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	04/03/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop a comprehensive care plan (individualized document developed to manage a patient's physical, mental, emotional, and social health needs) with interventions (action taken to improve a situation) for three of eight sampled residents (Residents 3, 6 and 7).Findings:1. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (disturbance of the brain's functioning that leads to problems like confusion and memory loss) and respiratory failure (serious condition that makes it difficult to breathe, lungs cannot get enough oxygen into the blood).During a review of Resident 3's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 3/28/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 3's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was severely impaired. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) for eating, oral hygiene, toileting hygiene, and upper body dressing. The MDS indicated Resident 3 required maximal assistance (helper does more than half the effort) for lower body dressing, showering/bathing, and personal hygiene.During a review of Resident 3's Skin Rash Report, dated 1/30/2026, the Skin Rash Report indicated Resident 3 had skin rash on bilateral hands.During a review of Resident 3's medical record, there was no care plan regarding Resident 3's skin rash on bilateral hands. 2. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses that included encephalopathy and chronic kidney disease (gradual loss of kidney function, kidneys are unable to filter wastes and excess fluids from blood).During a review of Resident 6's H&P, dated 12/14/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions.During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 6 required set-up assistance for eating and upper body dressing. The MDS indicated Resident 6 required supervision for oral hygiene, toileting hygiene, putting on/off shoes and lower body dressing. The MDS indicated Resident 6 required moderate assistance for showering/bathing and personal hygiene.During a review of Resident 6's Skin Rash Report, dated 1/28/2026, the Skin Rash Report indicated Resident 6 had skin rash on upper back.During a review of Resident 6's medical record, there was no care plan regarding Resident 6's rash on upper back. 3. During a review of Resident 7's AR, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included palliative care (medical care focused on relieving symptoms, pain, and stress from serious illnesses to improve quality of life for patients) and chronic kidney disease.During a review of Resident 7's H&P, dated 2/15/2026, the H&P indicated Resident 7 could make needs known but could not make medical decisions.During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 7 (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required set-up assistance for eating. The MDS indicated Resident 7 required moderate assistance for oral hygiene and upper body dressing. The MDS indicated Resident 7 required maximal assistance for toileting hygiene, showering/bathing, putting on/taking off footwear, lower body dressing and personal hygiene.During a review of Resident 7's Skin Rash Report, dated 9/8/2025, the Skin Rash Report indicated Resident 7 had skin rash on generalized body. The Skin Rash Report indicated Resident 7 complained of itchiness.During a review of Resident 7's medical record, there was no care plan regarding Resident 7's generalized body rash. During an interview on 4/3/2026 at 8:51 a.m. with Infection Prevention Nurse (IPN), IPN stated when a resident had a skin issue it had to be part of the resident's care plan. IPN stated the care plan must indicate monitoring resident's skin, following treatments as ordered by doctor, and maintaining skin moisture. The IPN stated a care plan must be developed to provide nursing staff with a plan on how to care for a resident with a rash.During an interview on 4/3/2026 and 12:16 p.m. with Treatment Nurse (TN), TN stated when a resident developed a skin rash a care plan must be developed. TN stated a care plan needed to be developed to inform nursing staff of the steps for residents to get better. TN stated if there was no care plan the residents would be at risk for not receiving the proper care and symptoms would get worse. TN stated all nurses are allowed to develop care plans for residents when a resident develops a skin rash. TN stated TN was not aware Residents 3, 6 and 7 did not have a care plan for their skin rashes.During the review of facility's Policy and Procedure (P&P) titled Goals and Objectives, Care Plans, dated 4/2009, the P&P indicated care plans would incorporate goals and objectives that lead to the resident's highest obtainable level of independence. The P&P indicated care plan goals and objectives are defined as the desired outcome for a specific resident problem. The P&P indicated goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved. The P&P indicated goals and objectives are reviewed and/or revised when there was a significant change in the resident's condition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review the facility failed to ensure an adequate amount of Certified Nursing Assistants (CNAs) worked in the South Dementia unit (unit designed to meet the specific needs of residents with dementia [a progressive state of decline in mental abilities]) on the NOC shift (overnight shift from 11 pm to 7 am) on 3/8/2026, 3/11/2026 and 3/21/2026, in accordance with the facility's Facility Assessment Tool (FAT - facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies), dated 3/19/2026. This failure had the potential to result in residents receiving inadequate care and supervision which can lead to falls, elopement, and delayed recognition of residents' significant changes in condition.Findings:During a concurrent interview and record review on 4/2/2026 at 11:30 am with Director of Staff Development (DSD), the FAT, the Nursing Staffing Assignment and Sign-in Sheet from 3/1/2026 to 3/31/2026, and CNA Timecards were reviewed. The FAT, dated 3/19/2026, indicated individual staff assignment 3.3 described how the facility determined and reviewed individual staff member assignments for coordination and continuity of care for residents within and across staff assignments. The FAT indicated CNAs were assigned to a run or round based on census and or resident's request. The FAT also indicated ratios for the NOC shift was one (1) CNA per 13 to 16 residents. DSD stated there should be three CNAs on the NOC shift for the locked unit (South Dementia unit). DSD stated on 3/8/2026, 3/11/2026, and 3/21/2026 there were only two CNAs on the NOC shift in the locked unit which meant the two CNAs had 25 residents each. DSD stated that because of the CNA shortage the residents were at a higher risk for falls, elopement, and there were less safety and security for the residents. DSD stated the facility did not follow the FAT. During an interview on 4/2/2026 at 4 pm with Registered Nurse Supervisor (RNS), RNS stated the DSD oversaw staffing and should be using the FAT which indicated three CNAs for the NOC shift. RNS stated the lack of CNAs affected the residents' safety and the residents were at higher risk of falls, elopement, and unsafe environment. During a review of facility Policy and Procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated 8/2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. 1. Licensed nurses and certified nursing assistants are available 24 hours a day, seven (7) days a week to provide competent resident care services including: a. assuring resident safety; b. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident; c. Assessing, evaluating, planning and implementing resident care plans; and d. responding to resident needs. 5. Nurse aides/nursing assistants are individuals providing nursing or related services to residents in the facility, including those who provide services through an agency or under a contract with the facility. 6. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment. 7. Factors considered in determining appropriate staffing ratios and skills include an evaluation of the diseases, conditions, physical or cognitive limitation of the resident population, and acuity.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete an SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form for two of eight sampled residents (Resident 3 and Resident 7) in accordance with the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status when:1. There was no SBAR found in Resident 3's medical record regarding Resident 3's skin rash (abnormal changes in skin color or texture and are typically associated with irritation or swelling) on both hands. 2. There was no SBAR found in Resident 7's medical record regarding Resident 7's generalized body rash.These deficient practices placed Resident 3 and Resident 7 at risk of not receiving appropriate care.Findings: 1. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included encephalopathy (disturbance of the brain's functioning that leads to problems like confusion and memory loss) and respiratory failure (serious condition that makes it difficult to breathe, lungs cannot get enough oxygen into the blood).During a review of Resident 3's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 3/28/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 3's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was severely impaired. The MDS indicated Resident 3 required moderate assistance (helper does less than half the effort) for eating, oral hygiene, toileting hygiene, and upper body dressing. The MDS indicated Resident 3 required maximal assistance (helper does more than half the effort) for lower body dressing, showering/bathing, and personal hygiene. During a review of Resident 3's Skin Rash Report, dated 1/30/2026, the Skin Rash Report indicated Resident 3 had skin rash on bilateral hands.During a review of Resident 3's medical record, there was no SBAR found in Resident 3's medical record regarding Resident 3's skin rash on both hands.2. During a review of Resident 7's AR, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included palliative care (medical care focused on relieving symptoms, pain, and stress from serious illnesses to improve quality of life for patients) and chronic kidney disease. During a review of Resident 7's H&P, dated 2/15/2026, the H&P indicated Resident 7 could make needs known but could not make medical decisions.During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 7 required set-up assistance for eating. The MDS indicated Resident 7 required moderate assistance for oral hygiene and upper body dressing. The MDS indicated Resident 7 required maximal assistance for toileting hygiene, showering/bathing, putting on/taking off footwear, lower body dressing and personal hygiene. During a review of Resident 7's Skin Rash Report, dated 9/8/2025, the Skin Rash Report indicated Resident 7 had skin rash on generalized body. The Skin Rash Report indicated Resident 7 complained of itchiness.During a review of Resident 7's medical record, there was no SBAR found in Resident 7's medical record regarding Resident 7's generalized body rash. During an interview on 4/3/2026 at 8:51 a.m. with Infection Prevention Nurse (IPN), IPN stated when a resident develops a skin issue, nursing staff must document the change of condition on a change of condition (COC) form (SBAR). IPN stated when a resident has a COC, residents must be monitored more closely, and findings must be reported to their physician. IPN stated documenting a COC (SBAR) was reporting a change in a resident.During an interview on 4/3/2026 and 12:16 p.m. with Treatment Nurse (TN), TN stated when there was a change in a resident, it had to be documented, and their physician had to be notified. TN stated when a resident developed a skin rash, that was a COC and it had to be (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented on a COC form. TN stated it was important to document resident's COC because it was a way to communicate a change in a resident and it indicated physician's notification. TN stated if a COC did not get documented, it created a risk for a resident not to receive the proper care for their skin rash and it would potentially get worse.During the review of facility's Policy and Procedure (P&P) titled Change in a Resident's Condition or Status dated 2/2021, the P&P indicated the facility promptly notifies the resident, attending physician, and the resident representative of changes in the resident's medical/mental condition. The P&P indicated a nurse would notify the resident's physician when there was a significant change in the resident's physical/emotional/mental condition. The P&P indicated, Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form.