| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 05A134 | A. Building<br>B. Wing | 08/21/2025 |

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| Landmark Medical Center | 2030 N. Garey Ave.<br>Pomona, CA 91767 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 79) was informed and provided information regarding housing alternatives after discharge. This deficient practice violated Resident 79's rights to be informed of Resident 79's treatment.Findings:During a review of admission Record (AR), the AR indicated Resident 72 was admitted to the facility on [DATE] with diagnoses that included psychosis (a mental health condition characterized by a loss of contact with reality), substance abuse (psychoactive drugs, such as alcohol, pain medications, or illegal drugs), and cigarette nicotine dependance.During a review Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 5/20/2025, the MDS indicated Resident 79 was cognitively intact, had clear speech made self-understand and understood. The MDS indicated Resident 79 was independent with eating, oral and toilet hygiene, dressing, and transfers (moving a resident from one flat surface to another).During a review of Resident 79's Social Service Quarterly -V3 (SSQ), dated 5/27/2025, the SSQ indicated Resident 79 verbalized depression due to missing the resident's family and being in the community [facility]. The SSQ indicated Resident 79 wanted to talk to someone about the possibility of leaving the facility and returning to live and receiving services in the community. The SSQ indicated the resident was in discharge planning and referrals were made to a local contact agency (LCA, an agency that provides information on available home and community-based services (HCBS), assists with transition planning, and offers case management to support a resident's move out of a nursing home and into the community).During a review of a facility email titled Referral Status Update, dated 7/3/2025, from an LCA to the Social Services Director (SSD), the email indicated Resident 79 was accepted into an outside rehabilitation program and was placed on a waiting list. During a record review of email titled (Resident 79) - Discharge Planning, dated 8/21/2025, from the LCA to the SSD, the email indicated Resident 79 was pre-approved for admission to an outside of the facility program and the LCA was expecting for a bed to become available at the program [for Resident 79]. During a concurrent observation and interview with Resident 79, inside Resident 79's room, on 8/18/2025 at 12:35 PM, Resident 79 stated I am on discharge planning (DC) and want to go home. I miss my daughter and they (the facility) are holding me here. I need someone to tell me what is going on, but no one is given me a reason why I need to stay here.During an interview and concurrent record review of Resident 79's paper and electronic medical record (chart) with the SSD, on 8/21/2025 at 11:58 AM, the SSD stated Resident 79 was accepted into a rehabilitation program on 7/2/2025. The SSD stated the SSD did not have any documentation that indicated Resident 79 was informed of Resident 79's acceptance into an outside rehabilitation program or that a projected date was set for housing. The SSD stated it was important for Resident 79 to be aware of the discharge planning and know how long the resident had to wait and for Resident 79 to move forward with Resident 79's life.A review of the facility's undated policy and procedure (P&P) titled, Resident Rights, the P&P indicated the resident has the right to participate in the development and implementation of his or her persons-centered plan of care. The P&P indicated, including the right to participate in the planning process. The P&P indicated the resident has the right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.During a review of the facility's P&P titled Nursing Services Policy, revised on 7/16/2024, the P&P indicated residents will remain actively engaged in his or her care planning process through the resident rights to participate in the development of and be informed in advance of changes in the care plan . Discharge planning - the facility has a discharge planning processing in place which addresses each resident's discharge goas and needs, including caregiver support and referrals to local contact agencies, as appropriate, and involves the resident. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a radio to one of one sampled resident (Resident 44) in a timely manner.This failure had the potential to lead to psychosocial decline, increased depression, and anxiety for Resident 44.Findings:During a review of Resident 44's admission Record (AR), the AR indicated Resident 44 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar type (mental health condition with a mix of symptoms including hallucinations, delusions and mood swings especially periods of very high energy and possibly depressive episodes) and insomnia (sleep disorder characterized by difficulty falling or staying asleep despite having adequate time and opportunity to do so).During a review of Resident 44's Care Plan (CP) regarding activities, initiated 6/10/2025, the CP indicated Resident 44 would be assessed for activities of interest and encouraged to participate.During a review of Resident 44's Activities- initial assessment (AIA), dated 6/10/2025, the AIA indicated Resident 44's hobbies included drawing and music. The AIA indicated it was very important for Resident 44 to listen to music.During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 6/18/2025, the MDS indicated Resident 44 had intact cognition (ability to understand and process information) with inattentive or disorganized thinking (rambling, unclear or illogical flow of ideas). The MDS indicated Resident 44 could independently (resident completes activity by themselves with no assistance from a helper) bathe, eat, and walk at least 150 feet. The MDS indicated under section F - Preferences for Customary Routine and Activities that it was very important for Resident 44 to listen to music. During a review of Resident 44's Program Monthly (PM), dated 8/6/2025, the PM indicated under CP Name: Anxiety, that Resident 44 was concerned about shopping and repeatedly asked staff when Resident 44 would be able to go shopping. During an interview on 8/20/2025 at 2:21 PM with Resident 44, Resident 44 stated Resident 44 wanted a radio to listen to music in Resident 44's room. Resident 44 stated Resident 44 had requested a radio multiple times from the Social Services Director (SSD) and had enough funds to purchase the radio but had not been given a reason why a radio still had not been provided. Resident 44 stated not having a radio was causing boredom and depression.During an interview on 8/21/2025 at 11:48 AM with the Social Service Director (SSD), the SSD stated the SSD made purchases, for residents, outside of the facility for items such as clothing, specific hygiene items, and radios on a quarterly basis since 2020. The SSD stated residents signed up on a list for shopping requests each month from the first to the tenth of the month and the SSD purchased the items if resident funds were available. The SSD stated the SSD took multiple shopping trips between 7/12/2025 and 7/30/2025 but only purchased items for the residents on the list. The SSD stated Resident 44's funds were not available during the SSD's last shopping trip. The SSD stated the next shopping trip would be sometime next month on 9/2025.During a concurrent interview and record review on 8/21/2025 at 1:47 PM with the SSD, the facility's policy and procedure (P&P) titled, Client Shopping, dated 1/2025 was reviewed. The P&P indicated the Social Service Department conduct monthly shopping outing for residents who cannot go out of the facility. These residents are newly admitted .and have not displayed appropriate behaviors for shopping in the community. These outings do not require the $100.00 minimum amount for shopping. The SSD stated Resident 44 had requested a radio after 7/10/2025 and did not sign up in time for the shopping trips that occurred on 7/2025. The SSD stated that even though the policy indicates shopping is done monthly, it is actually done quarterly because no other staff was designated to do the task and each trip could take several hours. The SSD stated Resident 44 had to wait until the next scheduled shopping trip to get a radio.During an interview on 8/21/2025 at 1:47 PM with the Administrator (ADM), the ADM stated the facility would make arrangements to obtain a radio for Resident 44 because Resident 44 had indicated to the ADM that a radio was very important and would help with Resident 44's depression. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure an environment free from physical abuse for two of six sampled residents (Resident 38 and 52) when: A. Resident 38 was punched (hit with a closed fist) by Resident 7 while unsupervised in the dining room on 8/13/2025.B. Resident 52 was hit by Resident 44 on the left side of the face on 8/12/2025. This deficient practice resulted in physical abuse (willful infliction of injury, deliberate aggressive or violent behavior with the intention to cause harm) to Residents 38 and 52 and mild pain (may be annoying and noticeable, but it doesn't keep you from performing normal activity) on Resident 52's left cheek. Additionally, there was potential for psychosocial harm to both residents.Findings:<br><br>A. During a review of Resident 7’s admission Record (AR), the AR indicated the facility admitted Resident 7 on 11/6/2024, with diagnoses that included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and low back pain.<br><br>During a review of Resident 7’s Minimum Data Set (MDS – a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 7’s cognition (the ability to think and process information) was intact. The MDS indicated Resident 7 was independent (resident completes the activity by themselves with no assistance from helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility .<br><br>During a review of Resident 38’s AR, the AR indicated the facility admitted Resident 38 on 5/8/2025, with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), obesity (excessive body fat), and psychoactive substance abuse (when drug-taking becomes a problem and the drug changes how your brain works, affecting your mood, thoughts, behavior, and perception).<br><br>During a review of Resident 38’s MDS, dated [DATE], the MDS indicated Resident 52’s cognition was intact. The MDS indicated Resident 52 was independent with ADL and was independent with mobility.<br><br>During a review of Resident 7’s Progress Notes, dated 8/13/2025, the progress notes indicated, at approximately 4:55 PM, Resident 38 was in the dining room with the rest of his peers waiting for dinner to be served. The notes indicated, a male peer [Resident 7] suddenly punched Resident 38 on his left cheek unprovoked who was sitting at a table away from him [Resident 7]. The notes indicated that staff intervened and separated both residents [placing them in] a safe environment. The notes indicated, upon assessment, Resident 7 stated, “he keeps bothering me, asking me for money”. Then he went into my face, so I punched him.” The notes indicated, “Resident 38 was talking to someone else at the time and remained seated on his chair. Resident 38 stated, “I don’t know him, and he does not know me. I’m new here. He just punched me out of nowhere.”<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 8/18/2025 at 11:18 AM, Resident 7 stated Resident 7 had an altercation with Resident 38 in the dining room while waiting for dinner. Resident 7 stated he could not recall the exact date or time. Resident 7 stated he reported Resident 38 kept asking him for money “over and over again, ” which made Resident 7 upset. Resident 7 stated Resident 7 became angry, lunged at Resident 38, and punched him in the face with a closed right fist. Resident 7 stated Resident 38 was asking Resident 7 for money on several occasions, and Resident 7 was tired of it.<br><br>During an interview on 8/18/2025 at 11:27 AM, Resident 38 stated that a few days ago, while sitting in the dining area waiting for dinner, Resident 7 suddenly walked up and punched him on the left cheek. Resident 38 stated Resident 38 did not remember the exact date or time, only that it was during dinner. Resident 38 stated Resident 38 had no problems with Resident 7, and [the incident] happened suddenly without warning. Resident 38 stated Resident 38 did not know why it [Resident 7 punched Resident 38] happened, and that [the incident] left him feeling frustrated, upset, and angry because Resident 38 was punched without reason. Resident 38 stated when staff spoke with Resident 38, they told him Resident 7 said Resident 38 was asking for money, Resident 38 denied this, stating. “I don’t ask him for money.” Resident 38 stated being caught off guard. Resident 38 stated staff were not directly inside the dining room [during the time of the incident].<br><br>During an interview on 8/20/2025 at 4:07 PM, Certified Nursing Assistant (CNA) 2 reported that on 8/13/2025, at approximately 5 PM CNA 2 was at the doorway of the dining room, letting residents in one by one while sanitizing their hands. CNA 2 reported the residents were in a single-file line. CNA 2 stated CNA 2 did not notice any unusual behavior or conflicts between Resident 7 and Resident 38. CNA 2 stated unfortunately there were no staff directly inside the dining room at the time [during the time of the incident]. CNA 2 stated staff were in the hallways or on route to the dining area for dinner-time monitoring. CNA 2 stated the incident may have been prevented if staff had already been inside the dining room monitoring the residents. CNA 2 stated CNA 2 did not witness the incident, only the aftermath, both residents were standing, and staff intervened to separate them. CNA 2 stated it was challenging to monitor residents entering the dining room and maintaining full control of the dining area while also sanitizing the resident’s hands at the same time. CNA 2 stated, ideally, staff should be present inside the dining room as residents gathered for mealtimes.<br><br>During an interview on 8/21/2025 at 10:27 PM with the Director of Nursing (DON), the DON stated, ideally, staff should be inside the dining room as residents lined up at the doorway to have their hands sanitized. The DON stated this allowed staff to observe residents as they gathered in the dining area and may have helped avoid conflicts. The DON stated with proper monitoring, staff could potentially have intervened in time to prevent issues from arising, such as the incident between Resident 7 and Resident 38. The DON stated this practice was essential to maintain a safe and secure environment.<br><br>B. During a review of Resident 52’s AR, the AR indicated Resident 52 was admitted to the facility on [DATE] with multiple diagnoses including paranoid schizophrenia and insomnia (sleep disorder characterized by difficulty falling or staying asleep despite having adequate time and opportunity to do so).<br><br>During a review of Resident 52’s Initial Medical History & Physical (H&P), dated 8/6/2025, the H&P indicated Resident 52 did not have the capacity to understand and make informed decisions.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 52’s MDS, dated [DATE], the MDS indicated Resident 52 had intact cognition with inattentive or disorganized thinking (rambling, unclear or illogical flow of ideas). The MDS indicated Resident 52 could independently bathe, eat, and walk at least 150 feet.<br><br>During a review of Resident 52’s 1:1 (one resident supervised by one staff) Counseling Progress Note (CN), dated 8/12/2025, the CN indicated Resident 52 stated Resident 44 was walking near Resident 52 and Resident 52 attempted to move out of the way. The CN indicated Resident 44 hit Resident 52.<br><br>During a review of Resident 52’s Pain Evaluation (PE), dated 8/12/2025, the PE indicated the condition that caused pain was being hit on the left cheek by a peer [Resident 44]. The PE indicated Resident 52’s pain was mild (pain that may be annoying and noticeable, but it doesn’t keep you from performing normal activity) and Tylenol (medication used to treat pain) was administered for mild pain.<br><br>During a review of Resident 44’s AR, the AR indicated Resident 44 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, bipolar type and insomnia.<br><br>During a review of Resident 44’s MDS, dated [DATE], the MDS indicated Resident 44 had intact cognition with inattentive or disorganized thinking. The MDS indicated Resident 44 could independently bathe, eat and walk at least 150 feet.<br><br>During a review of Resident 44’s Psychiatric Assessment (PA), dated 8/7/2025, the PA indicated Resident 44 had a normal, appropriate thought process and was compliant with medications.<br><br>During a review of Resident 44’s 1:1 CN, dated 8/13/2025, the CN indicated Resident 44 stated Resident 44 had been having “a bad day,” when Resident 52 got in the way of Resident 44 and Resident 44 aggressively told Resident 52 to move. Resident 44 stated in the CN that Resident 52 replied by cursing at Resident 44 and both residents hit each other at the same time.<br><br>During an interview on 8/20/2025 at 2:21 PM with Resident 44, Resident 44 stated Resident 52 was blocking the doorway to Resident 44’s room and Resident 52 cursed at Resident 44. Resident 44 stated Resident 52 attempted to hit Resident 44 but missed and Resident 44 responded by hitting Resident 52 on the left side of the face with a closed fist. Resident 44 stated Resident 44 hit Resident 52 for blocking the way and cursing at Resident 44.<br><br>During an interview on 8/20/2025 at 2:37 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 44 was not experiencing any acute (sudden) behavioral episodes prior to the physical altercation with Resident 52.<br><br>During an interview on 8/20/2025 at 2:54 PM with CNA 5, CNA 5 stated CNA 5 witnessed Resident 44 hit Resident 52 on 8/12/2025. CNA 5 stated CNA 5 witnessed Resident 44 walk towards Resident 44’s room when Resident 52 got in the way and both residents tried to get past each other but were moving in the same direction. CNA 5 stated Resident 44 then entered the room and suddenly hit Resident 52 on the left side of the head.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility’s P&P titled, “Physical Assault,” revised 9/2015, the P&P indicated: the facility is to provide a safe and secure environment. The P&P indicated due to the population worked with there will be some physically assaultive behaviors. The P&P indicated all forms of abuse, including resident-to resident assaults, must be reported immediately to the charge nurse, the director of nursing, the administrator, the conservator, and the doctor. 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. The P&P indicated physical Abuse is defined as willful infliction of injury; unreasonable confinement, intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. The P&P indicated physical Abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop or implement individualized person-centered care plans (CP) for four of four sampled residents (Resident 1, Resident 7, Resident 13, and Resident 47) by failing to ensure:A. CPs titled, Compliance with Activities of Daily Living [ADL, term used in healthcare that refers to self-care activities] and Oral/Dental Care, were implemented for Resident 13. On 8/18/2025, Resident 13 was observed with a dry crust around the lips and build up and discoloration on Resident 13's upper and lower teeth.B. A CP was developed that addressed smoking for Resident 7.C. A CP was developed for Resident 1 and Resident 47 that addressed the resident's diagnoses of Post Traumatic Stress Disorder (PTSD- a mental health condition that can develop after experiencing or witnessing a traumatic event).These failures had the potential to result in unmet individual needs for Resident 1, 7, 13, and 47 and the potential to result in the residents not receiving the necessary care and services to achieve an optimal level of function.Cross Reference F699Findings:<br><br>A. During a review of Resident 13’s admission Record (AR), the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnosis that included schizoaffective (a mental disorder effecting how a person thinks and feels) bipolar (a mental disorder with periods of depression and periods of elevated mood) disorder and cigarettes nicotine dependence.<br><br>During a review of Resident 13’s CP, titled Compliance with Activities of Daily Living [ADL, term used in healthcare that refers to self-care activities], initiated on 7/29/2024, the CP’s interventions indicated to prompt [Resident 13] to get up and shower, brush teeth, comb hair etc.<br><br>During a review of Resident 13’s CP titled “Oral/Dental Care,” initiated on 7/29/2024, the CP’s goal indicated to remove soft plaque (a sticky, colorless film of bacteria [living organism that can cause an infection] that forms on the teeth and gums) deposits and calculus (hard mineralized deposit that forms on the teeth over time) from [Resident 13’s] teeth. The CP’s interventions indicated to prompt the resident to complete grooming task which included oral hygiene; provide supervision/assistance with oral hygiene as needed, report any unusual observations (dry lips, sores, bad breath, etc) to charge nurses, and for Certified Nurse Assistance (CAN’s) to document that oral hygiene was given and any unusual observations.<br><br>During a review of Resident 13’s Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 7/29/2025, the MDS indicated Resident 13 was cognitively (ability to understand and process information) intact, had clear speech, and was able to understand and be understood. The MDS indicated Resident 13 needed supervision/touch assistance (helper provides cues as resident completes the activity) with personal hygiene (practices and habits that maintain cleanliness and prevent the spread of germs [bathing, brushing teeth]).<br><br>During an observation and concurrent interview on 8/18/2025 at 12:10 PM, Resident 13 had red/brown flakes on the edges of Resident 13’s mouth. Resident 13 had tan brownish colored build up on the upper and lower teeth. Resident 13 stated Resident 13’s teeth often bled.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview with CNA 3, on 8/21/2025 at 11:30 AM, CNA 3 stated CAN 3 gave Resident 13 toothbrushes, but CNA 3 did not ensure Resident 13 brushed Resident 13’s teeth. CAN 3 stated CNA 3 was not informed to monitor Resident 13’s oral hygiene or to remind Resident 13 to brush their teeth.<br><br>During an observation and concurrent interview with the Director of Nursing (DON), on 8/21/2025 at 12:31 PM, the DON stated Resident 13 had a dry brown crust around the lips. The DON stated Resident 13’s upper and lower teeth had a light brown to brown colored accumulation of plaque. The DON stated the facility staff were responsible for encouraging Resident 13 of hygiene (brush teeth, shower). The DON stated it was important to follow the CP to ensure proper interventions were being done and to update/adjust the CP when needed.<br><br>During a review of the facility’s policy and procedure (P&P) titled “Nursing Services Policy, ” revised on 7/16/2024, the P&P indicated the facility’s nursing services will provide the care and services to attain or maintain the highest quality of care practicable physical, mental, and psychosocial well-being, consistent with the resident’s comprehensive assessment and plan of care. The P&P indicated the facility provided necessary care and services to will that a resident’s abilities in activities of daily living do not diminish….<br><br>B. During a review of Resident 7’s AR, the AR indicated the facility admitted Resident 7 on 11/6/2024, with diagnoses that included paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and low back pain.<br><br>During a review of Resident 7’s Smoking – Safety Screen, dated 11/6/2024, the smoking – safety screen indicated Resident 7, smoked three times a day and was safe to smoke per the facility’s supervision protocol.<br><br>During a review of Resident 7’s MDS, dated [DATE], the MDS indicated Resident 7’s cognition was intact. The MDS indicated Resident 7 was independent (resident completes the activity by themselves with no assistance from helper) with ADLs and was independent with mobility.<br><br>During an observation on 8/18/2025 at 12:17 PM, Resident 7 was observed smoking out in the patio with staff supervision.<br><br>During an observation on 8/19/2025 at 12:22 PM, Resident 7 was observed smoking out in the patio with staff supervision.<br><br>During an interview and a concurrent record review on 8/19/2025 at 1:37 PM, Resident 7’s CPs were reviewed with Registered Nurse (RN) 1. RN 1 stated Resident 7’s CPs did not include a smoking CP. RN 1 stated all residents who smoked should have a CP [that addressed smoking] to ensure safety, compliance, and smoking cessation education. RN 1 stated CPs guided staff in providing quality care and carrying out interventions.<br><br>During an interview on 8/21/2025 at 10:27 AM, with the DON, the DON stated smoking CPs were necessary to ensure resident safety, reinforce compliance with the facility P&P, and provided education on smoking cessation. The DON stated CPs supported staff in delivering consistent, quality care.<br><br>(continued on next page) |

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| | 05A134 | A. Building<br>B. Wing | 08/21/2025 |

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| Landmark Medical Center | 2030 N. Garey Ave.<br>Pomona, CA 91767 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility’s P&P titled, Smoking Safety Screen Policy, updated on 7/2019, the P&P indicated:<br><br>· CP review: Ensure a specific plan of care addressing nicotine dependence and use is in place and tailored to the resident’s needs.<br><br>C. During a review of Resident 1’s AR, the AR indicated the facility admitted Resident 1 on 8/4/2022, with diagnoses that included PTSD, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) bipolar type (mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder.<br><br>During a review of Resident 1’s MDS, dated [DATE], the MDS indicated Resident 1’s cognition was moderately impaired. The MDS indicated Resident 1 was independent with ADL and was independent with mobility.<br><br>During a review of Resident 47’s AR, the AR indicated the facility admitted Resident 47 on 7/16/2025, with diagnoses that included PTSD, schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a medical illness causing persistent feelings of sadness, hopelessness, and loss of interest in activities that once brought joy).<br><br>During a review of Resident 47’s MDS, dated [DATE], the MDS indicated Resident 47’s cognition was intact. The MDS indicated Resident 47 was independent with ADL and was independent with mobility.<br><br>During an interview and concurrent record review 8/20/2025 at 3:10 PM, with Licensed Vocational Nurse (LVN) 2, Resident 1 and Resident 47’s admission Records and CPs were reviewed with LVN 2. LVN 2 stated Resident 1 and Resident 47 had documented medical diagnoses of PTSD in the admission medical record. LVN 2 stated Resident 1 and Resident 47 did not have CPs for PTSD. LVN 2 stated CPs should have been created because the residents had documented diagnoses of PTSD. LVN 2 stated CPs were important because they addressed signs and symptoms, maintained resident well-being, provided coping strategies, and guided staff in delivering consistent care for the residents.<br><br>During an interview on 8/21/2025 at 10:27 AM, the DON stated staff should have created and implemented a CP for residents with a PTSD diagnosis because the CP allowed staff to manage their symptoms, ensured safety, recognized triggers, and provided consistent care to minimize or prevent re-traumatization, even if the cause was unknown or not disclosed.<br><br>During a review of the facility’s P&P titled, “Baseline/Comprehensive Care Plan – Interdisciplinary Team [IDT, a team of health care professions who work together to establish plans of care for residents] Conference – Behavioral,” created on 11/26/2017, the P&P indicated the facility will:<br><br>· Develop and implement a baseline CP for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.<br><br>· Develop a comprehensive, person-centered care plan for each resident.<br><br>(continued on next page) |

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| Landmark Medical Center | 2030 N. Garey Ave.<br>Pomona, CA 91767 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility’s P&P titled, “Trauma Informed Care Policy and Procedures” created on 1/2020, the P&P indicated that trauma informed care plan will be opened if trauma is expressed or discovered any time during stay at the facility. |

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| F 0685<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assist a resident in gaining access to vision and hearing services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure eyeglasses were made available for one of one sampled resident (Resident 1) as indicated in the optometry consultation, dated 10/18/2024, and the care plan (CP) for impaired visual function. This deficient practice had the potential to result in worsening of Resident 1's vision and a psychosocial decline to Resident 1. Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/4/2022, with diagnoses that included right eye keratopathy (affects the cornea, the clear front window of the eye), bilateral (left and right) nuclear cataract (clouding/blurry vision), bilateral glaucoma (damages to the nerve of the eye) presbyopia (gradual loss of eye focusing) and schizoaffective disorder (hallucinations and mood swings).During a review of Resident 1's CP titled The resident has impaired visual function initiated on 8/4/2022, the CP's goal indicated for Resident 1 to remain in a safe environment with no injury and to use appropriate visual devises to promote participation in Activity of Daily Living (ADL, term used in healthcare that refers to self-care activities). The CP's interventions indicated to remind Resident 1 to wear Resident 1's glasses and ensure Resident 1 wore glasses that were clean and free from scratches and in good repair.During a review of a Resident 1's optometry consult, dated 10/18/2024, the consult's recommendations indicated bifocal glasses for Resident 1 and the Goal of Treatment was to improve vision and enhance Resident 1's quality of life. During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognition was moderately impaired. The MDS indicated Resident 1 was independent with ADL and was independent with mobility. The MDS indicated Resident 1's vision was severely impaired (see's colors and/or shapes) and Resident 1 needed corrective lenses (glasses).During a review of Resident 1's History and Physical (H&P), dated 8/6/2025, the H&P indicated Resident 1 needed eyeglasses.During an observation and concurrent interview with Resident 1, in the hallway, on 8/18/2025 at 12:04 PM, Resident 1 was carrying an empty case for glasses and stated Someone took my glasses! I need my glasses!During an observation and interview with Resident 1, inside Resident 1's room on 8/19/2025 at 2:56 pm, Resident 1 gave permission to search the resident's room for any glasses. Resident 1 stated there is no glasses! If I had them, I would be wearing them - I aint got no glasses. I had them a few months ago, but I don't have them now.During an observation of Resident 1's room and concurrent interview with Certified Nursing Assistant 2 (CNA 2) and Resident 1 on 8/19/2025 at 2:56 PM, CNA 2 searched Resident 1's bedside table and closet for Resident 1's glasses. CNA 2 stated there were no glasses inside Resident 1's room.During an interview with Licensed Vocational Nurse 1 (LVN 1) on 8/19/2025 at 2:59 PM, LVN 1 stated Resident 1's personal belongings were kept inside the resident's room. LVN 1 stated no personal belongings were kept in the nurse's station. LVN 1 stated LVN 1 had not seen Resident 1 wear glasses. LVN 1 stated glasses were important to see, that is basic.During an interview with CNA 3 on 8/21/2025 at 11:30 AM, CNA 3 stated I don't know if Resident 1 wears glasses. I have never seen Resident 1 with glasses.During an interview and concurrent record review with the Director of Nursing (DON), Resident 1's paper and electronic medical record was reviewed, on 8/21/2025 at 12:26 PM, the DON stated Resident 1 needed glasses. The DON stated it was important for Resident 1 to have and wear glasses to see and read.During a review of the facility's undated policy and procedure (P&P), titled Resident Rights, the P&P indicated the resident has the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. The P&P indicated the residents have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely. |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care or services that was trauma informed and/or culturally competent.<br><br>(continued on next page) |

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| F 0699<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure two of two sampled residents (Residents 1 and Resident 47) received Post Traumatic Stress Disorder (PTSD- a mental health condition that can develop after experiencing or witnessing a traumatic event) care that addressed their individual experiences, necessary to minimize the risk of re-traumatization. This deficiency could have potentially resulted in emotional distress, exacerbation of PTSD symptoms, and an increased risk of behavioral or psychological harm to Residents 1 and Resident 47.Cross Reference F656Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 8/4/2022, with diagnoses that included PTSD, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) bipolar type (mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 8/1/2025, the MDS indicated Resident 1's cognition (the ability to think and process information) was moderately intact. The MDS indicated Resident 1 was independent (resident completes the activity by themselves with no assistance from helper) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was independent with mobility.During a review of Resident 47's AR, the AR indicated the facility admitted Resident 47 on 7/16/2025, with diagnoses that included PTSD, schizophrenia (a mental illness that is characterized by disturbances in thought), and depression (a medical illness causing persistent feelings of sadness, hopelessness, and loss of interest in activities that once brought joy).During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47's cognition was intact. The MDS indicated Resident 47 was independent with ADL and was independent with mobility.During an interview and concurrent record review 8/20/2025 at 3:10 PM, with Licensed Vocational Nurse (LVN) 2, Resident 1 and Resident 47's admission Records were reviewed with LVN 2. LVN 2 stated Resident 1 and Resident 47 had documented medical diagnoses of PTSD in the admission medical record. LVN 2 stated Resident 1 and Resident 47 did not have CPs for PTSD. LVN 2 stated CPs should have been created because the residents had documented diagnoses of PTSD. LVN 2 stated CPs were important because they addressed signs and symptoms, maintained resident well-being, provided coping strategies, and guided staff in delivering consistent care for the residents. LVN 2 stated when a resident had a diagnosis of PTSD, it was important for the facility to recognize and identify the trauma, because this helped staff understand the resident's individual experiences and reduce the risk of re-traumatization. LVN 2 stated even if the residents did not disclose the exact trauma, staff were still required to address the PTSD in the plan of care [to implement the interventions]. LVN 2 recognized the facility did not create or implement a PTSD-specific plan of care for Residents 1 and 47, which placed the residents at risk for mental or emotional suffering related to their past trauma. During an interview on 8/21/2025 at 10:27 AM, the Director of Nursing (DON) stated that when residents have a diagnosis of PTSD, the facility was responsible for ensuring and developing a care plan that addressed each resident's trauma and unique experiences [with appropriate interventions] to reduce the re-traumatization. The DON stated that without a PTSD-specific care plan, residents' trauma-informed needs were not fully addressed, placing them at risk for psychological or emotional harm.During a review of the facility's policy and procedure (P&P) titled, Trauma Informed Care Policy and Procedures created on 1/2020, the P&P indicated the facility will be focused on providing culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Trauma is defined as resulting from an event, series of event, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individuals functioning and mental, physical, social, emotional, or spiritual well-being. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review, the facility failed to store food items in a manner that prevented food borne illness (condition caused by consuming contaminated food or beverages), in one of one kitchen (Kitchen 1), by:A. Failing to remove five of 47 apples and one of 16 onions that had spoiled (food that has deteriorated in quality and becomes unfit and/or unsafe for consumption).B. Failing to ensure employees kept personal belongings out of Kitchen 1.Findings:A. During a concurrent observation and interview on 8/18/2025 at 10:15 AM with the Dietary Supervisor (DS) in Kitchen 1, one bin containing 47 apples was observed. Five apples had a wrinkled outward appearance and/or were bruised, had broken skin with a soft texture when touched. The DS stated the apples were not good to eat anymore and should not have been in the bin. The DS stated the cook on duty inspected the produce every Thursday and it was an error for spoiled apples to be in the bin. During a concurrent observation and interview on 8/18/2025 at 10:20 AM with the DS in Kitchen 1, one bin containing 16 onions was observed. One out of 16 onions appeared flattened in a surrounding brown liquid that had a foul odor. The DS stated the spoiled onion should not have been in the bin and the spoiled produce would not be served to the residents. The DS stated spoiled food could potentially cause residents to become sick if eaten.During a review of the facility's policy and procedure (P&P) titled, Non-Refrigerated Produce Storage Inspection, dated 9/2025, the P&P indicated on Mondays and Thursdays, before produce is returned to the bins, the cook on duty will inspect all items to ensure they are safe to eat. Produce showing spoilage, damage, or that is expired will be immediately discarded according to facility protocol. B. During a concurrent observation and interview on 8/20/2025 at 12:15 PM with the DS in Kitchen 1, an employee's cellphone and keys were left unattended on top of a table across the refrigerator. The DS stated the DS had instructed employees multiple times not to leave personal items in Kitchen 1 and all personal items should be stored in the nearby locker to prevent the potential of food contamination in Kitchen 1.During an interview on 8/21/2025 at 2:57 PM with [NAME] (CK) 2, CK 2 stated employee cellphones should not be kept in Kitchen 1 because it would not be sanitary to have phones near resident food and it was against the facility's policy.During a review of the facility's policy and procedure (P&P) titled, Job Routine/ work conduct, undated, the P&P indicated all personal belongings must be kept in your [employee's] locker. |