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	05/06/2026

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement its abuse prevention policy by failing to report one allegation of injury of unknown origin to the state agency (Department of Public Health) and law enforcement within the required reporting time frames for one of five sampled residents (Resident 2).This deficient practice delayed the investigation of abuse and placed Resident 2, and other residents at risk for abuse and feelings of intimidation.Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a change (confusion, memory loss or loss of consciousness) in how your brain works due to an underlying condition), unspecified dementia with anxiety (significant cognitive decline and excessive worry or restlessness), and long-term use of anticoagulants (medications that prevent or reduce blood clotting). During a review of Resident 2's History and Physical (H&P), dated 11/6/25, the H&P indicated, Resident 2 did not have the capacity to understand and make medical decisions. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 2/5/26, the MDS indicated Resident 2 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 2 required the following: 1) setup or clean-up assistance (helper sets up or cleans up) in eating and upper body dressing; 2) required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) with oral hygiene, toileting hygiene, lower body dressing, and putting on/taking off footwear; and 3) partial/moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less that half the effort) with shower/bathe self and personal hygiene. During a review of Resident 2's Physician Orders (POs) active as of 4/1/26, the POs indicated the following orders:Monitor Anticoagulation Medication: Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle/joint pain, lethargy, bruising, sudden changes in mental status and/or vital signs, shortness of breath, bleeding in any orifice, abnormal lab. Document: ?N' if monitored and none of the above observed. Document ?Y' if monitored and any of the above observed, Notify MD and document in nurses' progress notes, every shift.Aspirin 81 Oral Tablet Chewable 81 mg (milligram; a unit of weight); Give 1 tablet by mouth one time a day for CVA (Cerebrovascular Accident) prophylaxis [prevention of strokes].Apixaban Oral Tablet 2.5 mg; Give 1 tablet by mouth two times a day for DVT (Deep Vein Thrombosis) Prophylaxis [preventive measures to stop dangerous blood clots from forming in deep veins] (Start date: 11/3/25).Galantamine Hydrobromide ER Oral Capsule Extended Release 24 Hour 8 mg; Give a capsule by mouth one time a day for dementia.Memantine HCl (hydrochloride) Oral Tablet 10 mg; Give 1 tablet by mouth two times a day for dementia.Metoprolol Tartrate Tablet 25 mg; Give 1 tablet by mouth two times a day for hypertension hold if systolic blood pressure less than 110 mmHg (millimeters of mercury; a unit of measurement for pressure) or heart rate less than 60 beats per minute. Administer with food to reduce the rate of absorption. This minimizes the risk of hypotension (Order date: 11/14/25). During a review of Resident 2's Medication Administration Record (MAR) for April 2026, the MAR indicated Resident 2 was monitored for side effects of anticoagulation medication every shift, which included (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bruising, lethargy and bleeding in any orifice (opening: natural passages in the human body). The MAR indicated no side effects were observed from 4/1/26 to 4/23/26, and 4/25/26 to 4/30/26. The only side effects observed during the month of April 2026 were on 4/24/26 on the evening shift. During a review of Resident 2's Change of Condition (COC)/Interact Assessment Form (SBAR, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) for the month of April 2026 included the following:COC, dated 4/1/26 - Generalized body rash. Nursing comments indicated treatment nurse performed body check on resident, noted generalized body rash; RN notified, full assessment rendered.COC, dated 4/19/26 - Resident noted with increased agitation and aggression behavior toward residents and nursing staff. Nursing comments indicated resident is encouraged to vent feelings. Able to focus and shift attention, complete assessment and evaluation of all body system done.COC, dated 4/23/26 - Resident noted with discoloration to left eye. Nursing comments indicated CNA [CNA 4] found resident's discoloration when CNA [CNA 4] delivered breakfast trays to resident. Charge nurse [LVN 3] assessed patient with left eye and noted no signs/symptoms of pain or discomfort at this time. No swelling, no open wounds, no signs/symptoms of distress noted. MD and RP (Responsible Person) notified. During a review of Resident 2's Interdisciplinary Team Conference (IDTC) notes, dated 5/2/26, the notes indicated on 4/23/26 at approximately 7:50 a.m. Resident 2 was noted with discoloration to left periorbital area, no skin breakage, laceration, bleeding, swelling, open wound, signs/symptoms of pain or discomfort noted at that time. The notes indicated under Additional Comments, the police department arrived at the facility on 5/2/26 to investigate an incident involving Resident 2. The notes indicated Resident 2 stated no recollection of the incident and reported possibility of being hit, possibly during a dream. The facility was informed the matter would be reported to APS (Adult Protective Services). During a concurrent observation and interview on 5/4/26 at 11:35 a.m. in Resident 2's room, Resident 2 was observed with dark discoloration above the left eye, along the bridge of the left side of the nose and underneath the left eye. Resident 2 was asked about her left eye discoloration and Resident 2 stated about 2 weeks ago she was hit by a teenager, a girl. Resident 2 was asked if the girl hit her intentionally and Resident 2 stated, Yes, the teenager was out of control. Resident 2 was asked if she had any type of fall and hit her head. Resident 2 stated she didn't have a fall. During a concurrent record review of the South Unit's Daily Assignment Binder and interview on 5/4/26 at 12:16 p.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated the Body Check by CNA during Shower, form indicated Resident 2's skin was clear on the back and front body diagrams on 4/22/26. CNA 1 stated Clear and a diagonal line is written if the resident doesn't have any new or unusual skin issues. If there is something new, then it is indicated on the form. The form is given to the Charge Nurse for review. During an interview on 5/4/26 at 12:55 p.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated there was a change of condition (COC) for Resident 2 completed on 4/23/26 for left eye discoloration. LVN 1 stated she didn't do the COC for 4/23/26; LVN 3 completed the COC. LVN 1 stated LVN 3 completed an incident report on 4/23/26 for Resident 2's left eye discoloration. During a concurrent interview and record review of the Body Check by CNA during Shower form, dated 4/24/26 with Licensed Vocational Nurse 1 (LVN 1) on 5/4/26 at 12:55 p.m., the form indicated Resident 2's skin was clear on the back body diagram and on the front body diagram was written Around eye discoloration. Circled above the knee on the front body diagram of Resident 2's left thigh, the words Discoloration were written. During an interview with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated Resident 2's discoloration was noted by CNA (unidentified) in the morning on 4/23/26 and the treatment nurse was notified, then a skin check assessment was completed. During an interview on 5/4/26 at 1:28 p.m. with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she completed the COC for Resident 2 after the CNA (unidentified) reported to her the discoloration around Resident 2's eye. LVN 3 stated she reported to her Nurse Supervisor RN 1 about the discoloration on Resident 2's left eye. LVN 3 stated she spoke with the Charge Nurse (NOC shift, not named) and CNA (NOC shift, not named) and they said Resident 2 did not (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have the discoloration of the left eye on the 4/22/26 NOC shift. LVN 3 stated she had received training in abuse and neglect recognition and reporting during her orientation a month ago. LVN 3 stated she reports any type of abuse to the Administrator (who is the abuse coordinator). LVN 3 stated she did not think the discoloration around the eye was abuse, and stated Resident 2 is on blood thinners. LVN 3 stated she asked Resident 2 if she fell or rubbed her eye, but Resident 2 told her no. LVN 3 stated she did not know what RN 1 reported; LVN 3 acknowledged she did not know if RN 1 reported abuse to the Administrator. During an interview on 5/5/26 at 11:20 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated she noticed Resident 2's left eye discoloration when she returned to work on 4/24/26. CNA 3 stated it was a large discoloration around the left eye. CNA 3 stated she asked Resident 2, What happen to your eye? Did you have a fall? CNA 3 stated Resident 2 just smiled and said no. CNA 3 stated when she completed the Body Check By CNA During Shower form on 4/24/26, she reported the left eye discoloration and left thigh discoloration to the charge nurse (does not remember name of nurse). During an interview on 5/5/26 at 12:42 p.m. with Registered Nurse Supervisor 1 (RN 1), RN 1 stated LVN 3 noted left eye discoloration, big orbital area large, Resident 2 not aware. CNA (unidentified) during breakfast tray delivery noticed left eye discoloration, Resident 2 didn't know until she saw herself in the mirror, no swelling, denied falls, no falls and no injury incidents. RN 1 stated she reviewed Resident 2's medications: anticoagulants: aspirin and apixaban. RN 1 stated Resident 2 has dementia and Resident 2 was asked if Resident 2 slept on her side or rubbed her eyes. RN 1 stated the focus was on Resident 2's left eye discoloration when she completed Resident 2's assessment. RN 1 denied suspicion for abuse when asked about Resident 2's left eye discoloration, and RN 1 stated she was more focused on the initial investigation, which was for left eye discoloration due to anticoagulant medications. RN 1 stated she did not do a full head-to-toe assessment on Resident 2 on 4/23/26. RN 1 stated she worked the next day on 4/24/26 and was unaware that the 4/24/26 CNA shower sheet indicated discoloration on Resident 2's left thigh. RN 1 stated she was sure that LVN 3 completed an incident report on 4/23/26 for Resident 2's left eye discoloration. During an interview on 5/4/26 at 1:11 p.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated she worked on 4/23/26, but left on that day without being notified about Resident 2's left eye or left thigh discoloration. LVN 5 stated she was notified on 4/24/26 about Resident 2's left eye and left thigh discoloration. LVN 5 stated on 4/23/26, LVN 3 only reported Resident 2's had left eye discoloration. LVN 5 stated if skin discoloration for Resident 2 was a new condition, then an investigation should have been done to determine the source. LVN 5 stated the discoloration around Resident 2's left eye is unusual because there were no prior occurrences before for Resident 2. LVN 5 stated the discoloration around Resident 2's left eye should be reported to the supervisor for proper investigation of the injury and to rule out abuse. LVN 5 stated if there is a suspicion for blood thinners causing skin discoloration around the eye, then a full head-to-toe assessment should be completed to identify any other possible areas that are starting or existing. During an interview on 5/5/26 at 4:05 p.m. with Registered Nurse Supervisor 1 (RN 1), RN 1 stated she did not believe Resident 2's left eye discoloration was abuse at time of the 4/23/26 assessment. RN 1 stated she was focused on the injuries due to blood thinners as the cause of the discoloration and did not rule out abuse as a probable cause of Resident 2's left eye discoloration. RN 1 stated she did not have Resident 2 undress to do a full body check on 4/23/26. RN 1 was asked if blood thinners only cause discoloration around the eye. RN 1 stated, No, it can be anywhere on the body. RN 1 acknowledged that a head-to-toe assessment was not performed for Resident 2 on 4/23/26. RN 1 acknowledged that a head-to-toe assessment was important because Resident 2 could have other discolorations on Resident 2's body that indicate abuse and should be reported to the physician (MD) to assist in further medical decision making. During a telephone interview on 5/5/26 at 4:18 p.m. with Registered Nurse Supervisor 2 (RN 2), RN 2 stated RN 2 the facility had a stand-up meeting that same week of when the facility discovered Resident 2's left eye discoloration [4/23/26]. RN 2 stated Resident 2 had an injury of unknown origin, but with a probable cause of anticoagulants and that was (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported on 5/2/26. RN 2 stated he completed an investigation that included reviewing Resident 2's electronic medical record [PCC-Point Click Care online], a full interview with Resident 2, any person who may saw what happened [but there were none], and then the case was brought to the department stand-up meetings. RN 2 stated he checked Resident 2's orders and MAR for monitoring or medication that can cause bleeding/bruising. RN 2 stated he checked Resident 2's room environment to see if Resident 2 could have bumped herself on something in the room. RN 2 stated he did not believe at the time he was investigating that it was abuse, based on review of information in Resident 2's medical record. RN 2 stated he was not informed about Resident 2's left thigh discoloration and did not report that on 5/2/26. RN 2 stated blood thinners can cause random discolorations on the body. RN 2 stated he did not have Resident 2 reassessed for a full body head-to-toe after he completed the PCC review and determined blood thinners as a probable cause. RN 2 acknowledged he did not rule out abuse for Resident 2's left eye discoloration. RN 2 acknowledged he has received training and in-services on abuse and neglect recognition and reporting injury of unknow origin. During a concurrent record review of Resident 2's Non-Pressure Sore Skin Problem (NPSS) Report and interview on 5/6/26 at 11:20 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated LVN 5 stated she created the NPPS report for Resident 2's left eye discoloration because that was the information reported to her on 4/24/26. LVN 5 stated the charge nurse gets report from the CNA by a skin check report and then the treatment nurse is notified. LVN 5 stated no one informed her on 4/24/26 about the left thigh discoloration on Resident 2's leg. LVN 5 stated the NPSS report indicated under Comments: Noted left orbital eye area with discoloration in place, no noted swelling. Resident able to verbalize needs, does not c/o (complain of) pain or discomfort, skin is intact. Order for monitoring noted and carried out. 6 cm [centimeter, a metric unit of length] in diameter, around eye 3 cm radius extending out from eye. During an interview on 5/6/26 at 3:28 p.m. with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated when she brought the breakfast tray to Resident 2 on 4/23/26, she noticed Resident 2's eye had a large bruise around the left eye. CNA 4 stated she asked Resident 2 what happened, but Resident 2 was unaware of the bruise around the left eye. CNA 4 stated she reported the left eye bruise to the charge nurse. CNA 4 stated Resident 2 had a prior altercation on 4/19/26 with a different roommate (unnamed) and that is why Resident 2 was moved into her current room. During a review of the facility's current Policy & Procedure (P&P) titled, Injury of Unknown Source, no revised date, the P&P indicated Purpose: To ensure that a complete and thorough investigation is conducted for an injury of unknown source.Content:1. An injury should be reported as an injury of unknown source when: The source of the injury was not witnessed by any person and the source of the injury could not be explained by the resident. The injury raises suspicions of possible abuse or neglect because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time.2. The facility shall follow the Abuse Allegation Investigation Policy to complete a thorough investigation of any injury of unknown source.3. The facility shall follow the Abuse Allegation Reporting if the injury meets the definition of an injury of unknown source. During a review of the facility's current Policy & Procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated, Policy Statement: 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) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility.