PRINTED: 09/16/2016
FORM APPROVED
OMB NO. 0938-0391

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

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 2nd POC reviewed - accepted	36396 9/30/16 08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDMARK MEDICAL CENTER	2030 N. GAREY AVE. POMONA, CA 91767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during an Entity Self-Report Visit. Complaint # CA00500306 - Substantiated Category: Quality of Care/Treament Representing the Department of Public Health: 36396 The inspection was limited to the specific components investigated and does not represent the findings of a full inspection of the facility.	F 000	1. Resident #1 will be free from accidents, hazards and will receive adequate supervision to prevent accidents. In this case to prevent going Absent Without Leave (AWOL) from outdoor activities held in the back parking lot of the facility. 2. All Resident's will be free from accidents, hazards and will receive adequate supervision to prevent accidents and AWOL's during Gardening Group. When Residents are participating in Gardening Group, they will be supervised at all times by two staff members and will not have more than 15 residents outside at one time. When outside, staff will be unoccupied and doing nothing else by giving full attention to Resident's under their supervision	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision to 1 of 18 Residents (Resident 1) who participated in a group activity. Resident 1 eloped from the facility during a group activity. This failure had the potential to result in harm to Resident 1 while off facility premises. Findings:	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rosemary C. Kirby — TITLE: Administrator — (X6) DATE: 9/27/16

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.

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F 323	Continued From page 1 A review of a document titled "Admission Record" indicated Resident 1 was admitted to the facility on 6/7/2016 with diagnoses that included, but not limited to, Paranoid Schizophrenia (mental disorder in which a person loses touch with reality); Gastro-esophageal Reflux Disease (heartburn) and Dermatitis (inflammation of the skin). A review of a document titled "Elopement Risk Assessment" dated 6/7/2016 indicated that Staff was aware of Resident 1's wander risk, and that Resident 1 was interested in group scheduled activities. A review of a document titled "Care Plan - Poor Impulse Control" dated 6/7/2016 indicated Resident 1 had a history of AWOL (absence without leave), assist client to identify/discuss feelings associated with impulsive behavior. An interview with Licensed Vocational Nurse (LVN) 1 was conducted on 8/25/2016 at 3:25 pm. LVN 1 stated Resident 1 was discovered missing from the facility on 8/23/2016 at around 7:00 pm. and stated that facility staff searched in the facility as well as outside premises per the facility protocol. LVN 1 stated Resident 1 could not be found. LVN 1 further stated that she reported the incident to the administrator and police department. An interview with CNA 1 was conducted on 8/25/2016 at 3:15 pm. CNA 1 stated that he saw Resident 1 outside on the patio on 8/23/2016 at around 6:30 pm during a group activity. CNA 1 also stated there were 2 activity staff present when he saw Resident 1 outside on the patio.	F 323	3. Program Director to monitor staff to Resident outing ration. In-service education has been done with Activity Staff to review procedures related to supervision during Gardening Group. In-service education was held for Activity Staff on 8/24/16. Quality Assurance Committee to review on quarterly basis. Administrator to monitor. 4. Corrective action completed 8/24/16	

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F 323	Continued From page 2 An interview with Activity Director was conducted on 8/25/2016 at 3:35 pm. Activity Director stated she conducted a gardening group activity on 8/23/2016 at 6:10 pm, and that 18 Residents joined the activity after announcing it over the intercom. Activity Director also stated she was with 1 activity staff that monitored for the 18 residents who joined the activity; they finished the gardening activity at around 6:45 pm. Activity Director said they did not check which residents went back inside the facility after the group activity. An interview with Activity Staff was conducted on 8/25/2016 at 4:05 pm. Activity staff stated they brought out too many residents for the group activity. Activity staff further stated that his focus during the group activity was the gardening and the Activity Director was the one monitoring the residents. Activity staff also stated they did not have a list of Residents who went out and joined the gardening group activity, and that they did not check if all the residents went back inside the facility. Activity staff said he was only aware that Resident 1 was missing when he received a call, while he was at home, from the facility at around 8:29 pm of the same day. An interview with Program Director was conducted on 8/25/2016 at 4:30 pm. Program Director stated that Resident 1 possibly eloped during group gardening activity. Program Director also stated that he reviewed the video surveillance recording at the parking lot and noted that Resident 1 was last seen in the video at around 6:30 pm but video did not show how Resident 1 eloped. Program Director also stated there should be 1 staff for every 4 residents to	F 323		

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F 323	Continued From page 3 monitor during an outside group activity. Program Director further stated that Resident 1 could have used a trash bin to step on and climbed over the side wall at the parking lot. A telephone interview was conducted with the mother of Resident 1 on 8/25/2016 at 3:10 pm. Resident 1's mother stated that her daughter came to her the night of 8/23/2016. Resident 1's mother also stated that Resident 1 was picked up by police and was placed back in prison. A review of an undated facility policy and procedure titled "Situation AWOL from within Facility" indicated the patio will be supervised by staff when clients are occupying it.	F 323		