poc accepted #42854 03/09/21

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION NG		PLETED
		05A134	B. WING_		02/2	4/2021
	PROVIDER OR SUPPLIER RK MEDICAL CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 N. GAREY AVE. POMONA, CA 91767		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	BE	(X5) COMPLETION DATE
	California Departminvestigation of one (FRI). FRI number: CA00 Representing the Exaluator Nurse #4 The inspection was investigated and do of a full inspection of a full inspection of Allege CFR(s): 483.12(c)(f) §483.12(c) In response of Allege CFR(s): 483.12(c)(f) §483.12(c) In res	cts the findings of the ent of Public Health during the Facility-Reported Incident 662864 Repartment: Health Facilities 2854 Illimited to the specific FRI Res not represent the findings of the facility. Bere issued for FRI number: d Violations		abuse made on his behalf by Landmark Medical Center who will be responsible for reporting to the State Departme of Public Health, Ombudsman, local Police, residents responsi party, attending physician, and medical director concerning an abuse, neglect, or mistreatment resident. The report will includ resident name, room number, type of abuse, persons involved and action taken by the facility. Documentation will also indica that the Abuse Coordinator, Administrator and Director of Nursing had been contacted within two hours of the incident	ent ible y of a le te	
ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	2/	(XB) DATE 24/24

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.

Event ID: 16FB11

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Facility ID: CA950000088

STATEMENT OF DEPOCHERIES AND PLAN OF CORRECTION MAKE OF PROVIDER OR SUPPLIER LANDMARK MEDICAL CENTER PORTON AS STREET ADDRESS, CITY, STATE, 2P CODE 200 N. GAREY AVE. PORTONA, OR 91767 PORTON AS STREET ADDRESS, CITY, STATE, 2P CODE 200 N. GAREY AVE. PORTONA, OR 91767 PORTON AS STREET ADDRESS, CITY, STATE, 2P CODE 200 N. GAREY AVE. PORTONA, OR 91767 PREFIX AND PLAN OF CORRECTION GENERAL REPORTS THE APPROPRIATE GENERAL REPORT WAS THE PROCESSED BY PAUL RESULATORY OR LSO IDENTIFYING SPORMATION) F 609 Continued From page 1 accordance with State law, including to the State SURVEY Agency, within 5 working days of the Investigations to the administrator or his or fier designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the Inciter, and if the ellaged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by. Based on observation, interviews, and record review, the facility failed to notify the Department within 2 hours of an ellegade sexual abuse made by one of three sempled residents (Resident 1), Resident 1 place of the properties of the		10 L OLY INTERNOUTE	W MICHIGAIN OFFICE				T	
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ANDMARK MEDICAL CENTER ANDMARK MEDICAL CENTER 2899 M. GARRY AVE. POMONA, GA 91767		•	05A134	B. WING			02/2	24/2021
POMONA, CA 91787 PROFESSION PROFES	NAME OF F	PROVIDER OR SUPPLIER			1			١
SUMMARY STATEMENT OF DEPOSENCIES (REGULATORY OR LOS IDENTIFYING INCOMPANION) PREFIX TABLE PROVINCERS PLANOF CORRECTION (REGULATORY OR LOS IDENTIFYING INCOMPANION) PREFIX TABLE PROVINCERS PLANOF CORRECTION (REGULATORY OR LOS IDENTIFYING INCOMPANION) PREFIX TABLE PROVINCERS PLANOF CORRECTION (REGULATORY OR LOS IDENTIFYING INCOMPANION) PREFIX TABLE PROVINCERS PLANOF CORRECTION (REGULATORY OR LOS IDENTIFYING INCOMPANION) PREFIX TABLE PROVINCERS PLANOF CORRECTION (REGULATORY OR LOS IDENTIFYING INCOMPANION) PREFIX TABLE PROVINCERS PLANOF CORRECTION (REGULATORY OR LOS IDENTIFYING INCOMPANION) PROVINCE AND INCOMPANION (REGULATORY OR REGULATORY OR PREFIX TABOUT CORRECTION (REGULATORY OR PROPERTY TABOUT CORRECTION (REGULATORY OR PROPERTY TABOUT CORRECTION (REGULATORY OR PROPERTY TABOUT CORRECTION (REGULATORY OR PREFIX TABOUT CORRECTION (REGULATORY OR PREFIX TABOUT CORRECTION (REGULATORY OR PREFIX TABOUT CORRECTION (REGULATORY OR PROPERTY OR PROPE	LANDMA	RK MEDICAL CENTE	iR .		1			
F 609 Continued From page 1 accordance with State law through established procedures. \$463.12(c)(4) Report the results of all Investigations to the administrator or his or her designated representative and to other officials to accordance with State law, including to the hoddent, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by. Based on observation, interviews, and record review, the facility falled to notify the Department within 2 hours of an allegade sexual abuse made by one of three sampled nesidents (Resident 1). Resident a laleged that on 11/1/19, she was reped by Resident 2 and the facility did not report this allegation to the Department. This deficient practice placed Resident 1 at risk for being further abused by Resident 2. which had the potential to cause a decline in the resident's physical, mental and emotional well-being. Findings: On 11/8/19 at 12:41 pm, an unannounced visit was made to the facility to investigate a facility reported holdent regarding resident to resident atternation. 1 A review of Resident 1° Face Sheet indicated the facility initially admitted the resident on 9/24/13 with diagnosis that included schloseffective disorder (chronic mental condition with symbolous).		O WALLA DO CYA	TELEDIT OF REPORTATED	lin.	L.,		N I	(VE)
F 609 Continued From page 1 accordance with State law through established procedures. \$483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the Incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility falled to notify the Department within 2 hours of an alleged sexual abuse made by one of three sampled residents (Resident 1). Resident 1 alleged that on 11/1/19, she was isped by Resident 2 and the facility did not report this allegation to the Department. This deficient practice placed Resident 1 at risk for being further abused by Resident 2, which had the potential to cause a decline in the resident's physical, mental and emotional well-being. Findings: On 11/8/19 at 12:41 pm, an unannounced visit was made to the facility to investigate a facility reported incident regarding resident to resident alternation. And director of Nursing has Been contacted within two hours Of the incident occurrence. 3.) Resident abuse in-service will be held Three times per year. Training will include, but not be limited to, how to deal with allegations of abuse, neglect, exploitation, sexual or mistreatment. All new employees will receive abuse in-service upon hire. In-service will include raining on timely reporting of alleged or suspected abuse to the abuse coordinator. Training on mandatory reporting and reporters responsibilities. Training will also include how to deal with allegations of abuse, neglect, exploitation, sexual or mistreatment. All new employees will receive abuse in-service upon hire. In-service will include training on timely reporting of alleged or suspected abuse to the abuse coordinator. Training on mandatory reporting and reporters responsibilities. Training will also include ho	Préfix	FACH DEFICIENCY	MUST BE PRECEDED BY PULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROP	BE	COMPLETION
great excitement/overactivity, and depression).	F 609	accordance with Structures. \$483.12(c)(4) Repoinvestigations to the designated represe accordance with Structure Agency, with incident, and if the appropriate correction of the REQUIREMENT by: Based on observative the facility from the structure of an by one of three samples on the saliegation to the This deficient practification of the samples of the potential to cause physical, mental and physical, mental and physical incident realization. 7. A review of Residual to the facility initially and schizoaffective discountry with a symptome like	ate law through established at the results of all a administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified we action must be taken. IT is not met as evidenced ion, interviews, and record alled to notify the Department alleged sexual abuse made upled residents (Resident 1). that on 11/1/19, she was and the facility did not report be Department. It is placed Resident 1 at risk used by Resident 2, which had se a decline in the resident's demotional well-being. I pm, an unannounced visit cility to investigate a facility garding resident to resident that included and the resident on als that included arder (chronic mental condition hallucinations, delusions,	F	509	And director of Nursing had Been contacted within two hour Of the incident occurrence. 3.) Resident abuse in-service will be Three times per year. Training will include, but not be limited to how to deal with allegations of abuse, neglect, exploitation, sexual or mistreatment. All new employees will receive abuse in-service upon hire. In-service will include training of timely reporting of alleged or sure abuse to the abuse coordinator. On mandatory reporting and reported to within the facility. Training will also include how to deal with allegations of abuse, neglect, exploitation or mistreatment. 4.) Staff Developer will carry out in Training three times per year. Mandatory reported to mistreatment or review in-service calendar for compliar strator to monitor timely in-service to misservice to misse	se held o, se on spected Training orters o is to o ment.	

CENTE	19 FUR MEDIOAILE	C MENIAVID CHITTING				NA BATT	COLOR STATE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	LETED
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		05A134	B. WING	3			4/2021
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F 609	(MDS, a standardizere screening tool resident had mode (mental action or pland understanding thinking and inatter During an observation Resident 1 was call interview, Resident 2 hit her on the heavithin the past two forced her into the penis into her moustated that she did Resident 1 stated in name) on 11/7/very embarrassed forced her to have not feel safe in the 2. A review of Residentiting diagnosis	nt 1's Minimum Data Set zed resident assessment and i), dated 10/8/19, indicated the rate impairment in cognition rocess of acquiring knowledge) that includes disorganized ntion. Ition on 11/8/19 at 12:59 p.m., im. During a concurrent i 1 stated on 11/7/19, Resident ad. Resident 1 further stated months, Resident 2 had bathroom, then forced his th and into her butt. Resident 1 not want him to do that. She informed facility staff (with 19. Resident 1 stated she felt and scared when Resident 2 sex. Resident 1 stated she did	F	609			
	Resident 2 was in (wrists, ankles, and concurrent intervial raid but could not s	p.m., during an observation, bed on five points restraints d abdomen). During a w, Resident 2 stated he hit a tate the name. Resident 2 sident 1 into sexual contact.					
	(DON) on 11/8/19	v with the Director of Nursing at 1:45 pm, DON stated ad Resident 2 of raping her, but ance to support her accusation.					

STATEMENT	OP DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		E SURVEY PLETED
and Plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	1	C
		05A134	B. WING			24/2021
	PROVIDER OR SUPPLIER ARK MEDICAL CENTI			STREET ADDRESS, CITY, STATE, ZIP CODE 2030 N. GAREY AVE. POMONA, CA 91767		
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F 609	During an interview (PD 1) on 11/8/19 allegation of rape of 11/1/19 but it was a facility investigated nothing happened it (allegation of rappolice because the collect as it was called the police reincidents and they stated the facility in were not able to sufacility's protocol for investigate, and dereport it to the police partment. PD 1 substantiating avid	w with the Program Director at 1:64 pm, PD 1 stated the was reported to the staff on not reported to the Department alse allegation. PD 1 stated the lit over the weekend, but with forcible rape. PD 1 stated e) was not reported to the are would not be any evidence too late. PD 1 stated they had begarding previous rape did not do a rape kit. PD 1 stated the or any abuse allegation is to spend on the situation would ce. Ombudsman and the stated if there was tence to what the person was acility would report to the police	F€	309		·
	Progress Note, da indicated during m reported Resident hand on left side of that Resident 1 did the residents and indicated no injury neurology check fabove the shoulde ADM and DON we and voicemail was A review of Reside Progress Note, da	ant 1's inter-Disciplinary ted 11/7/19 at 4:00 p.m., redication time, Counselor 1 2 hit Resident 1 with closed of her face. The note indicated in not hit back, staff separated assessed Resident 1. The note and physician order for or 72 hours related to potential or injury. The note indicated that are notified via text message is left to conservator. The inter-Disciplinary ted 11/8/19 at 2:00 p.m., riew was completed for incident				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	19 LOV MEDIAVIVE	A MEDIOWID SELVICES				Name 1 .			
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • • • •		CONSTRUCTION		PLETED		
		05A134	B, WING	-		02/2	: 4/2021		
NAME OF I	PROVIDER OR SUPPLIER				reet address, city, state, zip code				
LANDMA	ARK MEDICAL CENTE	er ·	2030 N. GAREY AVE. POMONA, CA 91767						
(X4) ID PREFIX TAG	PACH DEFIDIENCY	ntement of Depiciencies / Must be preceded by full, sc identifying information)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(00) COMPLETION CLATE		
F 609	for resident to resident it was reported Police, and the Der Services. A review of the Adnidated 11/8/19, indicated peer, Resident Resident 1 claimed Resident 2 but their this. The note indicated Resident denied having any	77/19 and care plan opened lent abuse. The note indicated to the Ombudsman, City partment of Public Health ministrator's narrative note, pated Resident 1 was hit by at 2. The note indicated that to have been raped by the is no evidence to support ated that Resident 1 was ing this on the unit. The note 2 admitted to hitting her but	F	309					
	p.m. the Administrative alleged sexual the alleged sexual Department because Resident 1 was satisfied that there was raped and that The Administrator when there is any awould call it in and report within first 2 would follow. A review of the factility Manawith a revision date alleged or suspecting lect, injuries of is reported, the fact designee, will notified agencies of such in	anterview on 11/2/719 at 3.00 ator stated she did not report abuse incident to the se she felt confident that it. The Administrator stated ported it. The Administrator as no evidence that Resident 1 it was part of her screaming, stated generally what happens case of alleged abuse, she there would be reflective in hours, then written report agement Abuse Reporting," a of 12/20, indicated when an ed case of mistreatment, an unknown source, or abuse tilty administrator, or his/her by the following persons or incidents: the State on agency responsible for							

STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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Manage day		08A134	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	02/2	24/2021
	PROVIDER OR SUPPLIER LRK MEDICAL CENTE	iR		20	MONA, CA 91767		
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F 610	ombudsman, the re record, law enforces resident's attending of the facility's policy timeframe in which of mistreatment, ne source should be re investigate/Prevent CFR(8): 483.12(c)(2) § 483.12(c) (2) In respondent, exploitation must \$483.12(c)(2) Have violations are thorous \$483.12(c)(3) Prevented to the contestigation is in progressing to the designated representation accordance with Standard investigations to the designated representation accordance with Standard in the appropriate correction in the second accordance with Standard in the second accordance with Standard in the second accordance correction in the second accordance with Standard in the second in th	facility, the local/State sident's representative of ment officials and the physicians. A further review y failed to include the an alleged or suspected case glect, injuries of an unknown ported the Department. (Correct Alleged Violation 2)-(4) nse to allegations of abuse, or mistreatment, the facility evidence that all alleged ighly investigated. In turther potential abuse, or mistreatment while the ogress. If the results of all administrator or his or her intative and to other officials in the law, including to the State in 5 working days of the alleged violation is verified we action must be taken. It is not met as evidenced	,	310	1.) Resident 1 will be free from any potential abuse, neglect, exploitation or mistreatment when any complaint of abuse has been brought against a resident by resident 1. The accused resident will be immediately removed from the unit away from the resident reporting The alleged abuse against them. 2.) All residents will be free from any potential abuse, neglect exploitation or mistreatment by		
	review, the facility fa the alleged sexual a investigated after or	on, interviews and record illed to have the evidence that buse was thoroughly the of three eampted residents that Resident 2 had sexually			resident two or any peer, with such behaviors. When a complaint of abuse has been brought against a resident and is being		

NAME OF PROVIDER OR SUPPLIER DEATISATION NUMBER: OBA134 B. WING STREET ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 PROPRETED COMPLETED COMPLETE CROSS N. GARRY AVE. POMONA, CA 91767 FROM DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) FROM DEPICIENCY OR LSO IDENTIFYING INFORMATION) FROM DEPICIENCY FROM DEPICIENCY OR LSO IDENTIFYING INFORMATION) FROM DEPICIENCY FROM DEPICIENCY FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 PROVIDER'S PLAN OF CORRECTION FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STATE, 2P CODE 2030 N. GARRY AVE. POMONA, CA 91767 FROM DARREST ADDRESS, CITY, STAT	OCIVIERO FOR WICHIOANE & WILLIAM STATE OF THE STATE OF TH			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
NAME OF PROVIDER OR SUPPLIER LANDMARK MEDICAL CENTER SITEET ADDRESS, CITY, STATE, ZIP CODE 2390 N. GARRY AVE. POMONA, CA 91767 SITEET ADDRESS, CITY, STATE, ZIP CODE 2390 N. GARRY AVE. POMONA, CA 91767 PREPIX (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSO IDENTIFYING INFORMATION) F 610 Continued From page 6 This deficient practice resulted in Resident 1 not being properly assessed and no collecting of evidence to determine if the resident had been raped, which placed the resident at risk for being further abused by Resident 2. Findings: On 11/8/19 at 12-41 pm, an unannounced visit was made to the facility to investigate a facility reported incident regarding resident to resident altercation. 1. A review of Resident 1's Face Sheet indicated the facility initially admitted the resident on 9/24/13 with diagnosis that included soft) and depression). A review of Resident 1's Minimum Data Set (MDS, a estandardized resident assessment and care screening bool), dated 10/8/19, indicated the alleged abuser is to be			(X1) PROVIDER/SUPPLIER/GLIA (DENTIFICATION NUMBER:			COMPLETED		
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CANDMARK MEDICAL CENTER 2030 N. GARRY AVE. FOMIONA, CA 91767			06A134	B, WING			02/2	4/2021
POMONA, CA 91767 PRINTED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDIED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION) PREFIX TAG	NAME OF	PROVIDER OR SUPPLIER			_			
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(mental action or process of acquiring knowledge and understanding) that includes disorganized thinking and inattention. During an observation on 11/8/19 at 12:59 p.m., Resident 1 was caim. During a concurrent interview, Resident 1 stated on 11/7/19, Resident 2 hit her on the head. Resident 1 further stated within the past two months, Resident 2 had forced her into the bathroom, then forced his pents in her mouth and in her butt. Resident 1 stated that she did not went him to do that. Resident 1 stated she informed facility staff (with no name) on 11/7/19. Resident 1 stated she felt yery embarrassed and scared when Resident 2	F 610	This deficient practibility properly assessive evidence to determ raped, which place further abused by Findings: On 11/8/19 at 12:4' was made to the fareported incident realtercation. 1. A review of Residence the facility initially a 9/24/13 with diagnoschizoaffective diagnoschizoaff	tice resulted in Resident 1 not besed and no collecting of line if the resident had been in the resident at risk for being Resident 2. I pm, an unannounced visit cility to investigate a facility agarding resident to resident condition resident to resident included and condition resident on the sist that included and experience mental condition relations and depression). Int 1's Minimum Data Set red resident assessment and between the impairment in cognition recess of acquiring knowledge that includes disorganized inton. Idon on 11/8/19 at 12:59 p.m., m. During a concurrent at stated on 11/7/19, Resident and har butt. Resident 1 not want him to do that, the informed facility staff (with 19, Resident 1 stated she felt	F6	310	accused resident will be immediately removed from the unit away from the resident reporting the alleged abuse against them. 3.) After claim of abuse has been made the facility will call the Pomona police to investigate and determine if the resident is to be sent to Pomona valley medical center for a trauma examination. The Pomona police will also determine if the alleged abuser is to be taken to jail or remain in the facility. To secure the resident safety the alleged abuser will be placed on a 1:1 until investigation is complete or other placement can		

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		05A134	T. VYING		REET ADDRESS, CITY, STATE, ZIP CODE	02/2	4/2021
	PROVIDER OR SUPPLIER ARK MEDICAL CENTE	iR		20	REET ADDRESS, CITY, STATE, ZIP CODE ISO N. GAREY AVE. DRIONA, CA 91767	-	
(X4) ID PREFIX TAG	reach depidiendy	Tement of Depoiencies I must be preceded by full SO (Dentifying Information)	ID PREFI TAG		FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 610	inot feel safe in the inot feel safe in the 2. A review of Resid the facility admitted admitting diagnosis (mental iliness which with reality). On 11/8/19 at 1:10 Resident 2 was in the concurrent interview girl but could not studented forcing Resident 1 accused (DON) on 11/8/19 at allegation of rape with the staff investigate nothing happened to During an interview (PD) on 11/8/19 at allegation of rape with 11/1/19, but it was at the staff investigate nothing happened to During an interview 2:38 pm, DON state because when the facility was una stated no physical a because it was inveno incident of what bocumed. DON staff regulations and as invented and as invent	sex. Resident 1 stated she did facility anymore. dent 2's Face Sheet indicated in the resident on 9/27/18 with the of paranoid schizophrenia on the mind does not agree p.m., during an observation, need on five points restraints abdomen). During a w. Resident 2 stated he hit a ate the name. Resident 2 ident 1 into sexual contact. With the Director of Nursing at 1:45 pm, DON stated in Resident 2 of raping her, but note to support her accusation. With the Program Director 1:64 pm, PD stated the was reported to the staff on a false allegation. PD stated ad it over the weekend, but with forcible rape. With the DON on 11/8/19 at ed a body check was not done investigation was conducted, bile to substantiate rape. DON assessment was done estigated and concluded that Resident 1 claimed had ted she was aware of the a clinical nurse.		310	4.) Quality Assurance nurse will monitor all allegations of abuse. Abuse inservice will be held three times per year for all staff. Administrator to monitor. 5.) Full compliance in effect 2/24/21		
	A review of Reside	nt 1's inter-Disciplinary	1				<u></u>

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING CO				TE SURVEY MPLETED C	
	:	05A134	B. WING		**************************************	E .	4/2021	
į	ROVIDER OR SUPPLIER IRK MEDICAL CENTE	R	,	20	reet address, city, state, zip code 130 n. garey ave. Omona, ca 91767			
(X4) ID · PREFIX TAG	MACH DEFICIENC	N'EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N I BE RIATE	COMPLETION DATE	
F 610	Indicated no docum	age 8 tween 11/1/19 and 11/8/19, nentation that investigation ressment was done regarding	F6	10				
	dated 11/8/19, indice mate peer, Resident Resident 1 claimed Resident 2, but the this. The note indice and scream indicated Resident	ninistrator's narrative note, cated Resident 1 was hit by a nt 2. The note indicated that it to have been raped by re was no evidence to support ated that Resident 1 was ing this on the unit. The note 2 admitted to hitting her misd having any physical	•			ļ		
	p.m., regarding the made by Resident there was no evide that it was part of hadministrator valid done for the allege screaming it out. Toase, should some	ated that no investigation was drape as resident was just the Administrator stated in any cone accuse another resident facility must investigate the						
	titled "Facility Mana with a revision date Upon receiving rep must be sent to Ma staff will do an exa determined by the the Police Officer i abuse. Administrat conduct internal in	ility's policy and procedures, agement Abuse Reporting," a of 12/20, indicated: write of sexual abuse, resident adical Center. Medical Center mination. This will be Police and will be arranged by investigating the alleged sexual for and any legal entitles will vestigation which will attempt to her residents could have been						

STATEMEN AND PLAN	T of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	•	05A134	B. WING			B.	C
	NAME OF PROVIDER OR SUPPLIER LANDMARK MEDICAL CENTER			8	Treet address, city, state, zip code 030 n. garey ave. Omona, ca 81767	02/	24/2021
(xa) ID Priepix Tag	Summary Btatement of Deficiencies (Each Deficiency Must be preceded by Full Regulatory or LSC Identifying Information)			IX	Provider's Plan of Correction (Each Corrective Action Should Cross-Referenced to the Appropi Deficiency)	RF	COMPLETION DATE
F 610	harassed or abuse All residents who he have a psychiatrist, therapist session to the trauma of sexua resident will be offer	ge 9 (sexually) by the parpetrator, ave been sexually abused will psychologist or ilcensed discuss the issues related to a second session to surrounding the abuse.	FI	810			,
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