87's physician orders (POs) for 7/2024, the POs indicated the following orders: 1. On 7/29/2024 at 6:38 PM -pen restriction for 7 days related to suicidal ideation (thoughts of wanting to take one's own life) 2. On 7/29/2024 at 6:44 PM - 1:1 monitoring related to threatening to hit peer and expressing suicidal ideation. 3. On 7/29/2024 at 10 PM - 5-point restraints (mechanical restraint device to restrict movement of both arms and legs) up to 4 hours related to danger to others (DTO) as manifested by agitation, punching, kicking, and cursing at peer. After release, place resident on 1:1 monitoring related to suicidal ideation. 4. On 7/29/2024 at 10 PM - Chlorpromazine hydrochloride (antipsychotic medication [main class of drugs used to treat people that have mental disorders like schizophrenia (mental disorder characterized by loss of contact with the environment)] 50 milligrams (mg, unit of measurement of mass) intramuscularly (IM, into a muscle) for severe agitation and assaultive behavior toward peers related to schizoaffective disorder. During a review of Resident 87's CP for physically assaultive behavior, initiated on 7/12/2024, the CP indicated the following: 1. On 7/12/2024, Resident 87 was kicking at staff when struggling again CPI (Crisis Prevention Intervention) protocol. 2. On 7/29/2024, Resident 87 assaulted her roommate, kicking, and punching her. The CP's Interventions included anticipating and meeting the resident's needs and verbal counseling to be done as needed. During a review of Resident 87's Nursing IDT Notes (NIDTN), dated 7/30/2024 timed at 12:20 AM, the NIDTN indicated at 10 PM, while on 1:1 monitoring, Resident 73 was heard laughing and Resident 87 asked Resident 73 to be quiet. The NIDTN indicated Resident 87 did not like Resident 73's response and got out of bed and began punching Resident 73. The NIDTN indicated Resident 73 retaliated and began punching Resident 87. The NIDTN indicated staff immediately responded to the room with both residents on the floor and Resident 87 was on top of Resident 73. The NIDTN indicated staff directed both residents to stop, but Resident 87 was non-compliant and became aggressive toward staff. (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 87's 1:1 Counseling Note (CN), dated 7/30/2024, timed at 3:23 PM, the CN indicated Resident 87 stated Resident 73 came to the room being loud, so Resident 87 asked Resident 73 to keep it down. The CN indicated Resident 73 responded by cursing at Resident 87. The CN indicated Resident 87 stated Resident 87 got triggered and started hitting her [Resident 73]. The CN indicated Resident 87 stated Resident 73 hit Resident 87 back. During a concurrent observation and interview on 8/5/2024 at 11:30 AM, Resident 87 walked in the hallway with staff providing 1:1 monitoring. When asked about the incident with Resident 73, Resident 87 stated, I hit the girl, because she was talking sh*t about me. During an interview on 8/7/2024 at 3:02 PM, C1 stated Resident 87 normally stayed in Resident 87's room and was very paranoid (extreme fear and distrust of others) over roommates. C1 stated Resident 87 was a danger to self because Resident 87 made threats to harm herself when Resident 87 wanted the staff to evict her roommate. During an interview on 8/9/2024 at 9:06 AM, Certified Nursing Assistant 3 (CNA 3) stated CNA 3 was assigned to provide 1:1 monitoring to Resident 87 and was sitting inside the room of Residents 73 and 87, who were roommates at the time of the incident (7/30/2024). CNA 3 stated Resident 87 had verbalized thoughts of hurting herself. CNA 3 stated Residents 87 and 73 were sleeping when CNA 3 stepped out of the room for about 30 seconds to speak with another coworker across the room. CNA 3 stated CNA 3 came back immediately and stood by Resident 87's and 73's doorway when CNA 3 heard Resident 87 mumbling. CNA 3 stated CNA 3 heard Resident 73 stating, Now you want to be quiet and cursed at Resident 87. CNA 3 stated, I did not think much of it. CNA 3 stated about a minute later, while standing by the doorway, CNA 3 heard Resident 87's feet on the ground. CNA 3 stated CNA 3 stepped closer to check on the residents, since both curtains were closed. CNA 3 saw Residents 87 and 73 grabbed each other from their hair, so CNA 3 tried to separate them by getting in between them. CNA 3 stated Licensed Psychiatric Technician 2 (LPT 2) entered the room immediately to help separate the residents. During an interview on 8/9/2024 at 12:13 PM, the Administrator (ADM) stated the facility must prevent any type of resident abuse, so 1:1 monitoring was used for residents who were on suicidal or homicidal (individual likely to take someone else's life) precautions. The ADM stated the staff assigned to provide 1:1 monitoring had to always have direct line of sight of the resident (unobstructed view of the resident). The ADM stated the staff must be within an arm's distance, so the staff could stop or redirect the residents before the resident hit another person. The ADM stated if the resident was suicidal, the staff assigned to provide 1:1 monitoring must stay inside the room and monitor the resident constantly. The ADM stated Resident 87 was on 1:1 monitoring for suicidal and homicidal precautions when the physical altercation occurred, 7/30/2024. The ADM stated the altercation began when Resident 87 told Resident 73 to shut up when Resident 73 came to the room talking. The ADM stated the staff did not intervene at the time. The ADM stated Resident 73 responded by cursing at Resident 87 and stating, Don't tell me to shut up. The ADM stated by the time the staff were able to get to the residents, Residents 73 and 87 were able to hit each other. During a review of the facility's undated policy and procedure (P&P), titled Facility Management Abuse Reporting, P&P indicated the following: 1. The facility must not condone resident abuse by anyone, including staff members, physicians, consultants, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, other residents, friends, or other individuals. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Abuse is defined as the willful infliction of injury, including unreasonable confinement, intimidation, punishment with resulting physical harm, pain, or mental anguish, or deprivation of goods or services necessary to attain or maintain physical, mental, and psychosocial well-being. 3. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. During a review of the facility's P&P, titled Policy and Procedure for 1:1 Monitoring, dated 5/2024, P&P indicated the following: 1. The facility must provide an atmosphere that is safe and secure for all residents and staff and make every effort to assure that residents and staff are safe and secure in a structured environment. 2. The 1:1 monitoring is a tool utilized to assist in providing a safe and secure environment until the resident is deemed stable upon evaluation by the psychiatric provider, medical director, psychologist, program director, or appropriate staff member. 3. The CNA assigned to the resident placed on 1:1 monitoring must seek, find, and document location and condition of the resident every 15 minutes during their shift, and this must be done in a timely manner with a clear and direct line of sight of the resident at all times. 4. A resident may be placed on 1:1 monitoring for the following reasons, but not limited to, the medical conditions, absence without leave (AWOL) precautions, assaultive behavior, suicide precautions, self-harm, other high-risk behaviors, and for 24 hours, if newly admitted . 36924 C1. During a review of Resident 9's Admission Record (AR), the AR indicated the facility admitted Resident 9 on 12/1/21 with diagnoses that included schizoaffective disorder, major depressive disorder, and psychoactive drug abuse (harmful use of alcohol and illicit drugs {illegal drugs}). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had intact cognition. The MDS indicated Resident 9 was able to ambulate independently. C2. During a review of Resident 57's AR, the AR indicated the facility admitted Resident 57 on 10/13/21 with diagnoses that included schizoaffective disorder (mental health condition), and major depressive disorder (serious mental illness affecting mood). During a review of Resident 57's MDS dated [DATE], the MDS indicated Resident 9 had moderately impaired cognition. The MDS indicated Resident 57 was able to ambulate independently. During an interview, on 8/6/24, at 3:49 p.m., with Resident 57, Resident 57 stated Resident 9 hit Resident 57's on the cheek yesterday (Resident 57 demonstrated with closed fist on right cheek). Resident 57 stated Resident 9 did not state the reason Resident 9 hit Resident 57. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 8/7/24, at 10:36 a.m., with Certified Nurse Assistant 2 (CNA 2), CNA 2 stated Resident 9 was not aggressive but would get worked up. CNA 2 stated Resident 9 wanted to get Resident 9's medication so Resident could go on a smoke break. CNA 2 stated sometimes during medication pass, Resident 9 would try to get ahead of other residents because smoke bread was after medication pass. CNA 2 stated Resident 9 exhibited behavior that Resident 9 was trying to get Resident 9's medication as soon as possible. CNA 2 stated residents must wait for all residents to get their medication before the residents were allowed to smoke outside. CNA 2 stated Resident 9 would become anxious (nervous excitement) while waiting to smoke. CNA 2 stated CNA 2 also had seen Resident 57 become physically aggressive to other residents. CNA 2 stated (on 8/6/2024), CNA 2 saw Resident 9 and Resident 57 talking normally, and the next thing CNA 2 saw Resident 9 and Resident 57 grabbed each other. CNA 2 stated CNA 2 did not see who grabbed who first as both residents were grabbing each other at the neck of their shirts. CNA 2 stated CNA 2 told Resident 9 and Resident 57 to separate and stop. CNA 2 stated when CNA 2 saw Resident 9 raised Resident 9's hand CNA 2 called out the code for physical altercation/residents assaulting each other. CNA 2 stated Resident 9 made contact with Resident 57's face. CNA 2 stated CNA 2 and other staff physically separated Resident 9 and Resident 57. CNA 2 stated Resident 9 was not able to land a second blow (hit) on Resident 57. During an interview on 8/7/24, at 4:10 p.m., Resident 9 stated (on 8/6/24), Resident 9 asked Resident 57 why Resident 57 was not moving up in line and Resident 57 hit Resident 9 on his left cheek. Resesident 9 stated Resident 9 hit Resident 57 back on Resident 57's cheek. Resident 9 stated Resident 9 was not injured and had no previous problem with Resident 57. During a concurrent observation and interview on 8/8/24, at 3:41 p.m., with the Director of Staff Development (DSD), a video with no audio (sound) was observed/reviewed. A physical altercation between Resident 9 and Resident 57 near the East Nurse Station was observed on the video. Resident 9 and Resident 57 were standing near the East Unit Nurse Station facing each other. Resident 9's hand was near Resident 57's face and Resident 9 was striking out towards Resident 57's face. Resident 57 was not striking at Resident 9. During an interview on 8/8/24, at 3:52 p.m., CNA 6 stated (on 8/6/24) CNA 6 saw CNA 2 ran toward Resident 9. CNA 6 stated CNA 6 saw Resident 9 holding onto the front of Resident 57's shirt. CNA 6 stated CNA 2 separated Resident 9 and Resident 57. CNA 6 stated CNA 6 went to Resident 57 to see if Resident 57 was okay and CNA 6 blocked Resident 57 so Resident 9 could not do anything else. CNA 6 stated Resident 57 said Resident 57 was okay. During an interview on 8/9/24, at 9:19 a.m. CNA 7 stated (on 8/6/24) CNA 7 was standing by the nurse station on East Unit and he heard a staff shouted hey. CNA 7 stated CNA 7 looked up and saw CNA 2 was already attempted to separate Resident 9 and Resident 57. CNA 7 stated CNA 7 ran to the residents (Residents 9 and 57) to calm Resident 9 and Resident 57. CNA 7 stated Resident 9's hand was in a fist but CNA 7 did not see if Resident 9 hit Resident 57. CNA 7 stated types of abuse include mental, physical. verbal, sexual, neglect, isolation, social media, abandonment, financial, and resident to resident altercation. During a review of the undated facility's Policy and Procedure (P&P), titled, Policy and Procedure- Physical Assault, indicated for the facility is to provide a safe and secure environment to staff and residents. The P&P indicated some examples of physical assault are, but not limited to: punches, kicks, spitting, throwing objects, pushing, grabbing of clothes or person to cause personal harm, etc.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 45064 Based on interview and record review, the facility failed to notify the Ombudsman (an official, public advocate, helps to resolve issues between parties through various types of informal mediation) regarding one of two sampled resident's (Resident 96) transfer/discharge. This failure had the potential to result in violation of Resident 96's rights regarding appropriate discharge and/or transfer and the potential for the Ombudsman to not be able to advocate for Resident 96. Findings: During a review of Resident 96's Admission Record (AR), the AR indicated the facility admitted Resident 96 on 10/18/2022 with diagnoses that included schizophrenia (a chronic [long standing] and severe mental disorder that affects how a person thinks, feels, and behaves characterized by loss of contact with the environment) and post-traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experienced or witnessed). During a review of Resident 96's Minimum Data Set (MDS-a standardized assessment and care planning tool), dated 4/16/2024, the MDS indicated Resident 96 had clear speech, adequate hearing, and had moderate impaired cognition (ability to think and process information). During a review of Resident 96's Physicians Order's (PO) dated 5/10/2024, the PO indicated to transfer Resident 96 to higher level of care. During a review of Resident 96's Progress Notes (PN), dated 5/10/2024, timed at 2:11 PM, the PN indicated Resident 96 was discharged from the facility to a higher level of care. The PN indicated Resident 96 took all of Resident 96's personal belongings and Resident 96's conservator and case manager were notified of the discharge. During a concurrent interview and record review of Resident 96's chart (medical record) on 8/9/2024 at 11:48 AM, with the Medical Records (MR), the MR stated there was no Notice of Proposed Transfer/Discharge Form in Resident 96's chart. The MR stated, the Social Service Designee (SSD) should fill out the Notice of Proposed Transfer/Discharge Form and notify the Ombudsman. During a review of Resident 96's Progress Notes (PN) with the MR, the MR stated, the PN did not indicate the Ombudsman was notified of Resident 96's transfer/discharge. The MR stated, it was important to notify the Ombudsman of transfers/discharges, so the Ombudsman knew where the resident was and could advocate for the resident. During an interview with the Social Service Designee (SSD) on 8/9/2024 at 1:06 PM, the SSD stated Resident 96 was discharged from the facility prior to 5/15/2024 and stated the SSD did not notify the Ombudsman of Resident 96's discharge, because the SSD was not aware the SSD needed to notify the Ombudsman when a resident (in general) was discharged . (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Transfer/Discharge Documentation revised on 4/24/2024, the P&P indicated, [the] Facility will: Notify Long-Term Care Ombudsman of facility-initiated discharges or transfers.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to develop and implement an individualized person-centered care plan (CP) for two of two sampled residents (Resident 44 and Resident 10) as indicated in the facility's policy and procedures (P&P) when, a. Resident 10's High Risk for Falls CP was not updated or addressed falls that occurred on 12/21/2023, 1/4/2024, 1/15/2024, 4/17/2024, 4/24/2024 and 7/7/2024. b. Resident 44 did not have an individualized CP that addressed Resident 44 being a high risk for falls and Resident 44 being legally blind. These failures had the potential to result in unmet individual needs for Residents 10 and Resident 44 and the potential to affect the resident's physical well-being. Additionally, there was a potential for Resident 10 and 44 to receive inaccurate or inconsistent provision of treatments and services. Findings: a. During a review of Resident 10's Admission Record (AR) indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included paranoid schizophrenia (feeling of distrust, suspicious, and fearful of someone without any good reason) and major depressive disorder (causes feelings of sadness and/or a loss of interest in activities once enjoyed), psychosis (a mental disorder characterized by a disconnection from reality), lack of coordination, difficulty walking, and muscle weakness. During a review of Resident 10s Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 7/19/2024, the MDS indicated Resident 10 had severe impaired cognition. During a review of Resident 10's Nursing Risk for Falls Evaluation, (NRFE)dated 12/21/2023, and 1/15/2024, the NRFE indicated Resident 10 was at high risk for falls. During a review of Resident 10's Progress Notes (PN), the PN indicated Resident 10 had falls on 12/21/2023, 1/4/2024, 1/15/2024, 4/17/2024, 4/24/2024 and on 7/7/2024. During an interview and concurrent review of Resident 10's paper and electronic medical records with the Quality Assurance Nurse (QAN), on 8/7/2024 at 9:48 AM, the QAN stated CPs were important to tract and implement interventions to prevent falls from occurring again and to find causes and precipitating factors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent record review of Resident 10's paper and electronic medical records-High Risk for Falls CP, date initiated 12/21/2023, with Registered Nurse 1 (RN 1) on 8/9/2024 at 11:34 AM, RN 1 stated high risk for falls CPs were updated after every fall. RN 1 stated Resident 10's risk for falls CP was not updated after each fall that occurred on 12/21/2023, 1/4/2024, 1/15/2024, 4/17/2024, 4/24/2024 and 7/7/2024. RN 1 stated it was important to indicate the proper interventions after every fall. RN 1 stated we (the facility) needed to evaluate interventions that were in-place to see if they were working or not working. During a review of the facility's P&P titled, Falls and Fall Risk Evaluations, dated 2/2024, indicated a care plan will be opened for a potential for injury/actual injury if indicated, and a care plan for actual fall. b. During a review of Resident 44's Admission Record (AR), the AR indicated Resident 44 was admitted to the facility 8/31/2023 with a diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), cataracts (clouding of the normally clear lens of the eye), tributary retinal vein occlusion (blurry vision or vision loss), and legal blindness (unable to see). The AR indicated Resident 66 was under conservatorship (a court appoints another person to act or make decisions for the person who needs help). During a review of Resident 44's Progress Notes (PN) - Monthly Medical Evaluation, dated 9/6/2023, the PNs indicated Resident 44 was confused, had a tangential (something that goes off in one direction) thought process, and judgement and insight was impaired. During a record review of Resident 44's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 5/31/2024, the MDS indicated Resident 44's behavior continuously disorganized thinking (rambling, irrelevant, unclear, or illogical) behavior. The MDS indicated Resident 44 had severely impaired vision (no vision or sees only light, colors, or shapes). During a review of Resident 44's NRFE, dated 5/27/2024, the NRFE indicated Resident 44 was a high risk for falls. During an observation on 8/5/2024 at 11:57 AM, Resident 44 was walking slowly to the dining room; holding on to the hallway hand rails to move from one location to the other. During an interview with the Quality Assurance Nurse (QAN), on 8/7/2024 at 10:15 AM, the QAN stated Resident 44 was legally blind and used the hallway side rails as a guide to move from one place to another. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and concurrent review of Resident 44's CP titled High Risk for Falls due to Being Legally Blind ., date initiated 3/25/2024, with RN 1, on 8/7/2024 at 3:58 PM, RN 1 stated the CP indicated assistance PRN (as needed) from staff with ambulation (gait, a manner of walking or moving on foot). RN 1 stated due to Resident 44's blindness and being unaware of Resident 44's surroundings, Resident 44 was a high risk for falls. RN 1 stated Resident 44 needed assistance from staff during activities of daily living (ability to bath and groom oneself and maintain dental, hair and nail care). RN 1 stated the resident's CP needed to address the resident's safety pertaining to gait every shift and not just PRN. RN 1 stated Resident 44 needed to be monitored in the dining room, in the shower, and during activities because there were other residents Resident 44 could bump into. RN 1 stated Resident 44's CP was not individualized to address Resident 44's safety related to blindness and high risk for falls. During a review of the facility's undated P&P titled, Baseline Care Plans/Comprehensive Care Plans, the P&P indicated the ultimate goal was to assist the resident to attain or maintain their highest practicable physical, mental and psychosocial well-being. Care plans will be updated as resident need mandates. During a review of the facility's P&P titled, Nursing Care Plans, dated 9/2021, the P&P indicated all nursing care plans are reviewed weekly during the weekly nursing summary.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to revise the Comprehensive Care Plan (CP) for falls following recurrent/repeated fall incidents for one of one sampled resident (Resident 84). This failure had the potential to result in an avoidable fall and injury to Resident 84. Findings: During a review of Resident 84's Admission Record (AR), the AR indicated Resident 84 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems), autonomic nervous system disorder (condition that causes dizziness and fainting when standing) and repeated falls. During a review of Resident 84's CP titled, High Risk for Falls (as identified on the Fall Risk Assessment) initiated on 1/21/2024, the CP indicated the following: -On 2/1/24- Resident 84 had a witnessed fall to bilateral knees. - On 2/6/24- Resident 84 had a high fall risk assessment. -On 2/19/24- Resident 84 had a witnessed fall with injury to left foot. -On 3/28/24- Resident 84 had witnessed fall on buttock. - On 4/11/24, Resident 84 had witnessed fall on buttock. -On 4/26/24- Resident 84 had witnessed fall onto the right buttocks. The CP goal was for Resident 84 to be free of complications related to falls. The CP interventions were not revised after Resident 84's recurrent falls. During a review of Resident 84's CP titled, Actual Fall, dated 1/21/2024, the CP indicated Resident 84 had previous actual falls on: 2/1/2024- Unwitnessed fall to bilateral knees. 2/2/2024- Unwitnessed fall at resident's bathroom. 2/19/2024- Unwitnessed fall with injury to left foot. 3/28/2024- Fall onto buttock. 4/11/2024- Fall onto buttock. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/26/2024- Witness fall onto right buttock. The CP interventions were not revised after Resident 84's recurrent falls. During a review of Resident 84's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/7/2024, indicated Resident 84's cognition (ability to think and process information) was moderately impaired (significantly limited) and Resident 84's mobility was independent. During an interview on 8/7/2024 at 9:58 AM with the Quality Assurance Nurse (QAN), the QAN was not able to provide documentation that Resident 84's Care Plan CP titled, Actual Falls and High Risk for Falls, were revised after Resident 84 had repeated falls. The QAN stated the facility needed to implement and identify interventions to prevent recurring falls for Resident 84. During a concurrent record review and interview on 8/8/2024 at 9:15 AM with the QAN, Resident 84's CP titled, Actual Fall, and High Risk for Falls were reviewed. The QAN stated Resident 84's CP have been a recycled CP (CP that had been reused or reactivated) and Resident 84's CPs were not revised/updated to address Resident 84's repeated falls. During an interview on 8/8/2024 at 11:05 AM the QAN stated the importance of revising the CP interventions was for the staff to determine which interventions were effective and which ones were not. During an interview on 8/9/2024 at 3:51 PM with Registered Nurse (RN 1), RN 1 stated CP revision was important because it was the facility's implementation and plan of action to respond to the current situation of the resident. RN 1 stated CP revision was important because it would identify which interventions implemented were effective or not in preventing falls. RN 1 stated, staff would not be able to evaluate the effectiveness of the action plan if the interventions were not documented. During a review of the facility's Policy & Procedure (P&P) titled Nursing Care Plan, dated September 2021, the P&P indicated all Nursing Care Plans are reviewed and updated Quarterly when the Quarterly MDS is due. Care Plans will be updated as resident needs mandate. Care Plans are updated by the interdisciplinary team.

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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** 36924 Based on observation, interview and record review, the facility failed to provide care and services to prevent a fall (move downward, typically rapidly and freely without control, from a higher to a lower level) for one of one sampled resident (Resident 84) who was assessed as high risk for fall, by failing to: 1. Ensure facility staff provided supervision/monitoring to Resident 84 to prevent recurrent (repeated) falls. 2. Ensure Resident 84's care plan (CP) for falls, titled, High Risk for Falls, dated 1/21/2024 had specific interventions to address Resident 84's recurrent falls. 3. Ensure Resident 84's CP was revised with new interventions after the resident's recurrent falls. As a result, on 6/19/2024 at 8:45 AM Resident 84 sustained a non-displaced fracture (a broken bone that retains its alignment) neck of the second (2nd) and third (3rd) metatarsals (five long bones in the foot connecting the ankle to the toes) on the left foot, while under the care of the facility. Cross reference F657 Findings: During a review of Resident 84's Admission Record (AR), the AR indicated Resident 84 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental condition that causes both a loss of contact with reality (psychosis) and mood problems), autonomic nervous system disorder (condition that causes dizziness and fainting when standing) and repeated falls. During a review of Resident 84's CP titled, High Risk for Falls (as identified on the Fall Risk Assessment) initiated on 1/21/2024, the CP indicated the following: -On 2/1/2024- Resident 84 had a witnessed fall to bilateral knees. - On 2/6/2024- Resident 84 had a high fall risk assessment. -On 2/19/2024- Resident 84 had a witnessed fall with injury to left foot. -On 3/28/2024- Resident 84 had witnessed fall on buttock. - On 4/11/2024, Resident 84 had witnessed fall on buttock. -On 4/26/2024- Resident 84 had witnessed fall onto the right buttocks. (continued on next page)

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	08/09/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CP's goal was for Resident 84 to be free of complications related to falls. The CP did not indicate specific interventions to address Resident 84's recurrent falls. The CP interventions were not revised after Resident 84's recurrent falls. During a review of Resident 84's CP titled, Actual Fall, dated 1/21/2024, the CP indicated Resident 84 had previous actual falls on: 2/1/2024- Unwitnessed fall to bilateral knees. 2/2/2024- Unwitnessed fall at resident's bathroom. 2/19/2024- Unwitnessed fall with injury to left foot. 3/28/2024- Fall onto buttock. 4/11/2024- Fall onto buttock. 4/26/2024- Witnessed fall onto right buttock. The CP did not indicate specific interventions to address Resident 84's recurrent falls. The CP interventions were not revised after Resident 84's recurrent falls. During a review of Resident 84's most recent quarterly Fall Risk Evaluation (FRE) dated 5/2/2024, the FRE indicated Resident 84 was assessed as high risk for fall due to Resident 84 had a history of three or more falls in the past three months, had gait (manner of walking) problem while standing and walking/decreased muscular coordination/unsteady gait, was taking three or four medications (unspecified) and had three or four pre-disposing conditions (unspecified). During a review of Resident 84's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/7/2024, the MDS indicated Resident 84's cognition (ability to think and process information) was moderately impaired. The MDS indicated Resident 84 was independent with mobility (ability to move freely). During a review of Resident 84's CP titled, Actual Injury to Left Foot-Swollen Related to Unwitnessed Fall, dated 6/19/2024, the CP indicated Resident 84 had a sprain (twist of a ligament of a joint) of the left ankle and closed non-displaced fracture of the second metatarsal bone of the left foot. The CP interventions included to place Resident 84 in wheelchair and use post-operative shoes (post -op shoes- is a medical show used to protect the foot and toes after an injury). The CP interventions also included orthopedic (referring to the bones) referral and non-weight bearing on the left foot. During a review of Resident 84's facility Radiology (X-ray a photographic or digital image of tissues and structures inside the body) Report of Resident 84's left foot dated 6/19/2024, the RR indicated Resident 84 had nondisplaced fracture neck of the 2nd and 3rdmetatarsals. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 84's Progress Notes: Status Post Fall Follow Up Investigation Note (PN) dated 6/20/2024 at 11:42 AM, the PN indicated Resident 84 stated Resident 84 thought she had a fall last night (6/19/2024). The PN indicated upon assessment by Registered Nurse 1 (RN1), RN 1 observed Resident 84's left foot/ankle was swollen, warm to touch and with discoloration. The PN indicated Resident 84 required minimal assistance to complete Activities of Daily Living (ADL) and ambulating. The PN indicated RN 1 noted limited Range of Motion (ROM-full movement of a joint) to Resident's 1's left foot/ankle. The PN indicated MD 1 was notified and MD 1 ordered Xray to the left foot/ankle of Resident 84. During a review of Resident 84's Routine Podiatry (referring to the feet) Consult (RPC) notes, dated 6/21/2024, the RPC indicated Resident 84 stated Resident 84 fell a few days ago and twisted Resident 84's left ankle and fractured Resident 84's 2nd and 3rd metatarsal head according to the X-ray results. During a concurrent observation in Resident 84's room and interview with Resident 84 on 8/6/2024, at 9:05 AM Resident 84 was alert, wearing a boot on the left foot and was in a wheelchair, wheeled by Certified Nursing Assistant 5 (CNA 5). Resident 84 stated Resident 84 was walking in the hallway and fell on [DATE]. Resident 84 stated Resident 84 blacked out (temporary loss of consciousness) and fell . During an interview with CNA 2 on 8/7/2024, at 10:25 AM CNA 2 stated Resident 84 would sometimes hold the rail in the hallway to ambulate. CNA 2 stated, on 6/19/2024, Resident 84 walked towards the dining room with one hand on the rail and Resident 84's legs started getting wobbly (unsteady) and Resident 84 fell on her buttocks. During an interview with the Quality Assurance Nurse (QAN) on 8/8/2024, at 12:11 PM the QAN stated the facility failed to identify the root cause of Resident 84's repeated falls. The QAN stated the facility had to identify specific interventions for Resident 1's repeated falls. During an interview, 8/9/2024, at 3:51 PM with RN 1, RN 1 stated before the most recent fall on 6/19/2024, Resident 84 was already confused and Resident 84's gait was sometimes unstable, putting Resident 84 at a risk for falls. During a review of the facility's Policy & Procedure (P&P), titled, Policy for Reporting/Investigating/Assessing/Evaluating Accidents and Incidents, updated 12/2021, the P&P indicated all attempts will be made to prevent residents from falling. The P&P further indicated, all residents are ambulatory when admitted and without use of walking devices. o Keep resident room free of clutter o Remind residents to tie shoes o Assure proper lighting in rooms and around the facility o Attempt to have residents wear proper foot ware o Encourage resident to wear proper fitting clothing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o Discourage running or fast walking in hall and common areas o Encourage residents to call for assistance using call lights if having issues with mobility

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents' (Resident 49) did not continue to experience progressive weight loss by failing to reassess Resident 49, provide meal intake encouragement for Resident 49 to consure 80 to 100% of Resident 49's meal, provide Nutrition Education Group every Saturday, and provide a banana for lunch and dinner in Resident 49's meal tray in accordance with the physician's order (PO), Resident 49's care plans (CP), and the facility's policy and procedures (P&P). These failures resulted in continued weight loss to Resident 49. Resident 49 lost 13.2 pounds (lbs. unit of weight) in six consecutive months from 3/2024 to 8/2024. Findings: During a review of Resident 49's Admission Record (AR), the AR indicated, Resident 49 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that combines symptoms of schizophrenia [a serious mental health condition that affects how people think, feel and behave], bipolar type (a mental health condition that affects your moods, which can swing from one extreme to another), hypokalemia (a blood level that is below normal in potassium, an important body chemical) and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). During a review of Resident 49's History and Physical (H&P), dated 4/13/2022, the H&P indicated, Resident 49 was confused and Resident 49's judgement and insight were impaired. During a review of Resident 49's CP, titled Weight Maintenance date initiated 10/31/2022, the CP indicated, two of the interventions were diet per POs and Resident 49 would be encouraged to eat 80-100% of meals served. During a review of Resident 49's CP, titled Risk for Malnutrition, date initiated 4/6/2023, the CP indicated, one of the goals was for Resident 49 would eat at least 50% of every meal offered and two of the interventions included to educate Resident 49 on the importance of nutrition - Nutrition Education Group would be available each week on Saturday and Resident 49 would be encouraged to eat 80-100% of meals served. During a review of Resident 49's RD Nutrition Assessment Admission/Annual NAA, dated 4/13/2023 timed at 1:31 PM the NAA indicated, to continue to monitor Resident 49's weights and encourage Resident 49 to increase po (oral) intake at every meal. During a review of Resident 49's Minimum Data Set (MDS, an assessment and screening tool), dated 7/4/2024, the MDS indicated, Resident 49's cognitive (ability to think and process information) skills were moderately impaired. The MDS indicated, Resident 49 was independent of eating and had no signs and symptoms of possible swallowing disorders. The MDS indicated, Resident 49 had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on the physician-prescribed weight loss program. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 49's Order Summary Report (OSR), dated active as of 8/7/2024, the OSR indicated, a diet of Regular, Large portions to include banana for lunch and ice cream for lunch and dinner for weight maintenance, dated 1/24/2023. During a review of Resident 49's undated Weights and Vitals Summary (WVS), the WVS indicated the following monthly weights from 3/8/2024 to 8/2/2024: 3/8/2024 112 lbs. 4/5/2024 107 lbs. 5/3/2024 102 lbs. 6/1/2024 100 lbs. 7/5/2024 100 lbs. 8/2/2024 98.8 lbs. The WVS indicated, Resident 49 had a weight loss of 13.2 lbs. (-11.79 %) in 6 months. During a concurrent observation on 8/5/2024 at 12:46 PM with Surveyor 2, Resident 49 arrived to the dining room for lunch. Resident 49 was observed to be petite (thin body frame) and moved slowly. Resident 49's lunch tray included a plate of pork chop stew with vegetables over rice, a small (5-ounce, oz., unit of weight or volume) Styrofoam bowl of coleslaw, a cup of orange sherbet ice cream, a slice of apple cobbler, a cup of milk, and a cup of water. There was no banana in Resident 49's lunch tray. Resident 49 ate 100% of the coleslaw, ate 100% of the orange sherbet ice cream, and drank 50% of the milk. No staff provided encouragement to eat more to Resident 49. Resident 49 returned the lunch tray back to the cart. During an observation on 8/5/2024 at 12:55 PM in the Dining Room, a staff (unnamed) was reminding residents lunch time was almost over. During a concurrent observation and interview on 8/6/2024 at 12:40 PM with Certified Nursing Assistant (CNA) 4, in the dining room, Resident 49 was not in the dining room. CNA 4 stated, Resident 49 did not want to come out for lunch. During an interview on 8/6/2024 at 3:35 PM with Resident 49, Resident 49 stated Resident 49 was not eating good because Resident 49 did not like the food the facility provided, and Resident 49 had lost weight. Resident 49 stated, Resident 49 preferred pizza and lasagna. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 8/8/2024 at 7:40 AM in the dining room with Licensed Vocational Nurse (LVN) 2, LVN 2 was collecting the residents' breakfast trays as residents came up to the cart after eating. Resident 49 was observed returning Resident 49's tray back to the cart. Resident 49's breakfast tray had 50% of food remaining (50% consumed). LVN 2 stated, LVN 2 had noticed Resident 49 lost weight. LVN 2 stated, Resident 49 normally ate 50% of Resident 49's meals on a good day and ate what Resident 49 liked to eat. LVN 2 stated, Resident 49 barely ate maybe 25% on a regular basis. LVN 2 stated, staff should have encouraged specific resident, like [Resident 49] if residents were not eating well and to remind Resident 49 to eat, important to have food in her stomach. During a concurrent interview and record review on 8/8/2024 at 8:12 AM with Dietary Aide (DA) 1 and DA 2, Resident 49's meal card was reviewed. The meal card indicated, regular large, salad, and ice cream, lunch and dinner. DA 1 stated, Resident 49 received what was indicated on Resident 49's meal card for lunch and dinner. During a concurrent interview and record review on 8/8/2024 at 9:54 AM with the Director of Nursing (DON), Resident 49's Medical Record (MR), including Resident 49's CP and the OSR were reviewed. The DON stated, Resident 49 was losing a lot of weight and the DON had talked to Resident 49 to ask what food Resident 49 liked. The DON stated, Resident 49 was not eating and only liked ice cream pudding. Resident 49's OSR, dated active as of 8/7/2024, indicated, a diet order, dated 1/24/2023, for Regular, Large portions to include banana for lunch. Additionally, Resident 49's CP, titled Weight Maintenance, date initiated 10/31/2022, indicated, interventions included diet per physician's order including banana at lunch and dinner and Resident 49 would be encouraged to eat 80-100% of meals served. The DON stated, Resident 49's meal tray should have included banana as ordered by the physician. The DON stated, the facility was aware of Resident 49's weight trending downward and an IDT (Interdisciplinary Team, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) should have been done [to discuss the weight loss]. The most current IDT addressing Resident 49's weight loss was conducted on 5/9/2024 timed at 11:04 AM and on 7/3/2024 timed at 11:24 AM. The IDT dated 7/3/2024 indicated, recommendations included to continue to encourage [meal] intake and update Resident 49's food preferences. The CP, titled Risk for Malnutrition, date initiated 4/6/2023, indicated, one of the goals was for Resident 49 to eat at least 50% of every meal offered and two of the interventions were to educate Resident 49 on the importance of nutrition and Nutrition Education Group would be available each week on Saturday and Resident 49 would be encouraged to eat 80-100% of meals served. The DON stated, staff should be encouraging residents who are not eating well and should have encouraged Resident 49 to eat more, for Resident 49's wellbeing and for Resident 49 not lose more weight. The DON stated, staff might just be thinking their role [entailed resident] safety only and when monitoring residents during dining. The DON stated, the DON needed to provide in-services to the staff. The DON stated, the DON did not know what Nutrition Education Group was and was unsure if it (Nutrition Education Group) was provided to Resident 49. During a concurrent interview and record review on 8/8/2024 at 10:34 AM with DA 1, Resident 49's meal card was reviewed. The meal card indicated, regular large diet, salad, and ice cream, lunch, and dinner. DA 1 stated, DA 1 did not know Resident 49 was supposed to get a banana with lunch and dinner. DA 1 stated, the kitchen provided Resident 49 with snacks but Resident 49 sometimes she eats, sometimes she [does] not. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 8/9/2024 at 10:11 AM with the Registered Dietician, Resident 49's MR including the NAA and CP were reviewed. The RD stated the last time a NAA was conducted for Resident 49 was on 4/13/2023. The RD stated, a NAA should have been done this year to reassess Resident 49 and to avoid weight loss. The RD stated, the RD did not know and had never heard of a Nutrition Education Group. The RD stated, following Resident 49's diet and recommendations was important to so that Resident 49 did not have further weight loss. During an interview on 8/9/2024 at 11:22 AM with the Quality Assurance Nurse (QAN), the QAN stated, the facility no longer offered the Nutrition Education Group since 7/2022. During a review of the facility's P&P titled, Weight Management Policy, updated 9/1/2020, the P&P indicated, it was the policy of the facility to assess and monitor residents monthly weight to ensure interventions were implemented to an acceptable weight as indicated. The P&P indicated, a planned intervention was implemented on all residents weight loss and weight gain. During a review of the facility's P&P titled, Policy for Carrying Out Orders from Medical/Psychiatric Providers, dated 5/2024, the P&P indicated, it was the facility policy to carry out all orders prescribed by any and all Medical and or Psychiatric Providers for all residents admitted to the facility.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36288 Based on interviews and record review, the facility failed to ensure the facility had a Registered Nurse (RN) at least 8 consecutive hours a day for 7 days a week for one of 10 sampled dates in July 2024 (7/28/2024). This failure had the potential to cause a decline in the residents' physical and/or psychosocial well-being related to insufficient supervision, monitoring, and coordination of care and services by an RN. Findings: During an interview on 8/7/2024 at 11:41 AM, the Director of Nursing (DON) stated another RN, other than the DON, was necessary to assist the charge nurses with supervision and monitoring of residents, since the facility has many resident incidents. The DON stated the RN was necessary to assist resident admissions and discharges to ensure all the care and services, including medications, were coordinated prior to transfers to board and care facilities. During an interview and concurrent review of staffing assignment on 8/7/2024 at 04:05 PM with the DON, the staffing assignment and RN timecards were reviewed. The DON stated on 7/28/2024, there was no RN, who worked in the facility. The DON stated the scheduled RN called in sick and no other RN was available to work at the time. During an interview and concurrent review on 8/9/2024 at 11:32 AM with the DON, the facility's policy and procedure (P&P 1), titled Staffing Policy (undated), was reviewed. The DON stated the facility must have an RN at least 8 consecutive hours 7 days per week to do RN duties. The DON stated P&P 1 did not indicate the daily 8 consecutive hours RN requirement. During a review of the Facility Assessment, dated 7/10/2024, the Facility Assessment indicated the plan to have 1 part-time RN Supervisor during the weekends and 1 full-time RN Supervisor during weekdays from Monday to Friday. In addition, during a review of the facility's RN Supervisor's Job Description (undated), the RN Job Description indicated some of the RN duties as follow: 1. Quarterly and admission assessments of residents; 2. Supervision of Charge Nurses and the floor staff; 3. Follow up on abnormal laboratory results; and 4. Assist with medical doctor visits and follow up on new orders.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 31333 Based on observation, interview, and record review, the facility failed to have a system in place to ensure safeguarding of all prescribed medications including controlled medications (medications with a high potential for abuse) for 17 of 17 Resident (Residents 18, 20, 25, 27, 28, 34, 37, 45, 51, 55, 57, 71, 84, 97, 148, 150, and 151) by failing to: 1. Maintain accountability records for all controlled substances/medications that were disposed of or destroyed with the unused supply between 1/1/2024 through 8/8/2024 and ensure each resident's individual controlled drug record (CDR, any Schedule 2 through Schedule 5 controlled drugs [potential for abuse and/or addiction] received or supplied by a pharmacy) for each controlled medication was used for accurate accountability of controlled medications for 6 of 6 sampled Residents (Residents 34, 71,97, 148, 150 and 151). Controlled medications included lorazepam and clonazepam (medications used to treat anxiety, a mental disorder characterized by persistent feelings of worry, nervousness, or unease strong enough to interfere with daily activities), zolpidem (medication used to treat insomnia, difficulty falling asleep), lacosamide and clobazam (medication used to treat seizures, a sudden rush of abnormal electrical activity in your brain). 2. Ensure medication carts and cabinets contained controlled medications and biologicals, were maintained locked, and not left unattended when not in use to prevent the potential for unauthorized access to medications that included noncontrolled medications stored in medication carts in two of two nursing stations (West Nursing Station Medication Cart and East Nursing Station Medication Cart) for 11 of 11 sampled Residents (Residents 18, 20, 25, 27, 28, 37, 45, 51, 55, 57 and 84). 3. Ensure the access keys were not the same keys to access other medications and controlled medications and were not stored inside the medication carts and failed to ensure licensed nurses (all licensed nurses) maintained possession of the keys to controlled medications and the keys were not left inside of an unlocked medication cart in the East Nursing Station. These deficient practices resulted in a facility wide system failure to secure and accurately account for and reconcile controlled medications for Residents 18, 20, 25, 27, 28, 34, 37, 45, 51, 55, 57, 71, 84, 97, 148, 150 and 151. The failure placed the facility at risk for medication errors, residents to receive more or less medication than prescribed, adverse reactions (harmful or unpleasant reaction, resulting from an intervention related to the use of a medication) such as: falls, hospitalization s, harm, and inability to readily identify the loss or drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of controlled medications. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 8/8/2024, while onsite at the facility, the California Department of Public Health (the Department) identified an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) regarding the facility's failure to ensure safeguarding of controlled medications. The survey team notified the Administrator (ADM), the Director of Nursing (DON), the Registered Nurse Supervisor (RNS), the Quality Assurance Nurse (QAN), the Social Services Designee (SSD), the Director of Staff Development (DSD), and the Infection Preventionist (IP) of the IJ situations on 8/8/2024, at 3:07 PM due to the facility failure to maintain countability for controlled medications for Residents 34, 71, 97, 148, 150 and 151, and failure to keep controlled medications locked/secured for Residents 18, 20, 25, 27, 28, 37, 45, 51, 55, 57 and 84. On 8/9/2024, the facility submitted an acceptable IJ Removal Plan (IJRP, plan that includes interventions to immediately correct the deficient practices). While onsite at the facility, the survey team determined the IJ situation was no longer present and confirmed/verified the facility's full implementation of the IJRP through observations, interviews, and record review. The IJ was removed on 8/9/2024 at 7:13 PM in the presence of the ADM, the DON, the QAN, and the DSD. The IJPR included the following immediate actions: 1. All controlled medications for the 17 sampled residents were immediately secured in a locked box within the medication cart. 2. A routine count sheet was created for each resident that received controlled medications. 3. All routine narcotic medications were moved to a locked box within the medication cart with individual counting sheets for each medication. 4. On 8/8/2024, the DON and the new Pharmacy Consultant (Pharm 3) conducted a facility-wide audit to identify all residents that received controlled medications. All 95 residents were considered at risk due to the systemic nature of the deficiency. The same immediate actions taken for the 17 sampled residents were implemented for all residents that received controlled medications. 5. On 8/08/2024, a root cause analysis was conducted, including interviews with nursing staff, review of medication administration records, and analysis of current policies and procedures. The analysis revealed: a. Lack of a robust system for controlled medication accountability b. Inadequate staff training on controlled medication management c. Insufficient security measures for medication storage 6. Effective 8/8/2024, a new controlled medication accountability system was implemented: a. Individual counting sheets for each resident's-controlled medication. b. Dual nurse sign-off (process that required two licensed nurses to approve or initiate a change) for waste (leftover or unused medications that were discarded) or refusal of controlled medications. (continued on next page)

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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	08/09/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Beginning 8/8/2024, the DON conducted audits of controlled medication management: a. Every shift for the next 48 hours (until 8/9/2024) b. Twice weekly for three weeks (until 8/31/2024) c. Weekly thereafter beginning 8/31/2024. The DON would review all discrepancies identified during the audits, notify the Medical Director and pharmacy as needed, and document the findings for Quality Assurance and Assessment (QAA, provides framework for evaluating a facility's systems to prevent deviation and to correct inappropriate care processes, responds to quality deficiencies identified in the facility) review. 2. Beginning 8/9/2024, the DON would oversee the disposal (discarding unused drugs) of discontinued controlled medications in collaboration with the facility's pharmacist. 3. Beginning on 8/9/2024, the destruction of medical records would be kept in accordance with Title 22 (state regulations). The Director of Nursing would report the monitoring plan results to the QAA Committee monthly. The QAA Committee would monitor on an ongoing basis until sustained compliance is achieved and report results in quarterly QAA meetings. Findings: 1. During a concurrent observation of the controlled medication storage inside the DON's office, and interview with the DON, on 8/7/2024 at 3:03 PM. The DON stated the DON's office was shared with the DSD and the IP. The DON stated controlled medications awaiting disposal were stored in a cabinet inside of the DON's office and the DSD kept the key to the cabinet. The cabinet was observed unlocked. The DON stated the DON placed the controlled medications, awaiting disposal, on top of a box inside of a cabinet. The DON stated the DON did not have a designated or secure location to store controlled medications awaiting disposal. During a concurrent interview with the DON and record review on 8/7/2024 at 3:08 PM, the CDR forms for Residents 34, 71, 97, 148, 150 and 151 indicated the following: a. Resident 34's CDR form with a pharmacy fill date of 2/7/2024, labeled for zolpidem tartrate 10 milligram (mg, unit of measurement) tablet, indicated a total of 30 tablets. The CDR form did not indicate signatures from licensed nurses to show the date, time, and quantity for each dose of zolpidem removed for administration to Resident 34. b. Resident 71's CDR form with a pharmacy fill date of 6/20/2024, labeled for lorazepam 1 mg, 1 tablet taken every 6 hours PRN (as needed), indicated a total quantity of 39 tablets and a disposed quantity of 36 tablets. The form indicated the DON and Pharm 1 signed on the bottom left of the form, dated 7/30/2024 for the disposal of 36 tablets. The CDR form did not indicate signatures from licensed nurses to show the date, time, and quantity for each dose of lorazepam removed for administration to Resident 71. c. Resident 97's CDR form with a pharmacy fill date of 1/24/2024, labeled for clonazepam 1 mg, indicated a total quantity of 75 tablets of clonazepam and a disposed quantity of 30 out of 75 tablets. The form indicated the DON and Pharm 1 signed on the bottom left of the form, dated 2/17/2024 for the disposal of 30 tablets. The CDR form did not indicate signatures from licensed nurses to show the date, time, and quantity for each dose of clonazepam removed for administration to Resident 97. (continued on next page)

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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. Resident 148's CDR form with a pharmacy fill date of 1/10/2024, labeled for lorazepam 1 mg, indicated a total quantity of 90 lorazepam tablets and a disposed quantity of 30 tablets. The form indicated the DON and Pharm 1 signed on the bottom left of the form, dated 2/22/2024 for the disposal of 30 tablets. The CDR form did not indicate signatures from licensed nurses to show the date, time, and quantity for each dose removed for administration to Resident 148. e. Resident 150's CDR form with a pharmacy fill date of 4/17/2024, labeled lorazepam 1 mg, tablet with instructions to administer one tablet by mouth twice daily indicated there were 58 lorazepam tablets and the disposal quantity was 29 out of 58 tablets. The form indicated the DON and Pharm 1 signed the form, dated 5/21/2024, on the bottom left to indicate the disposal of 29 tablets. The CDR form included a handwritten note that indicated, given routinely. The form did not indicate signatures from licensed nurses to show the date, time, and quantity for each dose removed for administration to Resident 150. f. Resident 151's CDR forms with pharmacy fill date of 2/7/2024, labeled for lacosamide 200 mg, give one tablet by mouth twice a day, indicated a total quantity of 60 tablets. The CDR form did not indicate signatures for the disposal of the medications nor signatures from licensed nurses to show the date, time, and quantity for each dose of lacosamide removed for administration to Resident 15. During a concurrent interview with the DON and record review on 8/7/2024 at 3:08 PM, the DON stated the signatures on the bottom of the CDR forms belonged to the DON and Pharm 1. The DON stated discontinued and expired controlled medications were last destroyed on 7/30/2024 with Pharm 1. The DON stated the section for dispensed medications on the CDR forms labeled for individual residents were left blank. The DON stated the facility did not accurately account for the discontinued and expired controlled medications. During an interview with the DON on 8/7/2024 at 3:15 PM, the DON stated both the DON and Pharm 1 would not go back to compare Residents' (Residents 34, 71, 97, 148 150 and 151's) MARs with each CDR form to ensure all doses of controlled medications were administered as ordered by the physician and to address the discrepancy between the original quantity and the disposal of medications. The DON stated, the DON and Pharm 1 did not verify or account for the disposal/destruction of controlled medications for each dose of controlled medication that were not recorded on the CDR forms. The DON stated the licensed nurses did not document on the CDR forms when controlled medications were removed and administered to the residents. The DON stated when Pharm 1 came to the facility to dispose controlled medications with the DON, the DON and Pharm 1 did not go back to compare with the residents' MAR or any residents' medical records. The DON stated the facility did not have a system to ensure all doses of the controlled medications were administered to the residents or to reconcile or account for the discrepancy between the original quantity delivered to the facility and the quantity destroyed. The DON stated the facility did not have a system to account for each dose of controlled medication being wasted, refused, or not administered to a resident as prescribed. The DON stated there was no shift change audit (a controlled medication reconciliation document signed by two nurses during shift change) done between the oncoming nurse (nurse starting the shift) and the outgoing nurse (nurse leaving) to verify that all controlled medications inside the medication carts were accurate and accounted for before endorsing the medication carts from one nurse to the next nurse. (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent observation of the medication cart in the [NAME] Nursing Station and interviews with LVN 3 and LVN 4 on 8/7/2024 at 3:40 PM, there were controlled medications stored together with noncontrolled medications in the medication cart. LVN 3 showed a large binder located on the [NAME] Nursing Station that was filled with CDR forms and had prescription labels from the facility's dispensing pharmacy. LVN 4 stated licensed nurses never filled the CDR forms out to account for each dose of controlled medications removed for administration to the residents. LVN 4 stated the licensed nurses did not count the controlled medications during shift change before endorsing the medication carts to the nurses from the next shift. During an interview on 8/7/2024 at 3:50 PM with LVN 3 and LVN 4, LVN 4 stated LVN 4 would not have any idea if controlled medications were missing, diverted for personal use, or if all the controlled medications for each resident were accounted for because nurses did not count the controlled medications between shifts. LVN 3 stated the licensed nurses would not know if controlled medications became missing or were misused because the medications were kept among the noncontrolled medications, and the controlled medications were not counted each day. During a telephone interview on 8/8/2024 at 8:19 AM with the DON and Pharm 1, Pharm 1 stated the facility's licensed nurses were supposed to document on the controlled drug count down sheet (CDR) each time they remove a controlled medication for resident administration. Pharm 1 stated the nurses were also expected to verify the controlled medications with two nurses during the change of shift to make sure the controlled medication count was accurate before the outgoing nurse endorsed (hands over the medication cart key) to the oncoming nurse, and if there were any discrepancies with the controlled medications, two nurses could work to resolve any concerns. Pharm 1 stated, that was the standard of practice for handling-controlled medications. Pharm 1 stated the controlled medication count down sheets (CDR) needed to be filed away as a permanent record to ensure controlled medication accountability. Pharm 1 was asked why Pharm 1 signed the blank (not filled in) CDR forms for Residents 34, 71, 97, 148, and 150 during controlled medication disposal when the original quantity was different from the quantity being destroyed for each resident-controlled medication, Pharm 1 stated Pharm 1 just destroyed what was presented to Pharm 1. Pharm 1 stated, I would not know if any medications [were] diverted or lost. Pharm 1 stated I am only documenting the narcotic medication I am disposing of right there. Pharm 1 stated I do not look at any other document to see or reconcile with the unused controlled medication that I am disposing of. Pharm 1 stated Pharm 1 had not provided any training to the facility's staff on medication storage or handling controlled medications. During an interview on 8/8/2024 at 8:50 AM with the DON, the DON stated the facility's practice was not using the CDR sheets during the removal of routine controlled medications since before the DON started working at the facility more than a year and half ago. During a telephone interview on 8/8/2024 at 9 AM with the DON and the facility's dispensing pharmacist (Pharm 2) Pharm 2 stated, Pharm 2 sent a CDR form for each resident's controlled medication to the facility. Pharm 2 stated, CDR forms were used to keep track of what was dispensed and administered to the residents. Pharm 2 stated, it was up to the facility's policy what process for keeping track of controlled medications the facility should follow. Pharm 2 stated it was the responsibility of the facility's Consulting Pharmacist (in general) to help keep the facility compliant with regulations. Pharm 2 stated Consulting Pharmacist needed to follow the facility's policy for handling controlled medications and ensuring the monitoring and accounting of controlled medications. Pharm 2 stated the facility must order controlled medications each time before a resident runs out of their medication by either calling the dispensing pharmacy or sending a faxed refill request. (continued on next page)

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	08/09/2024

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Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent telephone interview with Pharmacist Technician (PhTech) from the facility's dispensing pharmacy, and record review on 8/8/2024 at 11:13 AM, the Controlled Medication Report dated from 1/1/2024 through 8/8/2024 were reviewed, the Controlled Medication Report indicated the facility received the following controlled medications from the dispensing pharmacy for 35 individual residents and the total number of doses for each medication delivered to the facility from 1/1/2024 through 8/8/2024 were as follow: 1. Lorazepam 0.5 mg - 951 tablets 2. Lorazepam 1 mg - 1,861 tablets 3. Clonazepam 0.5 mg - 210 tablets 4. Clonazepam 1 mg - 3,101 tablets 5. Clonazepam 2 mg - 472 tablets 6. Zolpidem 10 mg - 60 tablets 7. Lacosamide 50 mg - 402 tablets 8. Lacosamide 200 mg - 180 tablets During an interview on 8/8/2024 at 3:14 PM with the ADM and the DON, the DON stated Pharm 1 had been to the facility many times and had not identified any concerns with the facility's handling of controlled medications. 2. During a concurrent observation of the controlled medication storage inside the DON's office, and interview with the DON, on 8/7/2024 at 3:03 PM. The cabinet was unlocked. The DON stated the DON placed the controlled medications, awaiting disposal, on top of a box inside of the cabinet. The DON stated the DON did not have a designated or secure location to store controlled medications awaiting disposal. During an interview on 8/7/2024 at 3:27 PM with DON and the DSD inside of the DON's office, the DSD stated, the DSD had the key to the cabinet inside of the DON's office that contained discontinued and expired controlled medications awaiting disposal. The DSD stated the key to the cabinet was hung and stored on a wallboard located inside of the DON's shared office space. The DON stated the cabinet was not kept locked. During an observation of the [NAME] Nursing Station Medication Cart and the East Nursing Station Medication Cart with the DON on 8/7/2024 from 3:44 PM to 4:26 PM, the following resident medications were observed and stored mixed together with noncontrolled medications: West Nursing Station Medication Cart included the following controlled medications for: (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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	05A134	A. Building B. Wing	08/09/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 8/8/2024 at 8:19 AM with the DON and Pharm 1, Pharm 1 stated Pharm 1 provided pharmacy consultant services to the facility in accordance with federal and state regulations. Pharm 1 stated controlled medications should be stored in a separate locked drawer inside of the medication cart. Pharm 1 stated Pharm 1 did not check the facility's medication storage every month. During an interview on 8/8/2024 at 8:50 AM with the DON, the DON stated the controlled medications that were routinely administered had never been locked or stored separately from the noncontrolled medications since the DON started working at the facility over a year and a half ago. The DON stated, I do not know if any controlled medication has been diverted, loss, or misused. During a concurrent interview with LVN 4 and observation of two medication carts in the [NAME] Nursing Station on 8/8/2024 at 9:50 AM, LVN 4 opened the [NAME] Nursing Station Medication Cart and stated there were currently six residents receiving controlled medications on the [NAME] Nursing Station. LVN 4 pulled the medication cards that were mixed with the noncontrolled medications and stated there were 13 medication cards. LVN 4 left the [NAME] Nursing Station Medication room without locking the two medication carts located inside of the [NAME] Nursing Station Medication Storage Room. During an interview with LVN 4 on 8/8/2024 at 10:23 AM. LVN 4 stated the two medication carts on the [NAME] Nursing Station were unlocked and the medication cart should have been locked before LVN 4 left the medication storage room. 3. During a concurrent observation of two medication carts on the East Nursing Station and interview with LVN 4 on 8/8/2024 at 10:25 AM, LVN 4 unlocked and entered the East Nursing Station, the two East Nursing Station Medication Carts were unlocked, and no licensed nurse or staff were present upon the surveyor's arrival with LVN 4 to the East Nursing Station. LVN 4 stated the two medication carts inside of the East Nursing Station were left unlocked and the East Nursing Station Medication Cart was assigned to LVN 1. LVN 4 stated LVN 4 did not know where LVN 1 was. LVN 4 opened the unlocked medication cart and opened a drawer that contained keys to both medication carts and to the locked narcotic drawer inside of the unlocked medication cart. LVN 4 was able to use the key to unlock the narcotic drawer. LVN 4 used the keys to lock the two medication carts in the East Nursing Station. LVN 4 stated unauthorized staff that worked in the facility had access to the nursing station, which included, certified nurse assistants (CNAs), floor staff, counselors, and housekeeping. LVN 4 stated the unauthorized staff had access to the medications inside of the medication carts including controlled medications because the medication carts were not locked, and the keys were left available to be used by others. During an interview on 8/8/2024 at 11:04 AM with LVN 1, LVN 1 stated LVN 1 left the medication cart on the East Nursing Station unlocked and LVN 1 should have locked the medication cart because there was a lot of medications inside that could be removed while LVN 1 was away from the cart. LVN 1 stated the medication cart was not secured to ensure access was limited to the medications by authorized staff (licensed nurses). (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the facility's Policy and Procedures (P&P) titled, Controlled Substance Prescriptions, dated 5/2022, the facility's P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances, and medications classified as controlled substances by state law, are subject to special ordering, receipt, and recordkeeping requirements in the facility, in accordance with federal and state laws and regulations. The Director of Nursing and the contracted pharmacist maintain the facility's compliance with federal and state law and regulations in the handling of controlled medications. Only authorized, licensed nursing and pharmacy personnel have access to controlled medication. Controlled substance medications are dispensed by the provider pharmacy in readily accountable quantities and containers designed for easy counting of contents. The pharmacy will provide an individual resident-controlled drug record (count sheet) for each controlled substance medication container dispensed to a resident. Controlled substance medications are stored at the facility under double lock on the medication cart separate from all other medications and counted at each change of custody. The access key to controlled medications is not the same key that allows access to other medications. The medication nurse on duty maintains possession of a key to controlled medications. During a review of the facility's P&P titled, Consultant Pharmacist Services Provider Requirements, dated 5/2022, the facility's P&P indicated, The consultant pharmacist provides consultation on all aspects of the provision of pharmacy services in the facility. In collaboration with facility staff, the consultant pharmacist helps to identify, communicate, address, and resolve concerns and issues related to the provision of pharmaceutical (relating to medical drugs, or the preparation use or sale of drugs) services. This includes, but is not limited to .Establishing a system of records for receipt and disposition of all controlled medications to enable an accurate reconciliation, and determining that drug records are in order and that an account of all controlled medications is maintained and periodically reconciled .Checking the medication storage areas at least monthly, and the medication carts at least quarterly, for proper storage and labeling of medications, cleanliness, and removal of expired medications. During a review of the facility's P&P titled, Controlled Substance Disposal, dated 5/2022, the facility's P&P indicated, Disposition is documented on the individual controlled substance accountability record/book . Accountability records for controlled substances that are disposed of or destroyed are maintained with the unused supply until it is destroyed or disposed of and then these records are stored for a period of time outlined per applicable law or regulation or facility policy. During a review of the facility's P&P titled, Storage of Medications, dated 5/2022, the facility's P&P indicated, Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes.) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.

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	05A134	A. Building B. Wing	08/09/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to ensure a medication regimen review (MRR- a thorough evaluation of a resident's medication regimen to promote positive outcomes and minimize adverse consequences and potential risks associated with medication) was completed by a licensed pharmacist monthly and failed to ensure the licensed pharmacist identified medication irregularities (refers to use of medication that is inconsistent with accepted standards of practice, not supported by medical evidence, and/or interferes with achieving the intended outcomes) for one of five sampled residents (Resident 23) on psychotropic medications (drugs that affect brain activities associated with mental processes and behavior). This failure had the potential to result in Resident 23 receiving unnecessary medication and could lead to increased side effects from duplicate medication therapy (practice of prescribing multiple medications for the same indication or purpose without a clear distinction of when one agent should be administered over another). Findings: During a review of Resident 23's Admission Record (AR), the AR indicated, the facility admitted Resident 23 to the facility on [DATE], with diagnoses including schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors.), major depressive disorder (serious mental illness affecting mood), and psychoactive drug abuse (harmful use of alcohol and illicit drugs {illegal drugs}). During a review of Resident 23's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 7/12/24, the MDS indicated, Resident 23's cognition (ability to think and process information) was moderately impaired (significantly limited). The MDS indicated, Resident 23 was independent with transfers and mobility. During a review of the facility's Medication Regimen Review Report (MRR Report), dated 2/22/24, the MRR Report indicated, Resident 23's drug regimen was not reviewed by the facility's Pharmacy Consultant (PC) for drug/medication irregularities in the month of February. During a review of the facility's MRR Reports dated 3/27/24, 4/18/24, 5/21/24, 6/19/24, and 7/30/24, the MRR Reports indicated, there were no recommendation for Resident 23 by the PC for drug/medication irregularities. During a review of Resident 23's Order Summary Report (OSR), dated 8/9/24, the OSR indicated the following physician orders: 1. Haloperidol Oral tablet, give 20 milligrams (mg, unit of measurement) by mouth two times a day for delusional (false belief) ideations/responding to internal stimulation (RTIS [individual's reaction to internal cues] related to schizoaffective disorder, bipolar type (mood disorder ranging from depressive lows to manic highs), ordered on 12/27/23. (continued on next page)

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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Haloperidol Oral tablet, give 5 mg by mouth one time a day for delusional ideations/responding to internal stimulation (RTIS) related to schizoaffective disorder, bipolar type, ordered on 2/27/24. 3. Haldol Deconoate (medication used to treat nervous, emotional, and mental disorder) Intramuscular (IM, injection into a muscle) Solution) inject 2 milliliter (ml, unit of measurement) intramuscularly every day shift every 4 weeks on Tuesday, for delusional ideations/responding to internal stimuli, ordered on 7/16/24. 4. Quetiapine Fumerate Oral Tablet (medication used to treat schizophrenia, bipolar disorder, and depression), give 100 mg by mouth one time a day for delusional ideations/RTIS related to schizoaffective disorder, bipolar type, ordered on 2/7/24. 5. Quetiapine Fumerate Oral Tablet, give 300 mg by mouth at bedtime for delusional ideations/RTIS related to schizoaffective disorder, bipolar type, ordered on 2/7/24. 6. Quetiapine Fumerate Oral Tablet, give 300mg by mouth in the morning for delusional ideations/RTIS related to schizoaffective disorder, bipolar type, ordered on 2/7/24. 7. Lithium Carbonate (medication to treat mood disorder) Oral Capsule, give 300 mg by mouth at bedtime for mood related to schizoaffective disorder, bipolar type, ordered 7/16/24. During a review of Resident 23's Medication Administration Record (MAR), dated 3/1/24 to 3/31/24, the MAR indicated, Resident 23 had one episode of RTIS, one episode of agitation, and two episodes of poor impulse control. During a review of Resident 23's MAR, dated 4/1/24 to 4/30/24, the MAR indicated, Resident 23 had no episodes of RTIS and one episode of poor impulse control. During a review of Resident 23's MAR, dated 5/1/24 to 5/31/24, the MAR indicated, Resident 23 had no episodes of RTIS. During a review of Resident 23's MAR, dated 6/1/24 to 6/30/24, the MAR indicated, Resident 23 had one observed episode of RTIS, one episode of socially inappropriate behavior, one episode of delusional ideations, one episode of agitation (nervous excitement), two episodes of poor impulse control (a problem with emotional or behavioral self-control), and no episodes of mood swings (sudden or intense change in emotional state). During a review of Resident 23's MAR, dated 7/1/24 to 7/31/24, the MAR indicated, Resident 23 had one episode of poor impulse control, one episode of RTIS, three episode of socially inappropriate behavior, and three episodes of mood swings. During a review of Resident 23's MAR, dated 8/1/24 to 8/9/24, the MAR indicated, Resident 23 had one episode of RTIS and one episode of delusional ideation. During an interview on 8/9/24 at 1:35 pm with the Director of Nursing (DON), the DON stated the pharmacy consultant needed to complete a medication regimen review monthly, identify medication irregularities, and make recommendations for the psychiatrist to make the final decision. (continued on next page)

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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Landmark Medical Center Medication Regimen Review Policy, updated January 2024, the P&P indicated, all residents had a Medication Regimen Review (MRR) monthly from the pharmacist consultant to monitor for any irregularities in the resident's medication regimen. The P&P indicated, the pharmacist documented any irregularities and recommendations on a MRR report. The P&P indicated, critical irregularities were brought to the attention of the ordering physician immediately.

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	05A134	A. Building B. Wing	08/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36288 Based on interviews and record review, the facility failed to ensure three of five sampled residents (Residents 41, 23, and 66) did not receive unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) by failing to: A. Accurately monitor the specific target behaviors for Resident 41's Lithium (medication used to stabilize mood), Prazosin (medication used to manage and treat hypertension, usually prescribed to reduce nightmares and improve sleep in residents suffering from post-traumatic stress disorder [PTSD, persistent mental disorder due to an extremely stressful or terrifying event]), Vistaril (antihistamine used to treat anxiety [excessive and persistent feelings of worry, fear, dread, and uneasiness that interfere with daily life]), and Trileptal (anticonvulsant used relieve mania [extremely elevated and excitable mood with excessive enthusiasm and overactivity], such as restlessness, hyperactivity, and insomnia) medications. B. Ensure Resident 23 did not receive duplicate therapy with physician orders for Haldol, Seroquel, Lithium. C. Ensure Resident 66, who was on three psychotropic medications, received behavioral monitoring. These failures had the potential to cause adverse effects to Residents 41, 23 and 66 due to the possible administration of unnecessary psychotropic medications. Findings: A. During a review of Resident 41's Admission Record (AR), the AR indicated the facility initially admitted Resident 41 on 7/25/2017 with multiple diagnoses including schizoaffective disorder (mental illness marked by a mix of symptoms of hallucinations [perceptual experiences in the absence of real external sensory stimuli], delusions [misconceptions or beliefs firmly held, contrary to reality], depression [persistently depressed mood or loss of interest in activities that interfere with daily life], and mania), chronic PTSD, psychoactive substance abuse (addiction to mild-altering drugs), recurrent major depressive disorder (mental disorder with persistently depressed mood or loss of interest in activities that interfere with daily life), and borderline personality disorder (mental health condition characterized by intense mood swings and feeling of uncertainty about how one sees oneself). During a review of Resident 41's Minimum Data Set (MDS, a standardized resident assessment and care-planning tool), dated 5/14/2024, the MDS indicated the Resident 41 had moderate impairment in cognition (ability to think, process, and recall information). The MDS indicated Resident 41 had difficulty focusing attention (easily distractible) and disorganized or incoherent thinking (rambling or irrelevant conversation). The MDS indicated Resident 41 was independent with most self-care activities and mobility. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's Monthly Medical Evaluation (MME 1), dated 7/17/2024, MME 1 indicated Resident 41 was confused, talking and delusional (with persistent beliefs contrary to reality), had impaired judgment (ability to form valuable opinions and make good decisions) and insight (awareness of the mental illness, deficits caused by and consequences of the illness, and the need for treatment), and had tangential thought process (series of connected thoughts that go off-topic and don't return to the original topic). During a review of Resident 41's Order Summary Report (OSR), the OSR indicated the following active orders as of 8/9/2024: 1. Order Date: 10/26/2023 - Vistaril 50 milligrams (mg, unit of measurement of mass) by mouth four times a day for anxiety related to schizoaffective disorder. 2. Order Date 12/22/2023 - Prazosin hydrochloride 4 mg by mouth at bedtime related to chronic PTSD. 3. Order Date 12/26/2023 - Trileptal 600 mg by mouth two times a day for mood related to schizoaffective disorder. 4. Order Date 4/22/2024 - Lithium Carbonate 900 mg by mouth at bedtime for mood related to schizoaffective disorder. During a review of Resident 41's Documentation Record (DR 1) for 8/2024, DR 1 indicated some of Resident 41's behaviors monitored were as follow: 1. Episodes of suicidal ideations as manifested by thoughts to cut self. 2. Episodes of responding to internal stimuli (RTIS) as manifested by statements that Resident 41 hears command hallucinations to cut self 3. Episodes of delusional ideations as manifested by guarded/paranoid of others 4. Episodes of accusatory statements as manifested by resident falsely accusing charge nurse of locking Resident 41 in the phone booth. 5. Episodes of anxiety as manifested by being restless/fidgety 6. Episodes of agitation as manifested by yelling/cursing at staff. 7. Episodes of poor impulse control as manifested by going into peers' room 8. Episodes of poor impulse control as manifested by picking up cigarette butts 9. Episodes of assaultive behavior as manifested by being assaultive to peer 10. Episodes of mood swings as manifested by rapid change in mood from calm to anxious/angry 11. Episodes of socially inappropriate behaviors as manifested by consensual sexual act with a female peer (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Episodes of depression as manifested by isolates/withdraws from others During an interview and concurrent review of Resident 41's medical records on 8/8/2024 at 10:12 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 41's AR 1, physician notes, physician orders, [DATE], and care plans were reviewed. LVN 1 was unable to state Resident 41's specific target behaviors being monitored for Vistaril and which manifested Resident 41's episodes of anxiety. LVN 1 was unable to state Resident 41's specific target behaviors being monitored for Trileptal and Lithium and which manifested Resident 41's mood problems. LVN 1 was unable to state Resident 41's specific target PTSD-related behavior/s being monitored for Prazosin. During an interview and concurrent review of Resident 41's medical records on 8/9/2024 at 10:28 AM with Registered Nurse 1 (RN 1), Resident 41's AR 1, physician notes, physician orders, [DATE], and care plans were reviewed. RN 1 stated Resident 41's behaviors were generally monitored, but Resident 41's physician orders for medications used as psychotropic medications did not specify the target behaviors for each medication. RN 1 stated it was important to specify each target behavior for each medication to accurately monitor the specific target behaviors and justify the continued use of each psychoactive medication with the least effective dosage and prevent the use of unnecessary psychotropic medications. RN 1 stated it was difficult to determine if Gradual Dose Reduction (GDR) was justified, because Resident 41's behaviors were not closely monitored per psychoactive medication. During a review of the facility's policy and procedure (P&P), titled Daily Behavior Monitor Log Point Click Care (PCC), dated 1/2022, the P&P indicated the following: 1. All shifts must monitor and document the observation of identified behaviors in the PCC Documentation record DOC Administration Record section of the HER with a linked progress notes describing the behavior observed. 2. Program and Nursing Staff are the primary staff responsible for this daily documentation. 3. Program Staff are designated to document observed behaviors during the day shift. 4. Nursing Staff are designated to document observed behaviors during the 3 p.m. - 11 p.m. shift and 11 p. m. - 7 a.m. shifts. 5. Behaviors being monitored must be directly related to the care plans and in correspondence with the prescribed medication. 6. Any new orders for behavior monitoring must be inputted into PCC. 7. The orders must be specific and comprehensive to the resident's behaviors. 8. The number of behaviors must be tallied under the Supplemental Documentation tab, then the Progress Note window would pop up for direct documentation into the DOC record. 9. Each month the Program Staff must summarize the number of behaviors in the Program Monthly - V 2.3.1 for the Psychiatrist to view. 36924 (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a review of Resident 23's AR, the AR indicated, the facility admitted Resident 23 to the facility on [DATE], with diagnoses including schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors.), major depressive disorder (serious mental illness affecting mood), and psychoactive drug abuse (harmful use of alcohol and illicit drugs {illegal drugs}). During a review of Resident 23's MDS, dated [DATE], the MDS indicated, Resident 23's cognition (was moderately impaired (significantly limited). The MDS indicated, Resident 23 was independent with transfers and mobility. During a review of Resident 23's OSR, dated 8/9/24, the OSR indicated the following physician orders: 1. Haloperidol Oral tablet, give 20 mg, by mouth two times a day for delusional ideations/responding to internal stimulation (RTIS) related to schizoaffective disorder, bipolar type, ordered on 12/27/2023. 2. Haloperidol Oral tablet, give 5 mg by mouth one time a day for delusional ideations/responding to internal stimulation (RTIS) related to schizoaffective disorder, bipolar type, ordered on 2/27/2024. 3. Haldol Deconoate (medication used to treat nervous, emotional, and mental disorder) Intramuscular (IM, injection into a muscle) Solution) inject 2 milliliter (ml, unit of measurement) intramuscularly every day shift every 4 weeks on Tuesday, for delusional ideations/responding to internal stimuli (RTIS) related to schizoaffective disorder, bipolar type), ordered on 7/16/2024. 4. Quetiapine Fumerate Oral Tablet (medication used to treat schizophrenia, bipolar disorder, and depression), give 100 mg by mouth one time a day for delusional ideations/RTIS related to schizoaffective disorder, bipolar type, ordered on 2/7/2024. 5. Quetiapine Fumerate Oral Tablet, give 300 mg by mouth at bedtime for delusional ideations/RTIS related to schizoaffective disorder, bipolar type, ordered on 2/7/2024. 6. Quetiapine Fumerate Oral Tablet, give 300mg by mouth in the morning for delusional ideations/RTIS related to schizoaffective disorder, bipolar type, ordered on 2/7/2024. 7. Lithium Carbonate (medication to treat mood disorder) Oral Capsule, give 300 mg by mouth at bedtime for mood related to schizoaffective disorder, bipolar type, ordered 7/16/2024. During a review of Resident 23's Medication Administration Record (MAR), dated 3/1/2024 to 3/31/2024, the MAR indicated, Resident 23 had one episode of RTIS, one episode of agitation, and two episodes of poor impulse control. During a review of Resident 23's MAR, dated 4/1/2024 to 4/30/2024, the MAR indicated, Resident 23 had no episodes of RTIS and one episode of poor impulse control. During a review of Resident 23's MAR, dated 5/1/2024 to 5/31/2024, the MAR indicated, Resident 23 had no episodes of RTIS. (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 23's MAR, dated 6/1/2024 to 6/30/2024, the MAR indicated, Resident 23 had one observed episode of RTIS, one episode of socially inappropriate behavior, one episode of delusional ideations, one episode of agitation (nervous excitement), two episodes of poor impulse control (a problem with emotional or behavioral self-control), and no episodes of mood swings (sudden or intense change in emotional state). During a review of Resident 23's MAR, dated 7/1/2024 to 7/31/2024, the MAR indicated, Resident 23 had one episode of poor impulse control, one episode of RTIS, three episode of socially inappropriate behavior, and three episodes of mood swings. During a review of Resident 23's MAR, dated 8/1/2024 to 8/9/2024, the MAR indicated, Resident 23 had one episode of RTIS and one episode of delusional ideation. During an interview on 8/9/2024 at 1:35 PM with the Director of Nursing (DON), the DON stated the pharmacy consultant needed to complete a medication regimen review monthly, identify medication irregularities (duplicate therapy, practice of prescribing multiple medications for the same indication or purpose without a clear distinction of when one agent should be administered over another), and make recommendations for the psychiatrist to make the final decision for Resident 23. 38108 C. During a review of Resident 66's AR, the AR indicated Resident 66 was admitted to the facility 4/19/2024 with diagnoses that included Schizoaffective disorder (a combination of symptoms of schizophrenia, and mood [temporary state of mind], such as depression or bipolar), bipolar type, and hypertension (elevated blood pressure). During a review of Resident 66's Progress Notes-Monthly Medical Evaluation (PN), dated 7/24/2024, the PNs indicated Resident 66 was cooperative and confused with clear speech. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had moderate impairment in cognition (ability to think, process, and recall information). The MDS indicated Resident 66 had difficulty focusing attention (easily distractible) and had disorganized or incoherent thinking (rambling or irrelevant conversation). The MDS indicated Resident 66 was independent with most self-care activities and mobility. During a review of Resident 66's OSR, orders active as of 8/9/2024, the OSR indicated the following physician orders dated 4/19/2024: 1. Abilify 15 milligrams (mg, unit of measurement) by mouth once a day for delusional (belief in altered reality) ideations (ideas or concepts) related to schizoaffective disorder, bipolar type. 2. Seroquel XR (extended release) 800 mg by mouth in the evening for delusional ideations related to schizoaffective disorder, bipolar. 3. Zyprexa 20 mg by mouth at bedtime for delusional ideations related to schizoaffective disorder, bipolar type. (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Zyprexa 5 mg by mouth two times a day for delusional ideations related to schizoaffective disorder, bipolar type. During a review of Resident 66's MAR- DR for 8/2024, the MAR indicated behaviors monitored for Resident 66 included: 1. Episodes of compliance with group (meetings) and participating in activities. 2. Episodes of agitation (unable to relax or be still) as manifested by pacing (walk at a steady consistent speed). 3. Episodes of poor impulse control (failure to resist a temptation or urge) as manifested by intrusive (unwelcome) demanding. 4. Episodes of responding to internal stimuli (RTIS, fulfill a perceived need) as manifested by smiles/laughs/talks to self/unseen others. 5. Episodes of socially inappropriate (not proper) behavior as manifested by kissing a male peer, holding hands with male peer. 6. Episodes of socially inappropriate behavior as manifested by consensual sexual acts with peers. 7. Episodes of anxiety (feeling of fear, dread and uneasiness) as manifested by restlessness (inability to rest or relax), repetitive questions. 8. Episodes of assaultive behavior (violent actions) as manifested by elbowed peer, throw things at staff. 9. Episodes of delusional (false beliefs or judgements) ideations as manifested by paranoid (['they don't like me']), was a singer for three years, a teacher working in a beauty shop, doing word searches was the resident's job. 10. Episodes of depression as manifested by withdraws/isolation from others, states feeling sad. 10. Episodes of mood swings as manifested by rapid change in mood form calm/content to sad/anxious/agitated. During an interview and concurrent record review of Resident 66's paper and electronic medical record with the DON, on 8/9/2024 at 5:09 PM, the DON was unable to state Resident 66's specific behaviors that were being monitored for Abilify, Seroquel, or Zyprexa. The DON stated the DON did not know how to distinguish which behaviors were monitored for which medication. The DON could not state which medication would be discontinued if Resident 66 no longer exhibited the type of behavior the medication was prescribed for. During a telephone interview with Resident 66's psychiatrist (MD, a medical doctor who specializes in mental health), on 8/9/2024 at 5:27 PM, the MD stated there should be specific monitoring for each prescribed psychotropic medication to obtain and evaluate the effectiveness of the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P, titled Daily Behavior Monitor Log Point Click Care (PCC), dated 1/2022, P&P indicated the following: 1. All shifts must monitor and document the observation of identified behaviors in the PCC Documentation record DOC Administration Record section of the HER with a linked progress notes describing the behavior observed. 2. Program and Nursing Staff are the primary staff responsible for this daily documentation. 3. Program Staff are designated to document observed behaviors during the day shift. 4. Nursing Staff are designated to document observed behaviors during the 3 p.m. - 11 p.m. shift and 11 p. m. - 7 a.m. shifts. 5. Behaviors being monitored must be directly related to the care plans and in correspondence with the prescribed medication. 6. Any new orders for behavior monitoring must be inputted into PCC. 7. The orders must be specific and comprehensive to the resident's behaviors. 8. The number of behaviors must be tallied under the Supplemental Documentation tab, then the Progress Note window would pop up for direct documentation into the DOC record. 9. Each month the Program Staff must summarize the number of behaviors in the Program Monthly - V 2.3.1 for the Psychiatrist to view.

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	05A134	A. Building B. Wing	08/09/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 31333 Based on observations and interviews the facility failed to ensure two of two medication storage rooms had thermometers or thermostats and failed to ensure temperatures and humidity was properly monitored and maintained as indicated in the facility's policy and procedures (P&P), titled, Medication Storage in the Facility, and Storage of Medication. This deficient practice had the potential to result in the loss of strength and integrity of stored medications, and the potential for residents requiring medications from the two medication storage rooms to receive deteriorated or ineffective medications. Findings: During an observation, on 8/6/2024 at 1:04 PM, in the [NAME] Nursing Station Medication Storage Room there was no wall thermostat or thermometer observed in the room. During an interview on 8/6/2024 at 1:20 PM with Licensed Psychiatric Technician (LPT) 1, LPT 1 stated the room temperature inside the [NAME] Nursing Station Medication Storage Room was not known, as there was no room thermometer and the licensed staff did not document the room temperature. LPT 1 stated sometimes the medication storage room got really hot. During a concurrent observation and interview on 8/7/2024 at 10:11 AM with Licensed Vocational Nurse (LVN) 1, inside the East Nursing Station Medication Room no temperature monitoring device [thermometer] was observed in the room. LVN 1 stated there was no thermometer inside the medication storage room and LVN 1 did not know the temperature in the medication storage room. LVN 1 stated the East Nursing Station Medication Storage Room contained emergency medication kits that were used during an emergency for residents on the East Nursing Station. During an interview on 8/7/2024 at 11:28 AM with Registered Nurse (RN) 1, RN 1 stated the licensed nurses have not been tracking medication room temperatures or humidity. RN 1 stated the medication's efficacy and potency may be affected if the storage temperature become too hot or too cold and the residents (in general) may receive ineffective medications or the incorrect dose due to deterioration of the medications. During an interview on 8/7/2024 at 12:38 PM, with Director of Nursing (DON), the DON stated the facility has not been monitoring the medication room temperature or humidity conditions for over a year. During a review of the facility's pharmacy P&P, titled, Medication Storage in the Facility, dated 5/2022, the P&P indicated, Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. Medication storage conditions are monitored on a monthly basis by the consultant pharmacist or pharmacy designee and corrective action taken if problems are identified .All medications are maintained within the temperature ranges noted in the United States Pharmacopeia (USP) and by the Centers of Disease Control (CDC). (continued on next page)

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	05A134	A. Building B. Wing	08/09/2024

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Landmark Medical Center	2030 N. Garey Ave. Pomona, CA 91767

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Room Temperature 59F to 77 F (15 C to 25 C) 2. Controlled Room Temperature (the temperature maintained thermostatically) 68 F to 77 F (20 C to 25 C) During a review of an undated facility's P&P titled, Storage of Medication, the P&P indicated, Medications will be safely and securely store (including proper temperature controls, appropriate humidity .) Medications will be stored at proper temperatures and other appropriate environmental controls to preserve their integrity.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 36924 Based on observation, interview, and record review the facility failed to ensure the minimum food holding temperature on the kitchen steam table was maintained at required temperature. This failure had the potential to affect the palatability (taste) of food and placed the residents at risk for food borne illness (illness from ingesting contaminated food). Findings: During a concurrent observation of the facility's kitchen and interview with the Dietary Supervisor (DS) on 8/9/2024 at 11:38 AM red enchilada sauce was held on the steam table at 120 degrees Fahrenheit. The DS stated food on the steam table were held between 155-165 degrees Fahrenheit. The DS stated 135 degrees Fahrenheit is the required holding temperature of food on the steam table. During an interview on 8/9/2024 at 12:12 PM with the DS, the DS stated the steam table holding temperature was important to stop bacterial growth and prevent foodborne illness. The DS stated the DS was unsure when was the last steam table calibration/service (comparing a device's measurement values to a known standard) done. The DS was not able to show an invoice for the last steam table calibration/service. During a review of the facility's undated Policy & Procedure (P&P) titled, Temperature Control of Equipment, the P&P indicated .food steam table are to be checked for proper working temperature and the amounts recorded on the appropriate log. This is to ensure safe and effective operation of this equipment. A review of the California Department of Education bulletin for Temperature Controls of Potentially Hazardous Food, revised October 2018, the bulletin indicated foods that are not immediately served after cooking, which is commonly known as held for service are at risk for time and temperature abuse. When the source of heat is available, hold hot food at 135 degrees Fahrenheit or higher and check the temperature every four hours. (https://www.cde.ca.gov/ls/nu/sf/mbnsdsfsp012008.asp)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to follow infection control practices and ensure one of one sampled resident's (Resident 8) closet, was maintained orderly and failed to ensure Resident 8's pile of clean clothes did not spill out (overflow) of Resident 8's closet and did touch the floor. This deficient practice had the potential to result in infection to Resident 8 and for Resident 8's clothes to become a breeding ground for dust mites and other allergens (a substance that could trigger an allergic reaction [a damaging immune response by the body to a substance]) that could potentially impact the health of Resident 8. Findings: During a review of Resident 8's Admission Record (AR), the AR indicated, Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that combines symptoms of schizophrenia [a serious mental health condition that affects how people think, feel and behave], bipolar type (a mental health condition that affects your moods, which can swing from one extreme to another), and personal history of COVID-19 (Coronavirus, a mild to severe respiratory illness that spread from person to person). During a review of Resident 8's History and Physical Examination (H&P), dated 3/11/2020 timed at 11:19 AM, the H&P indicated, Resident 8 was confused and Resident 8's thought process was tangential (a thought disturbance that involves a series of connected thoughts that go off-topic and don't return to the original topic) and Resident 8's judgement and insight were impaired. During a review of Resident 8's Minimum Data Set (MDS, an assessment and screening tool), dated 7/30/2024, the MDS indicated, Resident 8's cognition (ability to think and process information) status was intact. During a concurrent observation and interview on 8/5/2024 at 11:38 AM with Resident 8 and Licensed Psychiatric Technician (LPT) 1 in Resident 8's room, Resident 8 was observed sitting up in a chair at the foot of Resident 8's bed. Resident 8's closet located next to Resident 8's roommate's bed was observed with the door opened and a pile of clean clothes were disorderly stacked up inside, the closet was overflowing. There were clothing items touching the floor and resting on top of a pair of men's sandals and a pair of tennis shoes. Resident 8 stated, it's [closet] a mess! During an observation on 8/6/2024 at 8:34 AM in Resident 8's room, Resident 8's closet remained overflowing (same condition as 8/5/2024) with the door opened and a pile of clean clothing touching the floor and the top of the same pair of men's sandals and pair of tennis shoes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview on 8/7/2024 at 10:11 AM with Resident 8 and Certified Nursing Assistant (CNA) 2, Resident 8 stated Resident 8's closet was messy, and I didn't want it like that. CNA 2 stated, staff told and prompted residents to tidy up, but some residents did not tidy up. CNA 2 stated, staff tried to promote independence to the residents, but staff should assist residents when residents did not tidy up. CNA 2 stated, it was important for the closet to be orderly because everybody [residents] want[ed] to be neat, their clothes and Resident 8's clothes that were on the floor were considered dirty or contaminated. During an interview on 8/8/2024 at 7:50 AM with the Infection Preventionist (IP), the IP stated, the clothes piled up inside Resident 8's closet were clean clothes and should not be left spilling out or [touching] the floor, and it's [clothes] dirty now, for infection control [purposes]. The IP stated, Resident 8's clothing were considered dirty and contaminated and staff should prompt the residents since the residents were independent and staff should help and assist if residents did not tidy up. During a review of the facility's undated policy and procedure (P&P) titled, Infection Control Plan, the P&P indicated, one of the objectives was to provide a safe environment within the facility for the protection of residents, employees, and visitors. During a review of the facility's undated P&P titled, Standard Precaution Policy and Procedure, the P&P indicated, the purpose was to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. The P&P indicated, they are the basic level of infection control precautions which are to be used, as a minimum, in the care of all residents. During a review of the facility's undated P&P titled, Resident Rights, the P&P indicated, the residents had the right to a dignified existence and to a safe, clean, comfortable, and homelike environment.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 38108 Based on interview and record review, the facility failed to ensure one of five sampled resident's (Resident 44) responsible party (RP) was provided education regarding the benefits and potential risks associated with the COVID-19 (a respiratory viral infection that affects primarily the lungs and result in cough and difficulty breathing) vaccine prior to administration of the vaccine to Resident 44. This deficient practice had the potential to result in Resident 44's RP not to make an informed decision due to the facility not providing education regarding the benefits, risks, and potential side effects associated with the vaccine, or the opportunity to accept or refuse the vaccine. Findings: During a review of Resident 44's Admission Record (AR), the AR indicated Resident 44 was admitted to the facility 8/31/2023 with a diagnoses that included schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves), cataracts (clouding of the normally clear lens of the eye), tributary retinal vein occlusion (blurry vision or vision loss), and legal blindness (unable to see). The AR indicated Resident 66 was under conservatorship (a court appoints another person to act or make decisions for the person who needs help). During a review of Resident 44's Progress Notes (PN) - Monthly Medical Evaluation, dated 9/6/2023, the PNs indicated Resident 44 was confused, had a tangential (something that goes off in one direction) thought process, and judgement and insight was impaired. During a record review of Resident 44's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 5/31/2024, the MDS indicated Resident 44's behavior continuously disorganized thinking (rambling, irrelevant, unclear, or illogical) behavior. The MDS indicated Resident 44 had severely impaired vision (no vision or sees only light, colors, or shapes). During a review of Resident 66's Immunization History Report, the report indicated Resident 44 received the COVID-19 vaccine on 10/5/2023. During an interview and concurrent review of Resident 44's electronic and paper medical records (chart) with the Infection Preventionist (IP), on 8/9/2024 at 10:41 AM, the IP stated there was no documentation or consents to indicate Resident 44's conservator was informed nor gave consent for Resident 44 to receive the COVID-19 vaccine. The IP stated informed consents were important because Resident 44 was conserved and could not make his own decisions. The IP stated patient education was essential to be aware of the risks the vaccine may have and be given the option to refuse. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy and procedure titled Residents Vaccination Policy and Procedure, the P&P indicated the vaccination's purpose was to protect all residents from the known and substantial risk of respiratory virus. All residents are offered Covid-19 vaccine annually unless there are medical contraindications, or the resident/conservator refused. The P&P indicated, the consent would be obtained from the resident and/or conservator or responsible party and education would be provided on the risks and benefits of the vaccines.