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	01/22/2026

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

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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** Based on interview and record review, the facility failed to report an allegation of abuse for one of four sampled residents (Resident 15) to the California Department of Public Health (the Department), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), 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, dated 9/2022.This failure resulted in the delay of notification to the Department and had the potential to result in Resident 15 to be subjected to abuse while at the facility.Findings:a. During a review of Resident 15's admission Record (AR), the AR indicated Resident 15 was originally admitted to the facility on [DATE], and readmitted the resident on 9/24/2025 with diagnoses that included anxiety disorder (a mental health condition causing excessive, persistent fear and worry disproportionate to the situation), metabolic encephalopathy (a brain disfunction caused by a chemical, or metabolic problem in the body, leading to symptoms such as confusion, memory loss, and changes in personality), and dementia (a progressive state of decline in mental abilities).During a review of Resident 15's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 9/25/2025, the H&P indicated Resident 15 did not have the capacity to understand and make decisions.During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 15 had moderately impaired cognitive skills (ability to make daily decisions). The MDS indicated Resident 15 required partial/moderate assistance (helper does less than half the effort to complete the activity) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).During a review of Resident 15's Change of Condition form (COC), dated 1/22/2026, the COC indicated during a nursing interview on 1/22/2026 at 2:30 PM with Resident 15, Resident 15 stated Resident 15's roommate grabbed Resident 15's neck last week.b. During a review of Resident 17's AR, the AR indicated Resident 17 was readmitted to the facility on [DATE] with diagnoses which included anxiety disorder and metabolic encephalopathy.During a review of Resident 17's H&P, dated 9/27/2025, the H&P indicated Resident 17 did not have the capacity to understand and make decisions.During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 had moderately impaired cognitive skills for decision making and required partial/moderate assistance with ADLs.During a review of Resident 17's COC, dated 1/15/2026 and timed at 11 AM, the COC indicated Resident 17 had increased confusion and was verbally aggressive with staff (in general). Resident 17 was kept at the nurses' station for close supervision and the Nurse Practitioner (NP- a nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) ordered lorazepam (antianxiety medication) 1 milligram (mg, unit of measure) to be given by mouth to Resident 17 as needed for verbal aggression.During a review of Resident 17's Social Service Note (SSN), dated 1/15/2026 and timed at 3:07 PM, the SSN indicated Resident (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	17 was moved to a different room.During a review of Resident 17's SSN, dated 1/17/2026, the SSN indicated Resident 17 was discharged to General Acute Hospital (GACH) 1 for behavioral evaluation.During an interview on 1/21/2026 at 2:44 PM with Registered Nurse (RN) 1, RN 1 stated RN 1 called Resident 17's physician on 1/15/2026 at 11:10 AM to get antianxiety medication for Resident 17 because Resident 17 was verbally aggressive to staff (unidentified). RN 1 stated on 1/15/2025 at approximately 11 AM, RN 1 was informed by Licensed Vocational Nurse (LVN) 1 and by Certified Nursing Assistant (CNA) 22 that Resident 17 touched Resident 15 on the neck. RN 1 stated RN 1 assessed Resident 15 and Resident 15 did not have any changes or redness on the neck. RN 1 stated RN 1 informed the Director of Nursing (DON) that Resident 17 touched Resident 15 and the DON started an investigation. RN 1 stated abuse or allegations of abuse must be reported to the administrator and to the DON right away.During an interview on 1/21/2026 at 4:38 PM with Registered Nurse (RN) 3, RN 3 stated on 1/16/2026 at 4 PM, Family Member (FM) 1 told RN 3 on the phone that Resident 15 told FM 1 that Resident 17 choked Resident 15. After RN 3 spoke to FM 1, RN 3 interviewed Resident 15 regarding Resident 15's allegation that Resident 17 choked Resident 15. RN 3 stated RN 3 did not report to the administrator, to the Ombudsman, and to the police when Resident 15 told RN 3 on 1/16/2026 at 4:30 PM that Resident 15 was choked on the neck by Resident 15's roommate (Resident 17). RN 3 stated RN 3 must report to the administrator, the Department, the Ombudsman, and to local law enforcement within two hours when an allegation of abuse was made by a resident.During a phone interview on 1/22/2026 at 1:11 PM with Licensed Vocational Nurse (LVN) 6, LVN 6 stated LVN 6 did not report the allegation of abuse to the administrator after Resident 15 told LVN 6 on 1/16/2026 that Resident 15 was choked by Resident 17.During a phone interview with FM 1 on 1/23/2025 at 10:13 AM, FM 1 stated Resident 15 informed FM 1 on 1/16/2026 at 4:24 PM that Resident 17 grabbed Resident 15's shoulder and neck, and choked Resident 15, but Resident 15 was unable to say when the incident happened. FM 1 stated FM 1 spoke to the Director of Nursing (DON) on 1/16/2026 at 4:55 PM and FM 1 informed the DON that Resident 15 stated Resident 17 choked Resident 15.During a phone interview on 1/23/2026 at 11:16 AM with the Direct of Nursing (DON), the DON stated the DON did not report Resident 15's allegation of abuse to the Department, the Ombudsman, or law enforcement.During a phone interview on 1/23/2026 at 12:50 PM with the Administrator, the Administrator stated the Administrator did not receive an allegation of abuse report from staff (in general) on 1/16/2026.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/2022, the P&P indicated suspicion of abuse must be reported immediately to the administrator and must be reported to the Department, the Ombudsman, and to local law enforcement officials within two hours of an allegation.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide an accessible call light system as indicated in the facility's policy and procedure titled, Call System, Residents, by failing to ensure the call light pull cords were within reach from the floor for ten of 10 sampled residents (Residents 4, 15, 16, 20, 21, 22, 23, 24, 25, and 26) when using Bathroom [ROOM NUMBER] and Bathroom [ROOM NUMBER].This deficient practice had the potential to delay the provision of care for Residents 4, 15, 16, 20, 21, 22, 23, 24, 25, and 26 and negatively affect the residents' well-being when the residents were unable to call staff for assistance.Findings:1. During a review of Resident 4's admission Record (AR), the AR indicated, the facility initially admitted Resident 4 to the facility on [DATE], and readmitted Resident 4 on 10/8/25, with diagnoses that included metabolic encephalopathy (a group of conditions that causes brain dysfunction which alters brain function or structure), and schizophrenia (a chronic mental health condition marked by intense, irrational delusions and auditory hallucinations.During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 11/24/25, the MDS indicated Resident 4 had moderately impaired cognition (ability to think and process information). The MDS indicated, Resident 4 required substantial/maximal assistance with bathing, personal hygiene, toilet use, and lower body dressing.2. During a review of Resident 15's AR, the AR indicated, the facility initially admitted Resident 2 to the facility on 9/2/25, and readmitted Resident 15 on 9/24/25, with diagnoses that included metabolic encephalopathy, general anxiety disorder (persistent, excessive, and uncontrollable worry about daily events), history of falling, and generalized muscle weakness.During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15 had moderately impaired cognition. The MDS indicated, Resident 15 required partial/moderate assistance with bathing, personal hygiene, upper/lower body dressing, and toilet use.3. During a review of Resident 16's AR, the AR indicated, the facility initially admitted Resident 16 to the facility on [DATE], and readmitted Resident 16 on 1/13/26, with diagnoses that included acute respiratory failure with hypoxia (where the lungs cannot adequately transfer oxygen to the blood), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), difficulty in walking, other lack of coordination and history of falling.During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 had moderately impaired cognition.4. During a review of Resident 20's AR, the AR indicated, the facility initially admitted Resident 20 to the facility on 7/15/25 with diagnoses that included unilateral primary osteoarthritis of the right hip and right knee (degenerative, age-related condition causing localized cartilage breakdown, pain, stiffness, and reduced mobility on the right side of the body), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), general anxiety disorder, unsteadiness on feet, other lack of coordination, and acute kidney failure (a condition that slows blood flow to your kidneys).During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had moderately impaired cognition.5. During a review of Resident 21's AR, the AR indicated, the facility initially admitted Resident 21 to the facility on 7/23/25 with diagnoses that included fibromyalgia (a chronic condition that causes widespread pain), major depressive disorder, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), other lack of coordination, and difficulty in walking.During a review of Resident 21's MDS, dated [DATE], the MDS indicated, Resident 21 had severely impaired cognition.6. During a review of Resident 22's AR, the AR indicated, the facility initially admitted Resident 22 to the facility on 9/13/24 with diagnoses that included Type 2 diabetes mellitus with ketoacidosis without coma (a serious, acute complication where high blood sugar causes high (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ketone levels and metabolic acidosis without loss of consciousness), altered mental status (a change in cognitive function or level of consciousness), other lack of coordination, difficulty in walking, metabolic encephalopathy, and acute kidney failure.During a review of Resident 22's MDS, dated [DATE], the MDS indicated Resident 22 had moderately impaired cognition.7. During a review of Resident 23's AR, the AR indicated, the facility initially admitted Resident 23 to the facility on 5/3/22 with diagnoses that included heart failure (the heart cannot pump enough blood to meet the body's needs), Alzheimer's disease, major depressive disorder, other lack of coordination, and difficulty in walking.During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23 had moderately impaired cognition.8. During a review of Resident 24's AR, the AR indicated, the facility initially admitted Resident 24 to the facility on 1/26/23, and readmitted Resident 24 on 12/17/25, with diagnoses that included cellulitis of left finger (a skin infection that causes swelling and redness), acute bronchiolitis (a common lower respiratory tract infection, and other lack of coordination.During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 had severely impaired cognition.9. During a review of Resident 25's AR, the AR indicated, the facility initially admitted Resident 25 to the facility on 1/8/21, and readmitted Resident 25 on 10/24/25, with diagnoses that included other cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels), cognitive communication deficit (an impairment in communication due to underlying cognitive issues), heart failure, and major depressive disorder.During a review of Resident 25's MDS, dated [DATE], the MDS indicated Resident 25 had severely impaired cognition.10. During a review of Resident 26's AR, the AR indicated, the facility initially admitted Resident 26 to the facility on 8/29/17, and readmitted Resident 26 on 2/23/25, with diagnoses that included pneumonia (an infection/inflammation in the lungs), acute respiratory failure with hypoxia acute respiratory failure with hypoxia (where the lungs cannot adequately transfer oxygen to the blood), and other lack of coordination.During a review of Resident 26's MDS, dated [DATE], the MDS indicated Resident 26 had severely impaired cognition.During a concurrent observation and interview with Resident 15 on 1/22/26 at 10:47 a.m. in Resident 15's room, a floor mat was observed only on the right side of Resident 15's bed. Resident 15 stated she had fallen on the bathroom floor and was not able to reach the red pull cord to call for help.During an observation on 1/22/26 at 11:17 a.m. in Bathroom [ROOM NUMBER] (which is shared by Residents 15, 16, 25 and 26), the red pull cord was observed to be too short to reach from the floor.During an observation on 1/22/26 at 12:29 p.m. in Bathroom [ROOM NUMBER] (which is shared by Residents 4, 20, 21, 22, 23, and 24), the red pull cord was observed to be too short to reach from the floor.During a concurrent observation and interview on 1/22/26 at 2:40 p.m. in Bathroom [ROOM NUMBER] with CNA 26, CNA 26 acknowledged the red pull cord was too short and cannot be reached from the floor by a resident in case of an emergency. CNA 26 stated it was a safety issue for any resident that fell and could not call for help.During a concurrent observation and interview on 1/22/26 at 2:51 p.m. in Bathroom [ROOM NUMBER] with CNA 27, CNA 27 acknowledged the red pull cord was too short and cannot be reached from the floor by a resident to call for help. CNA 27 stated it was important for a resident to contact staff when help is needed.During a concurrent observation and interview on 1/22/26 at 3:21 p.m. in Bathrooms #1 and #2 with the Maintenance Assistant (MA), MA acknowledged all the red pull cords in the bathrooms were too short in length for the resident to reach from the floor. MA stated MA would immediately change all the pull cords to the proper length.During a review of the facility's P&P titled, Cally System, Residents, dated 9/2022, the P&P indicated, Policy Statement: Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. Policy (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interpretation and Implementation: Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.the resident call system remains functional at all times.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a safe and sanitary shower for 1 out of 1 shower room in the facility where a black substance was observed on the tile under the shower handle.This deficient practice had the potential for all residents who used the shower to be placed at risk for respiratory health hazards.Findings:During an observation on 1/22/26 at 2:57 p.m. in Bathroom [ROOM NUMBER] with CNA 27, Bathroom [ROOM NUMBER] was observed to be large enough to accommodate a shower across from the toilet area. A black substance on the tile (2 tiles in length; or 8 inches) was observed below the shower handle and above the grab bar.During a concurrent observation and interview on 1/22/26 at 3:21 p.m. in Bathroom [ROOM NUMBER] with the Maintenance Assistant (MA), MA stated the black substance on the shower tiles was mold and should be cleaned right away.During a concurrent observation and interview on 1/22/26 at 3:32 p.m. in Bathrooms #3 with the Housekeeping Supervisor (HKS), HKS stated the black substance on the shower tile would be cleaned immediately because it was a health hazard to residents who use the shower.During a review of the facility's P&P titled, Homelike Environment, revised 12/2021, the P&P indicated, Policy Statement: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The P&P further indicated, Policy Interpretation and Implementation: The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment.During a review of the facility's P&P titled, Maintenance Service, revised 2/2009, the P&P indicated, Policy Interpretation and Implementation: The maintenance department is responsible for maintaining the building, grounds, and equipment in a safe and operable manner at all times. The P&P further indicated, Functions of maintenance personnel include, but are not limited to maintaining the building in good repair and free from hazards.