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	05/28/2026

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 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 for one of five sampled residents (Resident 3) to the California Department of Public Health (the Department), to the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and to the local law enforcement a resident-to-resident altercation within two hours in accordance with the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, dated September 2022.This failure resulted in the delay of notification to the Department and had the potential for Resident 3 to be subjected to abuse while at the facility.A. During a review of Resident 3's Face Sheet (FS-document that contains a patient's personal and contact information, diagnoses and brief medical history, allergies, and name and contact information of patient's physicians), the FS indicated the facility readmitted Resident 3 on 3/19/2026 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), unspecified dementia (a progressive state of decline in mental abilities), and cognitive communication deficit (difficulty in communication due to impaired thinking and understanding).During a review of Resident 3's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/20/2026, 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 3/25/2026, the MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort to complete the activity) with most activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily), with transfers and with walking.During a review of Resident 3's COC (Change of Condition) Interact Assessment Form, dated 5/6/2026 and timed at 12:30 PM, the COC indicated on 5/6/2026 at 11:30 AM Registered Nurse (RN) 1 received a report from a licensed vocational nurse (LVN) (unidentified) that Resident 4 pushed Resident 3 to the wall and Resident 3 slid down to the floor.B. During a review of Resident 4's FS, the FS indicated the facility admitted Resident 4 on 10/3/2025 with diagnoses including bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from lows of depression to elevated periods of emotional highs), and dementia.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 rarely/never understood with severely impaired decision making. The MDS indicated Resident 4 required partial/moderate assistance with showering, personal hygiene, lower body dressing, with walking and with transfers.During a review of Resident 4's H&P, dated 5/15/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.During an interview on 5/19/2026 at 2:27 PM with the Director of Nursing (DON), the DON stated the DON was aware that Resident 4 pushed Resident 3 when they were sitting next to each other on 5/6/2026 in the dining room. The DON stated a certified nursing assistant (CNA) (unidentified) reported the incident to the charge nurse (unidentified) who no longer worked at the facility and the CNA and the charge nurse informed the DON regarding the incident. The DON stated the incident was not reported to CDPH because nothing happened. The DON stated the CNA stated Resident 4 had an impulse and Resident 3 stated Resident 3 was fine and Resident 3 did not sustain (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	any injury.During an interview on 5/27/2026 at 3:26 PM with the DON, the DON stated the local law enforcement was not notified when Resident 4 pushed Resident 3 on 5/6/2026. The DON stated the incident was not a reportable incident because Resident 4 had an involuntary reflex that pushed Resident 3.During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, dated September 2022, the P&P indicated, If resident abuse. is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The P&P indicated immediately is defined as within two hours of an allegation involving abuse.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 11) who was re-admitted to the facility after a surgical procedure had a skin assessment.This failure had the potential for Resident 11 receiving delayed care and treatment for Resident 11's surgical wounds which could lead to infection.During a review of Resident 11's Face Sheet (FS, document that contains a patient's personal and contact information, diagnoses, and medical history), the FS indicated Resident 11 was re-admitted to the facility on [DATE] with diagnoses that included lack of coordination and displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing (patient had surgery on the left thigh bone and is now in the healing phase).During a review of Resident 11's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 10/5/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 11's Discharge/Transfer Documentation, dated 5/26/2026, indicated the resident had an operative procedure of an open treatment of left intertrochanteric (left thighbone) femur (longest bone in a human body) fracture (a break of the bone) with intramedullary nail (a metal rod inserted into the long bone). During an observation on 5/28/2026 at 10:30 am inside Resident 11's room with Certified Nurse Assistant 6 (CNA 6), three separate wounds were observed on Resident 11's lateral (on the outer side) left leg; one wound on the left hip had four staples, one wound on the mid-thigh with six staples, and one wound on the lower thigh with seven staples.During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 5/27/2026 at 3:10 pm, Resident 11's medical record and Resident 11's Skin Reassessment (SR), dated 5/26/2026, were reviewed. RN 1 stated Resident 11's SR, dated 5/26/2026, was blank and RN 1 was unable to find an admission skin assessment for Resident 11. RN 1 stated it was important to do an initial skin assessment upon Resident 11's admission to assess Resident 11's surgical site and the status of the wound. RN 1 stated failure to closely monitor and assess surgical wounds could lead to infection.During a concurrent interview and record review with RN 2, on 5/27/2026 at 4:23 pm, RN 2 stated RN 2 worked as the RN Supervisor when Resident 1 was re-admitted on [DATE]. RN 2 stated RN 2 did not assess Resident 2's surgical wound upon admission. RN 2 stated it was important to assess a wound upon admission to assess for any signs of infection.During a concurrent interview and record review of Resident 11's medical record with the Director of Nursing (DON), on 5/28/2026 at 11:35 am, the DON stated skin assessments were necessary for newly admitted residents, especially for post-surgical residents to ensure a proper baseline was completed and to promptly assess for early signs of infection.During a review of the facility's policy and procedure (P&P) titled, admission Assessment and Follow Up: Role of the Nurse, revised on 9/2012, the P&P indicated , The purpose of the procedure is to gather information about the resident's physical, emotional, cognitive and psychosocial condition upon admission.Conduct a physical assessment, including the following systems: skin. Conduct supplemental assessments (following facility forms and protocol) including skin assessment. The following information should be recorded in the resident's medical record: all relevant assessment data obtained during the procedure.