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	04/17/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview and record review, the facility staff member failed to notify the responsible party when 1 of 3 sample residents (Resident 1) moved to another room. This failure resulted in lack of timely communication with Resident 1's responsible party regarding changes in Resident 1's Room/environment.During a review of Resident 1's admission Record (AR-Face Sheet), the AR indicated the facility admitted Resident 1 on 2/5/2026, with diagnoses including dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury), and Alzheimer's disease (progressive mental deterioration).During a review of Resident 1's History and Physical (H&P), dated 2/7/2026 the H&P indicated, Resident 1 does not have the mental capacity to make medical decisions.During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/11/2026, the MDS indicated the cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and required partial/moderate assistance for activities of daily living. During a review of Resident 1's Nurses Note, dated 3/18/2026, the Nurses note indicated Resident 1 was moved to a different room.During an interview on 4/17/2026 at 1 PM with the Social Service Designee (SSD), the SSD stated Resident 1 was moved from one room to another room, but facility staff did not notify Resident 1's responsible party. The SSD stated Resident 1's responsible party should have been notified.During a review of the facility's policy and procedure (P&P) titled, Room Change/Roommate Assignment, revised 2021, indicated that prior to a room change, all parties involved, including the resident and responsible party, are to be given advance notice of the change. The policy indicated that room changes are to be documented in the resident's medical record.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to ensure adequate supervision for 1 of 3 sampled residents (Resident 1) who required supervision during showers.This failure resulted in Resident 1 being found in the shower area without staff supervision, placing the resident at risk for injury.Findings:During a review of Resident 1's admission Record (AR-Face Sheet), the AR indicated the facility admitted Resident 1 on 2/5/2026, with diagnoses including dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury), and Alzheimer's disease (progressive mental deterioration).During a review of Resident 1's History and Physical (H&P), dated 2/7/2026 indicated, the H&P Resident 1 does not have the mental capacity to make medical decisions.During a review of Resident 1's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/11/2026, the MDS indicated Resident 1's cognitive (the ability to think and process information) skills for daily decisions making was moderately impaired, and required partial/moderate assistance for activities of daily living. During an interview on 4/17/2026 at 1 PM with Resident 1, Resident 1 stated Resident 1 entered the shower and showered by herself. Resident 1 stated staff later instructed her that she is not allowed to shower independently and must wait for staff assistance.During an interview on 4/17/2026 at 1 PM with the Social Service Designee (SSD), the SSD stated Resident 1 was found in the shower area without staff present. The SSD stated Resident 1 required supervision and should not have been showering independently.During an interview on 4/17/2026 at 2 PM with Registered Nurse 1 (RN1), RN 1 stated, Resident 1 required supervision during showers. RN 1 stated staff should be aware of the resident's whereabouts and Resident 1 should not have been in the shower by herself.During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, revised 2017, indicated the facility is responsible for identifying risks and implementing interventions to prevent accidents, including ensuring adequate supervision based on the resident's assessed needs.During a review of the facility's policy and procedure (P&P) titled, Bath, Shower/Tub, revised 2018, indicated staff are to remain with the resident throughout the bath or shower and that residents are not to be left unattended during bathing.