STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055126	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chino Valley Health Care Cente	2351 S Towne Avenue Pomona, CA 91766

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 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. 44027 Based on interview and record review, the facility failed to report an allegation of abuse for one of three 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 Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised March 2023. This failure resulted in a delay in notification to the Department and had the potential to result in Resident 1 to be subjected to abuse while at the facility. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/14/2022 and readmitted Resident 1 on 3/29/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), dementia (a group of thinking and social symptoms that interferes with daily functioning), and unsteadiness of feet. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/2024, the MDS indicated Resident 1 was moderately impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 1 required supervision (oversight, encouragement or cuing) from staff for lower body dressing and bathing. During a telephone interview on 4/8/2025 at 12:02 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 saw CNA 2 mistreat and physically abuse Resident 1 on 3/31/2025 at 6:49 p.m. CNA 1 stated CNA 1 reported the incident of abuse to Licensed Vocational Nurse (LVN) 1 and Registered Nurse (RN) 1. CNA 1 stated CNA 1 also reported the incident to the Director of Nursing (DON) via telephone 30 minutes later. CNA 1 stated CNA 1 wrote out a written statement about the incident of abuse and gave it to the DON. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/8/2025 at 3:47 p.m. with RN 1, RN 1 stated RN 1 was the supervisor at the facility on 3/31/25 when CNA 1 reported an incident that CNA 1 witnessed between CNA 2 and another resident. RN 1 stated RN 1 called the DON, and that RN 1, LVN 1, and CNA 1 spoke together with the DON over speaker phone. RN 1 stated CNA 1 reported CNA 2 was aggressive toward a resident (in general). RN 1 stated the facility did not report the incident to the Department, the Ombudsman, or the police. During a telephone interview on 4/9/2025 at 10:35 a.m. with CNA 2, CNA 2 denied abusing Resident 1. CNA 1 stated the facility suspended CNA 2 because someone alleged CNA 2 had been abusive towards Resident 1. During an interview on 4/9/2025 at 10:55 a.m. with LVN 1, LVN 1 stated LVN 1 heard the DON instruct CNA 1 to write a written statement regarding CNA 1's concerns about CNA 2's treatment of a resident (in general). During an interview on 4/9/2025 at 12:15 p.m. with the Director of Staff Development (DSD), the DSD stated all allegations of abuse must be reported 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. During a concurrent interview and record review on 4/9/2025 at 12:29 p.m. with the DON, CNA 1's untitled written statement, dated 3/31/2025 was reviewed. The written statement indicated CNA 2 verbally and physically abused Resident 1. The DON stated the facility should have reported the allegation of abuse on 4/1/2025 after receiving the written statement from CNA 1. During a concurrent interview and record review on 4/9/2025 at 1:30 p.m. with the DSD, CNA 1's untitled written statement, dated 3/31/2025 was reviewed. The DSD stated the DSD received the written statement on 4/1/2025. The DSD stated the written statement contained allegations of abuse. The DSD stated the facility should have reported the allegations of abuse within two hours. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised March 2023, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) . The P&P indicated allegations of abuse were to be reported within two hours. The P&P indicated, The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility. b. The local/state ombudsman. b. The resident's representative. c. Law enforcement officials .

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 44027 Based on interview and record review, the facility failed ensure two of 13 sampled staff understood the facility's Policies and Procedures (P&P) regarding abuse reporting by failing to: 1. Ensure Certified Nursing Assistant (CNA) 1 knew who the facility's Abuse Coordinator (a designated staff member for overseeing and coordinating the facility's efforts to prevent resident abuse) was. 2. Ensure Registered Nurse (RN) 1 knew which agencies needed to be notified about allegations of resident abuse. RN 1 did not know that all allegations of abuse must be reported 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. This failure had the potential to result in residents (in general) to be subject to abuse while residing at the facility. (Cross reference F609) Findings: During a telephone interview on 4/8/2025 at 1:38 p.m. with CNA 1, CNA 1 stated CNA 1 did not remember if CNA 1 received training from the facility regarding abuse prevention. CNA 1 stated CNA 1 did not know who the facility's Abuse Coordinator was. CNA 1 stated CNA 1 did not know the facility had such a position. During a telephone interview on 4/8/2025 at 3:47 p.m. with Registered Nurse (RN) 1, RN 1 stated incorrectly the facility had 24 hours to report allegations of abuse against residents (in general). RN 1 stated RN 1 did not know what agencies the facility was required to report allegations of abuse to. RN 1 stated RN 1 did not know how to report allegations of abuse against residents (in general). During a follow up telephone interview on 4/9/2025 at 11:22 p.m. with RN 1, RN 1 stated RN 1 would not report an allegation of abuse against a resident (in general) until RN 1 investigated the allegation and confirm the abuse did happen. During an interview on 4/9/2025 at 12:15 p.m. with the Director of Staff Development (DSD), the DSD stated all allegations of abuse must be reported to the Department, the Ombudsman, and to the local law enforcement, within two hours. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, the P&P indicated, The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives . Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. (continued on next page)

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