Removed 8/18/16 | 8-23-16
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2016
FORM APPROVED
OMB NO. 0938-0391

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 _____	C 07/28/2016

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 a facility reported incident investigation. Complaint #: CA00482411 - Substantiated CA00482297 - Substantiated Category: Resident/Patient/Client Abuse Representing the Department of Public Health: 28074 36502 36535 This 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 and the alleged abuser were immediately separated by staff. Licensed Nurse performed physical assessment, no injury noted. Physician and Conservator of resident 1 and alleged abuser notified. Close monitoring of resident 1 was indicated times 72 hours and completed including Neuro checks for further complications. Alleged abuser was placed on 1:1 continuous observation for two hours then on Q15 minutes ec observation for two hours to prevent further escalation of behavior. The Physician ordered new medication to decrease Assaultive behavior of alleged abuser on 3/31/16.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279	Resident 2 was newly admitted from an acute Psychiatric Facility. Resident 2 and alleged abuser were immediately separated. Licensed staff performed physical assessment to Resident 2, no injury noted. Resident 2 was put on Neuro Checks for 72 hours for safety precaution and monitored for further complication. Alleged abuser was placed on 1:1 continuous observation times two hours then Q15 for two hours to minutes ec prevent further escalations of behavior. The Physician ordered new medication to decrease assaultive behavior of alleged abuser on 3/29/16.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X8) DATE: 8/16/16

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 279	Continued From page 1 be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop, implement, and modify the care plans for Residents 1 and 2 after a resident to resident altercation. The failure of the facility to develop or modify the plans of care to address each resident's changing needs put them at risk for serious harm. Findings: On 5/25/16 at 1:50 p.m., an unannounced visit was made to the facility to investigate two entity reported incidents (ERI) regarding resident abuse. a) A review of the clinical record indicated Resident 1 was admitted to the facility on 6/13/13. Resident 1's diagnoses included schizoaffective disorder (mental disorder characterized by abnormal thought processes and deregulated emotions), hypertension (high blood pressure), and psychoactive substance dependence. A review of Resident 1's Minimum Data Set (MDS), a standardized assessment and screening tool, dated 3/17/16, noted the resident was alert, oriented, able to make needs known, and understand others. On the other hand,	F 279	2.) Resident 1 care plan was revised by counselor on 6/21/16. That revision included measures to prevent Resident 1 from being further assaulted by other peers, such as 1:1 discussion with counselor and licensed nursing staff to discuss the importance of personal space. Alleged abuser of Resident 1 plan of care that addressed physically assaultive behavior was updated by counselor on 3/30/16, to include de-escalation techniques such as relaxation to decrease anger. Resident 2 was admitted on 3/28/16 one day prior to the incident on 3/29/16. Resident 2 was not observed to manifest any assaultive behavior toward peer. Plan of care had been developed on admission on 3.28.16 by Licensed Nursing Staff to address potential injury due to admission. Alleged abuser care plan was updated by counselor on 3/30/16 which will address physically assaultive behavior and included interventions to deal with response to internal stimuli to prevent further assault toward peers. 3. Care Plan must be developed to address measures to prevent injury to residents as part of facility admission procedure. Care Plan s are reviewed quarterly and as necessary for every incident that occur.	

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F 279	Continued From page 2 Resident 1 has behaviors of inattention, disorganized thinking, and verbal behavioral symptoms directed towards others. A review of the ERI indicated that on 3/30/16 at 7:30 a.m., while Resident 1 was standing on the hallway while his room was being cleaned when Peer came out of his room and punched Resident 1. Resident 1 got hit in the chest area and moved away. There was no apparent injury to Resident 1. A review of Resident 1's care plan, updated 3/14/16, entitled, " Potential for Victimization " indicated that Resident 1 gets in peers' faces and the potential to get hit. The staff's interventions included to praise resident for appropriate behavior and one on one to discuss the importance of personal space. On 5/25/16 at 2:50 p.m., during a concurrent interview with both the director of nursing (DON) and medical records director, both stated that the care plan titled " Potential for Victimization" should have been updated to address the resident's recent altercation incident with another resident in the facility to prevent occurrence of the same incident . A review of the undated facility policy titled, "Interdisciplinary Treatment Plan" indicated that a plan must be developed and interventions to be used will not only be clear to the resident and the clinician, but also to any authorized person reading the medical record. b) A review of Resident 2's clinical record	F 279	4. Inservice was conducted on 7/25/16 by Program Director with Special Treatment Program Staff. Inservice addressed care plan revisions and updated interventions. This inservice will be held quarterly (July, October, January, April) by Interdisciplinary Team (Nursing and Special Treatment Program Staff) 5. Program Director and Director of Nursing will monitor Care Plan Quarterly and as needed. Quality Assurances Committee to review care plan during quarterly meeting and as needed. Administrator to assure compliance. 6.) Full Compliance in effect 8/28/16.	

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F 279	Continued From page 3 revealed Resident 2 was admitted to the facility on 3/28/16. Resident 2's diagnoses included schizoaffective disorder (mental disorder characterized by abnormal thought processes and deregulated emotions) and asthma (inflammatory disease of the airways of the lungs). A review of Resident 2's Minimum Data Set (MDS), a standardized assessment and screening tool, dated 4/7/16, noted the resident was alert, oriented, able to make needs known, and understand others. On the other hand, Resident 2 has behaviors of inattention and disorganized thinking. A review of the ERI indicated that on 3/29/16 at 7:55 a.m., while Resident 2 was eating breakfast in the dining room, a Peer hit him on the right side of his head, pushed him down in the chair, and kicked him on the right buttock. Facility staff intervened and escorted Peer to his room. No injuries were reported. On 5/25/16 at 3:50 p.m., during an interview, the director of nursing (DON) stated that the staff follow the crisis prevention intervention to manage residents who are agitated and at risk for altercation. DON also stated that care plan was not completed for Resident 2 because he did not cause any problem and incident happened only a day after admission. A review of Resident 2's clinical record, revealed that there was no care plan to prevent occurrence of resident to resident altercation. A review of the undated facility policy titled,	F 279		

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