STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A134	A. Building B. Wing	09/04/2024

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from abuse for two of two sampled residents (Residents 1 and 4) as indicated in the facility's policy and procedure (P&P) titled, Elder/Dependent Adult Abuse, by failing to: a. Protect Resident 1 from being kissed on the neck by Resident 2. b. Protect Resident 4 from being spit on and intimidated by Resident 3. These failures resulted in Resident 1 to feel disgusted and for Resident 4 to feel afraid. These failures had the potential to negatively impact the health and well-being of Residents 1 and 4. Findings: a1. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses including unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition, hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and insomnia (persistent problems falling and staying asleep). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/20/2024, the MDS indicated, Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was independent from staff for dressing, toileting, and eating. During a review of Resident 1's care plan (CP) titled, Resident to Resident Abuse Victim-Sexual Harassment ., initiated 8/29/2024, the CP indicated, Client (Resident 1) reported male peer (Resident 2) kissed her on the back of the neck. She (Resident 1) did not consent to kiss. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Progress Notes (PN), dated 8/29/2024, timed at 8:59 a.m., the PN indicated on 8/29/2024, At approximately 0835 (8:35 a.m.), the resident (Resident 1) was observed by writer (Licensed Psychiatric Technician [LPT] 1) at the nursing station asking for toothpaste. The PN indicated as writer (LPT 1) exited the nursing station to attend the needs of the resident (Resident 1), peer (Resident 2) was observed walking up behind the resident (Resident 1) and giving her (Resident 1) a kiss on the back of her neck. The residents (Resident 1 and 2) were immediately separated . a2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses including schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 was independent from staff for dressing, toileting, and eating. During a review of Resident 2's CP titled, Resident to Resident Abuser -Sexual Harassment ., initiated 8/29/2024, the CP indicated, Client (Resident 2) kissed female peer (Resident 1) without consent on the back of the neck. During a review of Resident 2's PN, dated 8/29/2024, timed at 8:40 a.m., the PN indicated on 8/29/2024, At approximately 0830 (8:30 a.m.) writer (LVN 1) observed resident (Resident 2) walk past peer (Resident 1) and kiss her (Resident 1) on the neck and continue to walk away. During a concurrent observation and interview on 8/30/2024 at 9:48 a.m. with the Director of Staff Development (DSD), video footage (VF) of Resident 2 kissing Resident 1 was observed. The VF showed Resident 1 standing on the outside, looking into the [NAME] Nurse's Station with a staff person (DSD stated the staff person was LVN 1) on the inside of the [NAME] Nurse's Station. The VF showed Resident 2 walking past Resident 1, behind Resident 1. The VF showed Resident 2 stopped behind Resident 1 and leaned his face to the left of Resident 1's neck. The VF showed Resident 1 flinching away from Resident 2's face to Resident 1's neck. During an interview on 8/30/2024 at 12:00 p.m. with Resident 2, Resident 2 stated Resident 2 kissed a girl (Resident 1). Resident 2 stated Resident 2 kissed her neck and pointed to the side of his neck. Resident 2 stated he kissed her because Resident 2 thought she (Resident 1) needed a friend. Resident 2 stated she looked sad. Resident 2 stated she told staff at the nurse's station, he kissed me. Resident 2 stated the nurse told Resident 2, don't do that anymore. During an interview on 8/30/2024 at 12:18 p.m. with Resident 1, Resident 1 stated Resident 2 kissed Resident 1 on Resident 1's neck. Resident 1 stated Resident 1 did not know Resident 2 was going to kiss Resident 1's neck. Resident 1 stated the kiss made Resident 1 feel disgusted. Resident 1 stated Resident 2 told LVN 1 that Resident 2 had kissed Resident 1 on the neck. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b1. During a review of Resident 3's Admission Record (AR), the AR indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), 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 3's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/2/2024, the MDS indicated, Resident 3 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 was independent from staff for dressing, toileting, and eating. During a review of Resident 3's CP titled, Resident to Resident Abuse ., initiated 8/12/2024, the CP indicated on 8/26/24, Client (Resident 3) cursed and spat at peer (Resident 4), then picked up chair as if going to throw it. During a review of Resident 3's PN, dated 8/26/24, timed at 8:35 a.m., the PN indicated (on 8/26/24, untimed), Reported by peer (Resident 4), resident (Resident 3) had an altercation with peer (Resident 4) picking up a chair and spit at peer (resident 4). Upon investigation, resident (Resident 3) admitted to spitting at peer (Resident 4). b2. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and insomnia (persistent problems falling and staying asleep). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 4 was independent from staff for dressing, toileting, and eating. During a review of Resident 4's CP titled, Resident to Resident Abuse Victim ., initiated 8/26/2024, the CP indicated, Peer (Resident 3) cursed and spat at client (Resident 4), then picked up chair as if going to throw it. During a review of Resident 4's PN, dated 8/26/2024, timed at 8:33 a.m., the PN indicated on 8/26/2024, untimed, Resident (Resident 4) approached writer (Licensed Vocational Nurse [LVN] 1) reporting an altercation with peer (Resident 3) picking up a chair and spit at her (Resident 4). Writer (LVN 1) asked where the spit landed on her (Resident 4), resident (Resident 4) pointed to her left hand . The PN indicated Upon investigation, footage reviews peer (Resident 3) picking up a chair in the air feet away from the resident (Resident 4) and was never thrown . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 9/3/2024 at 10:05 a.m. with LVN 1, Resident 3's Progress Notes, dated 8/26/2024, was reviewed. The PN indicated on 8/26/2024, Reported by peer (Resident 4), resident (Resident 3) had an altercation with peer (Resident 4) picking up a chair and spit at peer (resident 4). Upon investigation, resident (Resident 3) admitted to spitting at peer (Resident 4). LVN 1 stated Resident 4 told LVN 1 Resident 3 had spit on Resident 4 and that Resident 3 had thrown a chair at Resident 3. LVN 1 stated the video footage showed Resident 3 lifting up a chair but then putting it back down on the floor. LVN 1 stated when LVN 1 followed up with Resident 3, Resident 3 cursed at LVN 1 and told LVN 1 Resident 3 was going to spit on LVN 1 if LVN did not stop. During a concurrent observation and interview on 9/3/2024 at 12:02 p.m. with the DSD, video footage (VF) of Resident 3 spitting on Resident 4 was observed. The VF showed Resident 3 pitting at Resident 4 on 8/26/24 at 8:25 a.m. The VF also showed Resident 3 raising a plastic chair over head and face Resident 4 in a threatening stance. The DSD stated the VF showed Resident 3 spitting at Resident 4. During an interview on 9/3/2024 at 12:20 p.m. with Resident 4, Resident 4 stated Resident 3 spit on Resident 4's face. Resident 4 stated Resident 4 felt scared when Resident 3 held the chair over his head. During a review of the facility's P&P titled, Elder/Dependent Adult Abuse, revised 3/22/2024, the P&P indicated, this facility will protect the rights, safety, and well-being of each resident regardless of physical or mental condition against any and all forms of abuse including freedom from neglect, exploitation. The P&P indicated, Abuse - includes . Physical, sexual, verbal abuse and exploitation .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to report an allegation of sexual abuse (non-consensual sexual contact of any type with a resident) for one of two sampled residents (Resident 1) to the California Department of Public Health (the Department), the Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and to the local law enforcement, within two hours, in accordance with the facility's policy and procedure (P&P), titled Elder/Dependent Adult Abuse, revised 3/22/2024. This failure resulted in the delay of notification to the Department and had the potential for Resident 1 to be subjected to further sexual abuse while at the facility. (Cross Reference F610) Findings: 1. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses including unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition, hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and insomnia (persistent problems falling and staying asleep). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/20/2024, the MDS indicated, Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was independent from staff for dressing, toileting, and eating. 2. During a review of Resident 3's AR, the AR indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), 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 3' MDS, dated [DATE], the MDS indicated, Resident 3 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 was independent from staff for dressing, toileting, and eating. During an interview on 8/30/2024 at 9:00 a.m. with the Administrator (ADM), the ADM stated Resident 1 had reported months previously that Resident 3 had kissed Resident 1. The ADM stated Resident 1's allegation against Resident 3 was not reported to the Department at the time Resident 1 first made the allegation of sexual abuse. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/2024 at 12:18 p.m. with Resident 1, Resident 1 stated Resident 3 kissed Resident 1 on Resident 1's neck and that Resident 3 also placed both hands on Resident 1's breasts when Residents 1 and 3 were standing in line for the conference room. Resident 1 stated the incident took place a long time ago and that Resident 1 did not remember exactly when the incident happened. During an interview on 8/30/2024 at 2:36 p.m. with Group Leader Counselor (GLC) 1, GLC 1 stated Resident 1 informed GLC 1 sometime around March 2024 that Resident 3 kissed Resident 1's neck. GLC 1 stated GLC 1 did not remember the exact date Resident 1 informed GLC 1 about the allegation against Resident 3. GLC 1 stated GLC 1 informed her supervisor, the Program Director (PD), about the allegation of sexual abuse from Resident 1. GLC 1 stated GLC 1 did not inform ADM about Resident 1's allegation of sexual abuse. During an interview on 9/3/2024 at 9:45 a.m. with the PD, the PD stated GLC 1 informed the PD that Resident 1 alleged Resident 3 kissed Resident 1's neck. The PD stated the PD did not document the incident and did not remember the exact date GLC 1 informed the PD about Resident 1's allegation of sexual abuse. The PD stated Resident 1's allegation against Resident 3 was considered an allegation of sexual abuse. The PD stated the PD did not inform the ADM about Resident 1's allegation of sexual abuse because the PD could not substantiate the incident happened. During an interview on 9/3/2024 at 1:52 p.m. with the ADM, the ADM stated all allegations of abuse needed to be reported to the Department, the ombudsman, and the police within two hours of the allegation being made. The ADM stated the Abuse coordinator (the ADM) also needed to be notified of all allegations of abuse. During a review of the facility's P&P titled, Elder/Dependent Adult Abuse, revised 3/22/2024, the P&P indicated, this facility will protect the rights, safety, and wellbeing of each resident regardless of physical or mental condition against any and all forms of abuse including freedom from neglect, exploitation. The P&P indicated, Abuse - includes . Physical, sexual, verbal abuse and exploitation . The P&P indicated, all alleged violations of abuse must be reported to, The facility administrator and to other officials in accordance with State law, including to State Survey Agency, LTC Ombudsman, Local law enforcement .immediately but not later than 2 hours .

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to thoroughly investigate and document the investigation of an allegation of sexual abuse (non-consensual sexual contact of any type with a resident) for one of three sampled residents (Resident 1) in accordance with the facility's policy and procedure (P&P), titled Elder/Dependent Adult Abuse, revised 3/22/2024. This failure had the potential to result in Resident 1 to experience sexual abuse while in the care of the facility. (Cross Reference F609) Findings: 1. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses including unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition, hyperlipidemia (a condition in which there are high levels of fat particles [lipids] in the blood), and insomnia (persistent problems falling and staying asleep). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/20/2024, the MDS indicated, Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was independent from staff for dressing, toileting, and eating. 2. During a review of Resident 3's AR, the AR indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), 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 3' MDS, dated [DATE], the MDS indicated, Resident 3 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 was independent from staff for dressing, toileting, and eating. During an interview on 8/30/2024 at 12:18 p.m. with Resident 1, Resident 1 stated Resident 3 kissed Resident 1 on Resident 1's neck and that Resident 3 also placed both hands on Resident 1's breasts when Residents 1 and 3 were standing in line for the conference room. Resident 1 stated the incident took place a long time ago and that Resident 1 did not remember exactly when the incident happened. During an interview on 8/30/2024 at 2:36 p.m. with Group Leader Counselor (GLC) 1, GLC 1 stated Resident 1 informed GLC 1 sometime around March 2024 Resident 3 kissed Resident 1's neck. GLC 1 stated GLC 1 did not remember the exact date Resident 1 informed GLC 1 about the allegation against Resident 3. GLC 1 stated GLC 1 informed her supervisor, the Program Director (PD), about the allegation of sexual abuse from Resident 1. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/3/2024 at 9:45 a.m. with the PD, the PD stated GLC 1 informed the PD that Resident 1 alleged Resident 3 kissed Resident 1's neck. The PD stated the PD did not document the incident and did not remember the exact date GLC 1 informed the PD about Resident 1's allegation of sexual abuse. The PD stated Resident 1's allegation against Resident 3 was considered an allegation of sexual abuse. The PD stated the PD did not document the results of the PD's investigation into the allegation. During an interview on 9/3/2024 at 1:52 p.m. with the Administrator (ADM), the ADM stated Resident 1's allegation of sexual abuse was not thoroughly investigated. The ADM stated all investigations of abuse should include interviewing residents (in general) and staff (in general) who might know about the incident. The ADM stated the investigation must also be documented and the documentation must be kept for [AGE] years. During a review of the facility's P&P titled, Elder/Dependent Adult Abuse, revised 3/22/2024, the P&P indicated, The facility will: i. Identify staff responsible to conduct an immediate investigation of any allegation of any form of abuse. ii. Exercise caution in handling evidence that could be used in a criminal investigation. iii. Identify and interview all persons involved including alleged victim, perpetrator, witnesses, others who may have knowledge of alleged violations; iv. Focus on determining if abuse, neglect, exploitation or mistreatment has occurred and the extent/ cause v. Immediately reassign any involved employee to duties that do not involve resident contact or suspend employee vi. Document evidence that all alleged abuse violations are thoroughly investigated. vii. Take all necessary actions as a result of the investigation.