

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Chino Valley Health Care Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review the facility failed to ensure one of one sampled resident (Resident 59) was treated with dignity by failing to provide privacy while accessing Resident 59's gastrostomy tube (G-tube, a tube inserted through the belly to bring nutrition and/or medications directly to the stomach) during medication administration.</p> <p>This deficient practice resulted in Resident 59's legs and diaper (adult brief) getting exposed and could have resulted in Resident 59 to feel humiliated, embarrassed, and ashamed.</p> <p>Findings:</p> <p>During a review of Resident 59's Admission Record (AR), the AR indicated, Resident 59 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including encounter for attention to gastrostomy (a surgical procedure used to insert a G-tube), cachexia (a general state of ill health involving great weight loss and muscle loss) and unspecified dementia (a general term for the impaired ability to remember, think, or make decisions that interferes with activities of daily life) with unspecified severity with other behavioral disturbance.</p> <p>During a review of Resident 59's Care Plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), titled, Alteration in elimination patterns . date initiated, 1/2/24, the CP indicated, one of the interventions was to always treat resident with respect and dignity.</p> <p>During a review of Resident 59's History and Physical Examination (H&P), dated 4/3/24, the H&P indicated, Resident 59 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 59's Minimum Data Set (MDS, an assessment and screening tool), dated 4/8/24, the MDS indicated, Resident 59's cognitive (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 59 was dependent (helper does all of the effort) for everyday activities and had a feeding tube.</p> <p>A record review of Resident 59's Order Summary Report (OSR), dated 4/2024, the OSR indicated, Resident 59's medications were ordered to be administered via PEG-tube (another term for G-tube).</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent observation and interview on 4/30/24 at 8:41 a.m. with Licensed Vocational Nurse (LVN) 4, during medication administration, Resident 59 lying in bed and the bed was positioned in the middle between two occupied beds. LVN 4 drew the drapes on both sides of Resident 59's bed but did not draw the drapes all the way around Resident 59's bed. LVN 4 removed Resident 59's sheet (bed linen) to access Resident 59's G-tube and exposed Resident 59's legs and diaper during medication administration. LVN 4 stated, LVN 4 should have drawn the drapes all the way around Resident 59's bed for privacy and dignity.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications through an Enteral Tube, date revised November 2018, the P&P indicated, one of the steps in the procedure to prepare the resident was to fold bed linens to the resident's waist and cover the chest with a towel or Chux pad.</p> <p>During a review of the facility's P&P titled, Dignity, date revised February 2021, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, residents are treated with dignity and respect at all times. The P&P indicated, staff promotes, maintains and protects resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</p> <p>Based on interview and record review, the facility failed to ensure two of two sampled residents (Residents 33 and Resident 57) and/or their representatives were provided information regarding the right to formulate an advance directive (AD, legal documents that provided instructions for medical care and only went into effect if a person cannot communicate his/her own wishes).</p> <p>This failure had the potential to result in Resident 33 and Resident 57 and/or their representative to receive unwanted care and treatment and/or unnecessary life-sustaining treatment.</p> <p>Findings:</p> <p>a. During a review of Resident 33's Admission Record (AR), the AR indicated the facility admitted Resident 33 to the facility on [DATE], and readmitted Resident 33 on 8/12/2022, with diagnosis that included dysphagia (difficulty swallowing), abnormal posture, and dementia (a decline in mental ability severe enough to interfere with daily life). The AR indicated the facility listed Family Member (FM) 1 as Resident 33's emergency contact.</p> <p>A review of Resident 33's Advance Directive Acknowledgment (AD Acknowledgement) dated 8/1/2019, the AD Acknowledgement indicated, the form was provided in English. The AD Acknowledgment indicated Resident 33 signed the form on 8/1/2019.</p> <p>During a review of Resident 33's Care Plan (CP) titled, Language Barrier, revised on 11/11/2019, the CP indicated, Resident 33 was at risk for communication difficulties because the resident spoke Arabic. The CP interventions included staff would provide/utilize communication boards in the resident's preferred language.</p> <p>During a review of Resident 33's History and Physical (H&P), dated 8/10/2023, the H&P indicated, Resident 33 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 33's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/7/2024, the MDS indicated, Resident 33's preferred language was Arabic and Resident 33's cognitive skills (ability to think, learn, and reason) was moderately impaired. The MDS indicated, Resident 33 was dependent (helper did all effort) on staff for eating, toileting, shower/bath, dressing, and personal hygiene and required maximal assistance (helper did more than half the effort) with sit to lying (the ability to move from sitting on side of bed to lying flat on the bed) and sit to stand (ability to move from lying on back to sitting on the side of the bed).</p> <p>During a concurrent interview and record review on 4/30/2024 at 1:51 pm with the Social Services Representative (SSR), Resident 33's AD Acknowledgment was reviewed. The SSR stated Resident 33's AD Acknowledgment was provided in English. The SSR stated Resident 33 did not speak English. The SSR stated Resident 33 could not participate in active conversation and could not make decisions. The SSR stated a person who spoke a different language needed to be informed of an AD in their respective language to fully understand the AD.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/2/24 a 10:23 am with the Director of Nursing (DON), the DON stated Resident 33 was Arabic speaking and could not make decisions regarding medical or basic care needs. The DON stated when medical or care decisions were needed, the facility would call FM 1. The DON stated it was important for residents to fully understand what they were signing because it was their right.</p> <p>b. During a review of Resident 57's AR, the AR indicated the facility admitted Resident 57 to the facility on [DATE], with diagnosis that included metabolic encephalopathy (a problem in the brain), dementia (a decline in mental ability severe enough to interfere with daily life), Alzheimer's disease (disease causing memory loss and other mental functions) and anxiety (a feeling of worry, nervousness, or unease). The AR indicated, the facility listed FM 2 as Resident 57's primary decision maker, emergency contact, and guarantor.</p> <p>A review of Resident 57's AD Acknowledgement dated 7/21/2023, the AD Acknowledgement indicated, Resident 57 signed the form on 7/21/2023.</p> <p>During a review of Resident 57's History and Physical (H&P), dated 7/23/2023, the H&P indicated, Resident 57 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 57's MDS, dated [DATE], the MDS indicated, Resident 57's cognitive skills were moderately impaired, and Resident 57 required moderate assistance with eating, personal hygiene, sit to stand, and toilet transfers.</p> <p>During an interview on 4/30/24 at 8:53 am with the MDS Coordinator (MDSC), the MDSC stated Resident 57 was not able to make medical decisions and FM 2 was the decision maker for Resident 57. The MDSC stated FM 2 needed to be consulted regarding Resident 57's AD because the right decision and the correct care should be provided according to the wishes of the resident and/or his/her family.</p> <p>During a concurrent interview and record review on 5/1/24 at 10:33 am with the SSR, Resident 57's AD Acknowledgment was reviewed. The SSR stated Resident 57 did not have the capacity to make decisions, yet Resident 57 signed the AD Acknowledgment dated 7/21/23. The SSR stated FM 2 was Resident 57's primary decision maker and SSR should have called FM 2 because the resident was not able to understand and make decisions.</p> <p>During an interview with the DON on 5/2/24 at 10:20 am, the DON stated Resident 57 should not have been allowed to sign the AD Acknowledgement because Resident 57 lacked the capacity to make decisions per physician's assessment.</p> <p>A review of the facility's policy and procedure (P&P) titled, Advance Directive, revised in 9/2022, the P&P indicated, the resident had the right to formulate an AD, including the right to accept or refuse medical or surgical treatment. The P&P indicated, ADs were honored in accordance with state law and facility policy. The P&P indicated, if the resident was incapacitated and unable to receive information about his or her right to formulate an AD, the information may be provided to the resident's legal representative.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a standardized assessment and care-screening tool) was accurate for two of three sampled residents (Residents 7 and 8)</p> <p>a. Resident 7's MDS did not indicate Resident 7 had the active diagnosis of schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>b. Resident 8's MDS did not indicate Resident 8 had active diagnoses of Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination) and bipolar disorder (a mental illness that causes unusual shifts in a person's mood).</p> <p>These failures had the potential for Residents 7 and 8 not to receive appropriate treatment and/or services.</p> <p>Findings:</p> <p>a. During a review of Resident 7's Admission Record (AR), the AR indicated Resident 7 was admitted to facility on 2/11/20 with multiple diagnoses including schizophrenia and dementia (a group of thinking and social symptoms that interferes with daily functioning).</p> <p>During a review of Resident 7's History and Physical (H&P), dated 2/16/24, the H&P indicated, Resident 7 had a diagnosis of schizophrenia.</p> <p>During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 was moderately impaired with cognitive skills (the ability to make daily decisions). The MDS indicated Resident 7 required supervision from staff for dressing and eating. Resident 7's MDS did not indicate Resident 7 had the active diagnosis of schizophrenia.</p> <p>b. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to facility on 3/29/24 with multiple diagnoses including anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities) Parkinson's disease, and bipolar disorder.</p> <p>During a review of Resident 8's H&P dated 3/29/24, the H&P indicated Resident 8 had diagnoses of bipolar disorder and Parkinson's disease.</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8 was moderately impaired with cognitive skills. The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort) from staff for dressing and bathing. Resident 8's MDS did not indicate Resident 8 had the active diagnoses of Parkinson's disease and bipolar disorder.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 4/30/24 at 2:38 p.m. with the MDS Coordinator (MDSC), Resident 7's MDS, dated [DATE] was reviewed. Resident 7's MDS failed to indicate Resident 7 had active diagnosis of schizophrenia. The MDSC stated she used all of Resident 7's medical record, including the H&P, to complete the MDS assessment. The MDSC stated she did not assess Resident 7 as having an active diagnosis of schizophrenia because Resident 7 was not taking any medications for schizophrenia.</p> <p>During a concurrent interview and record review on 4/30/24 at 2:44 p.m. with the MDSC, Resident 8's MDS, dated [DATE] was reviewed. Resident 8's MDS failed to indicate Resident 8 had active diagnoses of Parkinson's disease and bipolar disorder. The MDSC stated, the MDS needed to indicate Resident 8's active diagnosis of Parkinson's disease. The MDSC stated the assessment needed to be accurate to ensure the resident was provided the right care addressing all the active diagnoses. The MDSC stated the CMS's RAI Version 3.0 Manual (RAI) indicated to mark whatever active diagnoses the resident (in general) had. The MDSC stated the reason it was important to complete the MDS accurately was because Centers for Medicare & Medicaid Services (CMS) needed to know the status of the residents in the facility.</p> <p>During a concurrent interview and record review on 4/30/24 at 3:26 p.m. with the MDSC, the facilities manual titled, CMS's RAI Version 3.0 Manual, dated October 2023, was reviewed. The manual indicated to include active diagnoses in the completion of the MDS. The manual indicated to use the resident's (in general) recent H&P to identify active diagnoses to include in the MDS assessment. The MDSC stated active diagnoses included the diagnoses the doctor indicated on the resident's H&P.</p> <p>During an interview on 4/30/24 at 3:30 p.m. with the facility's Administrator (ADM), the ADM stated the physician documented active diagnoses on the H&P.</p> <p>During a review of the facility's P&P titled, Comprehensive Assessment, revised March 2022, the P&P indicated, Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</p> <p>Based on interview and record review, the facility failed to revise the care plans for one of one sampled resident (Resident 19). The facility failed to revise Resident 19's care plans for falls regarding the use of bilateral (left and right) floor mats.</p> <p>This deficient practice had the potential for the Resident 19 to not receive proper and consistent care.</p> <p>Findings:</p> <p>During a review of Resident 19's Admission Record (AR), the AR indicated, the facility admitted Resident 19 to the facility on [DATE], and readmitted Resident 19 on 10/4/2023, with diagnoses that included blindness, lack of coordination (not able to move different parts of the body together well or easily), unsteadiness (liable to fall, not steady in position) on feet, and dementia (a group of symptoms caused by disorders that affect the brain).</p> <p>During a review of Resident 19's Care Plan (CP) titled, Falling Star Program, revised on 11/14/2023, the CP indicated, Resident 19 was at risk for falls. The CP interventions included floor mats as indicated.</p> <p>During a review of Resident 19's Interdisciplinary Team (IDT, a group of professional and direct care staff that have primary responsibility for the development of a plan for an individual receiving services) meeting notes dated 11/20/2023, timed at 3:51 pm, the IDT meeting notes indicated, both nursing and therapist reevaluated Resident 19's room including use of bilateral floormats. The IDT meeting notes indicated the therapist gave recommendations to remove the bilateral floormats due to potential risk for tripping when Resident 19 was using her mobility cane. The IDT meeting notes indicated the IDT made a decision to remove Resident 19's floormats.</p> <p>During a review of Resident 19's CP titled, Risk for Fall/Injury, revised on 2/12/2024, the CP indicated, Resident 19 was at risk for fall/injury. The CP interventions included bilateral floormats to minimize injury when resident rolled out of bed.</p> <p>During a review of Resident 19's CP titled, Side Rail/Entrapment Assessment/Care Plan V1.0, dated 4/9/2024, the CP indicated, Resident 19 had diagnosis/condition pertaining to side rails safety. The CP interventions included to provide a low bed with floor mat if indicated.</p> <p>A review of Resident 19's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 4/9/24, the MDS indicated, Resident 19's cognitive skills (ability to think, learn, and remember) were moderately impaired.</p> <p>During a concurrent observation and interview on 4/30/2024 at 12:59 pm with the Infection Preventionist Nurse (IP), inside Resident 19's room, the IP stated there were no floor mats on the right and left side of Resident 19's bed.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/30/24 at 1:03 pm with the IP, the IP stated Resident 19's CPs titled, Risk for Fall/Injury and Falling Star Program, were not updated. The IP stated interventions in residents care plans needed to be updated for staff to know which interventions were working and which ones were not.</p> <p>During an interview on 5/2/24 at 10:20 am with the Director of Nursing (DON), the DON stated Resident 19's floor mats were removed per the therapist's recommendation and IDT meeting conducted on 11/20/2023. The DON acknowledged that Resident 19's care plans for falls regarding the use of bilateral floor mats were not revised. The DON stated Resident 19's care plans needed to be updated because care plans were where the facility staff based their interventions from.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised in 3/2022, the P&P indicated, assessments of residents were ongoing and care plans were revised as information about the residents and the residents' condition changed. The P&P indicated, the facility reviewed and updated the care plan when there had been a significant change in the resident's condition and when the desired outcome was not met.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273</p> <p>Based on interview and record review the facility failed to ensure 1 of 3 sampled discharged (when a resident no longer needs to receive services and is sent home or moved to another facility or location) residents (Resident 102) and Resident 102's family were involved in developing Resident 102's post-discharge plan prior to Resident 102's discharge on 2/20/2024.</p> <p>This failure had the potential for Resident 102 and Resident 102's family to not have the chance to ask questions regarding Resident 102's placement and post-discharge care which could result in a difficult transition to the post-discharge setting.</p> <p>Findings:</p> <p>During a review of Resident 102's Admission Record (AR), the AR indicated Resident 102 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a serious mental illness that interferes with a person's ability to think clearly, manage emotions, make decisions, and relate to others).</p> <p>During a review of Resident 102's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 12/28/2023, the MDS indicated Resident 102's cognitive (ability to understand and process information) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated Resident 102 needed supervision or touching assistance with activities of daily living (ADL, basic self-care tasks which includes bathing or showering, dressing, personal hygiene, getting in and out of bed or a chair, walking, and using the toilet).</p> <p>During a review of Resident 102's Post-Discharge Plan of Care (PDPC), undated, the PDPC indicated Resident 102's family was notified of Resident 102's final post-discharge plan on 2/20/2024.</p> <p>During an interview on 5/2/2024 at 11:30 AM with the Social Service Representative (SSR), the SSR stated Resident 102 and Resident 102's family should have been informed of Resident 102's final discharge plan at least two weeks prior to Resident 102's discharge. The SSR stated resident (in general) and family involvement in developing Resident 102's post-discharge plan should be documented in the resident's clinical record. The SSR reviewed Resident 102's clinical record and was unable to find documentation that indicated Resident 102 and Resident 102's family were involved in developing Resident 102's post-discharge plan.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Discharge Summary and Plan, dated 10/2022, the P&P indicated, When a resident's discharge is anticipated, a discharge summary and post-discharge plan is developed to assist the resident with discharge .The resident/representative is involved in the post-discharge planning process and informed of the final post-discharge plan .</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108</p> <p>Based on observation, interview and record review, the facility failed to ensure one of one staff (Registered Nurse 2, [RN 2]) had specific competencies (a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully) to communicate with Resident 33, who spoke and communicated in Arabic</p> <p>This deficient practice resulted in RN 2 could not understand Resident 33's needs and had the potential to result in a decline in Resident 33's quality of life.</p> <p>Findings:</p> <p>During a review of Resident 33's Admission Record (AR), the AR indicated Resident 33 was readmitted to the facility on [DATE] with diagnosis that included dysphagia (difficulty swallowing), abnormal posture and dementia (a decline in mental ability severe enough to interfere with daily life).</p> <p>During a review of Resident 33's Minimum Data Set (MDS, a resident assessment and care-screening tool), dated 3/7/24, indicated Resident 33's preferred language was Arabic. The MDS indicated Resident 33 had adequate (no difficulty) hearing. The MDS indicated indicted Resident 33 was dependent (helper does all effort) with eating, toileting, shower/bath, dressing, personal hygiene, and maximal assist (helper does more than half) with sit to lying (moves from lying flat to sitting in bed) and sit to stand (sting in a chair to standing).</p> <p>During a record review of Resident 33's care plan titled, Language Barrier, revised on 3/21/24, indicted for staff to provide/utilize communication boards in the resident preferred language as part of the facility's interventions.</p> <p>During a record review of Resident 33's care plan titled Activities: Language Barrier, revised on 3/21/24, indicated to provide Arabic speaking staff/volunteers as needed. The care plan indicated for staff to provide Resident 33 with communication book as part of the facility's intervention.</p> <p>During an observation and an attempted interview with Resident 33, in the hallway, on 4/29/24 at 10:28 am, Resident 33 attempted to answer the interview questions in a different language and stated, uhh, uhh.</p> <p>During an observation of Resident 33 and with RN 2, on 4/29/24 at 10:33 am, RN 2 attempted to communicate with Resident 33 in English. Resident 33 was observed mumbling words in a different language. Resident 33 raised Resident 33's hands up and down, pointed to Resident 33's legs and attempted to move Resident 33's blanket. RN 2 stated, you say you are good?</p> <p>During an observation and concurrent interview on, 4/29/24 at 10:38 am, RN 2 stated Resident 33 did not speak English and RN 2 obtained a communication book (CB). Resident 33 continued to use hand gestures and attempt to communicate with RN 2 in Arabic. RN 2 was observed holding the CB, but did not open the CB to communicate with Resident 33's.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/29/24 at 10:41 am, RN 2 stated Resident 33 communicated and spoke Arabic. RN 2 stated RN 2 did not understand or speak Arabic and did not use or show the CB to Resident 33. RN 2 stated CB needed to be used to better understand Resident 33's needs and provide better care for Resident 33. RN 2 stated the CB had words and gestures in Arabic that RN 2 could have used to better communicate with Resident 33. RN 2 stated it was important for every nurse to give the care the resident needs.</p> <p>During an interview with the Director of Nursing (DON), on 5/2/24 at 10:27 am, the DON stated Resident 33 only spoke Arabic. The DON stated CB should be opened and used to translate and communicate with the resident. The DON stated CT were important to attend to the residents needs as soon as possible.</p> <p>A review of the facility's undated policy titled, Accommodation of Needs Related to Communication Barriers, indicated communication needs will be identified and appropriate interventions will be developed in order to accommodate the needs of the resident.</p> <p>A review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, revised on 8/2022, indicated the 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 . Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. Staff must demonstrate the skills and techniques necessary to care for resident needs including but not limited to: communication.</p>

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</p> <p>Based on observation, interview, and record review, the facility failed to monitor for side effects of psychotropic medications (medications that affects brain activities associated with mental processes and behavior) for one of five sampled residents (Resident 64) according to the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated July 2022.</p> <p>This failure had the potential for Resident 64 to experience a decline in health and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 64's Admission Record (AR), the AR indicated Resident 64 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including type 2 diabetes mellitus (a chronic [long standing] condition that affects the way the body processes blood sugar), hypertension (high blood pressure), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).</p> <p>During a review of Resident 64's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/16/24, the MDS indicated Resident 64 was moderately impaired with cognitive skills (ability to make daily decisions). The MDS indicated Resident 64 required supervision from staff for toileting, dressing, and personal hygiene. The MDS indicated Resident 64 took psychotropic medications.</p> <p>During a review of resident 64's Order Summary Report dated 3/29/24, active orders as of 4/1/24, the Order Summary Report indicated the following physician orders: Seroquel (Quetiapine Fumarate, a medication used for the treatment of schizophrenia), order date 11/15/23, oral tablet 50 Milligram (MG, a unit of measurement) give one tablet by mouth (PO) one time a day for paranoid schizophrenia manifested by persistent paranoia that he [Resident 64] is being followed and watched by people. The Order Summary Report indicated physician orders, dated 5/30/23, to monitor for Tardive Dyskinesia (TD, involuntary movements of tongue, jaw, face, and mouth) and tally with hashmarks and to monitor for potential side effects of Seroquel, including Tardive Dyskinesia.</p> <p>During a review of Resident 64's care plan titled Anti-Psychotics, revised 11/18/22, the care plan indicated to monitor for side effects of the medication Seroquel.</p> <p>During an observation on 4/29/24 at 2:47 p.m., Resident 64 was sitting on the edge of Resident 64's bed. Resident 64 stuck Resident 64's tongue out of Resident 64's mouth repeatedly (tongue thrusting [a facial tic, involuntary movement]).</p> <p>During a concurrent observation and interview on 4/30/24 at 9:09 a.m. with Certified Nursing Assistant (CNA) 1, Resident 64 was sitting at the edge of Resident 64's bed. Resident 64 was observed to be exhibiting tongue thrusting. CNA 1 stated Resident 64 tended to exhibit tongue thrusting whenever CNA 1 cared for Resident 64.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 4/30/24 at 9:55 a.m. with the Treatment Nurse (TN), Resident 64 was sitting at the edge of his bed. Resident 64 was observed to be exhibiting tongue thrusting. The TN stated the tongue thrusting was a side effect from Resident 64's medications. The TN stated Resident 64 exhibited tongue thrusting all the time. The TN stated the tongue thrusting was a sign of TD.</p> <p>During a concurrent interview and record review on 4/30/24 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 64's Medication Administration Record (MAR), for April 2024 was reviewed. The MAR indicated Resident 64 took Seroquel once a day every day in April 2024. The MAR indicated to monitor for potential side effects of Seroquel with a special concern for TD. The MAR did not indicate Resident 64 exhibited signs of TD for any day in April 2024. LVN 1 stated Resident 64 sticks his tongue out once and a while. LVN 1 stated the behavior of Resident 64 sticking out the tongue is TD. LVN 1 stated the MAR was not accurate and the MAR should indicate Resident 64 exhibited TD. LVN 1 stated Resident 64's MAR should be accurate to know if medications were effective and to address any side effects.</p> <p>During a concurrent interview and record review on 5/2/24 at 10:01 a.m. with the Director of Nursing (DON), Resident 64's MAR was reviewed. The DON stated staff should document in the MAR when Resident 64 exhibited side effects of the psychotropic medications. The DON stated it was important to monitor for the side effects to lessen the effects of medication. The DON stated the doctor needed to be aware of the side effects so they [the facility] can either adjust the medications [dose] or prescribe a medication to treat the side effect.</p> <p>During a review of the facility's P&P titled, Psychotropic Medication Use, dated July 2022, the P&P indicated a psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. The P&P indicated, Residents receiving psychotropic medications are monitored for adverse consequences, including . neurologic effects - agitation, distress, extrapyramidal symptoms, neuroleptic malignant syndrome, Parkinsonism, tardive dyskinesia, cerebrovascular events .</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review the facility failed to ensure one of four sampled residents (Resident 55) observed during medication pass (term used to describe the process through which medication is administered [given] to patients) was free of significant medication errors by failing to ensure Resident 55's routinely scheduled medication, Tramadol (a strong opiod [class of drug used to reduce pain] medication used to treat moderate to severe pain that is not being relieved by other types of pain medicines) was administered.</p> <p>This failure had the potential to cause a decline in Resident 55's physiological well-being related to poor management of Resident 55's pain and the potential for Resident 55 to experience withdrawal (physical and mental symptoms that occur after stopping or reducing intake of a drug) symptoms.</p> <p>Findings:</p> <p>During a review of Resident 55's Admission Record (AR), the AR indicated, Resident 55 was admitted to the facility on [DATE] with multiple diagnoses including idiopathic progressive neuropathy (nerve damage causing unusual sensations, numbness, and pain in the hands and feet), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with daily activities), and unspecified nondisplaced fracture of fourth cervical vertebra (a bone is broken in the neck region of the spine), subsequent encounter for fracture with routine healing.</p> <p>During a review of Resident 55's History and Physical Examination (H&P), dated 2/5/24, the H&P indicated, Resident 55 had the capacity to understand and make decisions.</p> <p>During a review of Resident 55's Minimum Data Set (MDS, an assessment and screening tool), dated 2/8/24, the MDS indicated, Resident 55's cognitive (ability to think and reason) status was moderately impaired. The MDS indicated Resident 55 received a scheduled pain medication regimen.</p> <p>During a review of Resident 55's Order Summary Report (OSR), with active orders as of 4/1/24, the OSR indicated, a physician's order dated 3/22/24 for Tramadol HCL oral tablet 50 mg (milligrams, a unit of measurement of mass) 1 tablet given by mouth every morning and at bedtime for pain management (to be administered on a routine basis to control pain). The order did not indicate any parameters (specific instructions that can be measured) to hold Tramadol.</p> <p>During an observation on 4/30/24 at 8:08 a.m. during the medication pass, LVN 4 was preparing all of Resident 55's medications that were due at 9 a.m. Resident 55 was observed sitting up in bed, awake, alert, and in no distress. LVN 4 stated, Resident 55 stated Resident 55's pain level was 0 (zero) and LVN 4 would hold (not give) the medication Tramadol. LVN 4 did not state if LVN 4 would notify the physician regarding Tramadol being held.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/30/24 at 12:44 p.m. with LVN 4, Resident 55's Medication Administration Record (MAR) dated 4/30/24 was reviewed. The MAR indicated, the 9 a.m., dose of Tramadol was coded 9 with LVN 4's initials. LVN 4 stated, the PCC (Point Click Care, a leading electronic health record) would populate code 9 in the MAR when a medication was not administered. LVN 4 stated, the order for Tramadol was to give 1 tablet by mouth every morning and at bedtime for pain management. LVN 4 stated, LVN 4 assessed Resident 55 for pain. LVN 4 stated Resident 55 had no pain and LVN 4 held the medication Tramadol. LVN 4 stated there were no parameters [on the physician's] order that indicated when to hold Tramadol and by holding the medication, LVN 4 was not following physician's orders. LVN 4 stated, holding Tramadol could affect Resident 55 and the pain could come back. LVN 4 stated LVN 4 should have notified the physician.</p> <p>During a review of Resident 55's MAR, dated April 2024, the MAR indicated, Tramadol was not given on the following dates 4/7/24, 4/23/24, and 4/30/24 and coded 9 with LVN 4's initials.</p> <p>During a review of Resident 55's Care Plan (CP, provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), titled, History of Malignant Neoplasm (cancerous tumor [abnormal mass of tissue]): am at risk for actual/increased: pain. date initiated 2/2/24, the CP indicated, one of the interventions was to administer Resident 55's pain medications as ordered.</p> <p>During a review of Resident 55's CP, titled, ADL/SELF CARE DEFICIT date initiated 2/2/24, the CP indicated, one of the interventions was to administer Resident 55's pain medication as ordered.</p> <p>During a review of Resident 55's CP, titled, ADVANCE DIRECTIVES/POLST (Physician Orders for Life-Sustaining Treatment, a standing medical order form that records patient's treatment wishes in the event of a medical emergency), date initiated 2/2/24, the CP indicated, one of the interventions was to administer Resident 55's pain medications as ordered.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Administering Medications, date revised April 2019, the P&P indicated, medications were administered in a safe and timely manner, and as prescribed. The P&P indicated, medications are administered in accordance with prescriber orders, including any required time frame.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307</p> <p>Based on observation, interview, and record review the facility failed to follow safe and proper food storage practices, in one of one kitchen (Kitchen 1), in accordance with professional standards for food service safety and the facility's policy and procedure (P&P) by failing to label/date food items in the kitchen.</p> <p>This deficient practice could result in serious complications from food borne illness (illness caused by the ingestion of contaminated food or beverage) and/or affect the quality and palatability of food to the residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on [DATE], at 8:34 a.m. with the Dietary Manager (DM) during the initial tour of Kitchen 1, the following were observed:</p> <ol style="list-style-type: none"> one undated/unlabeled 16 oz (ounces, a unit of weight) can of Sprease brand of all-purpose oil-based spray with no cap on and located on the counter by the stove. 5 unlabeled/unmarked sealed plain plastic packages of multiple frozen waffles were inside the stand alone freezer. <p>The DM stated, the opened oil spray can should have a cover on and should have been labeled for staff to know if the item had expired, to know when the open date was, to know the expectancy and the quality of the food, and to prevent food borne illness. The DM stated, serving foods with unknown expiration dates, or serving expired foods would result in residents not having good food.</p> <p>During a review of the facility's undated policy and procedure (P&P) titled, Dry Goods Storage Guidelines, the P&P indicated, the storage length for oil that was opened on shelf was 3 months.</p> <p>During a review of the facility's undated P&P titled, Freezer Storage Guidelines, the P&P indicated, baked goods that included waffles had a length of time in freezer of 3 months.</p> <p>During a review of the facility's undated P&P titled, Procedure for Freezer Storage, the P&P indicated, all frozen foods should be labeled and dated.</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a policy regarding use and storage of foods brought to residents by family and other visitors.</p> <p>34273</p> <p>Based on observation, interview, and record review the facility failed to implement the facility's policy and procedures (P&P), for food items in one of one refrigerator (Refrigerator 1), that indicated labeling food brought into the facility by family and visitors for residents, with the resident's name, the item, and the use by date when,</p> <ol style="list-style-type: none"> 1. Staff did not know when to discard food brought in by family and other visitors. 2. Staff did not know who was responsible for checking Refrigerator 1 located in the South Station and determine when foods were to be discarded. <p>These failures had the potential for residents to eat spoiled foods and develop foodborne illness.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 5/1/2024 at 1:10 pm with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, When family brings food in, we let them know we can only keep food for 24 hours. LVN 2 stated the only refrigerator used to store residents' food was in the South Station utility room. Refrigerator 1 was observed in the South Station utility room with LVN 2. There was a sealed jar of instant coffee in Refrigerator 1 labeled with a resident's name but was not labeled with the date the coffee was brought in by the resident's family. The sealed instant coffee jar did not have a use-by-date. LVN 2 stated staff who received foods from a resident's family was responsible for labeling the food.</p> <p>During a concurrent observation and interview on 5/1/2024 at 1:18 pm with LVN 3, LVN 3 stated when a resident's family brought food in, the staff who received the food should label the food with the resident's name, room number, and date of when the food was brought in, so other staff would know when to discard the food. LVN 3 stated food should be discarded according to the use-by-date on the package or if the food looked spoiled. LVN 3 stated if the food did not have a use-by-date, then staff would, Discard [the food] depending on [the] product. Refrigerator 1 was observed in the South Station utility room with LVN 3. LVN 3 explained the initials on the log posted on the refrigerator door indicated the refrigerator was checked by the NOC (night) shift (11pm-7am) charge nurse and AM (morning) shift (7am-3pm) charge nurse. LVN 3 stated the NOC and AM shift nurses who checked Refrigerator 1, checked the temperature, checked the food inside the refrigerator for discard dates, checked for spoiled food, and cleaned any spillage Refrigerator 1. LVN 3 picked up the jar of instant coffee inside Refrigerator 1 and was unable to find a use-by-date. LVN 3 stated LVN 3 was not aware of any specific policy that indicated when staff was to discard food if the food did not have a use-by-date. LVN 3 stated the South Station utility room was the only refrigerator in the facility where residents' foods were kept. LVN 3 stated the nurse assigned to Medication Cart A and the nurse assigned to Medication Cart C were responsible for checking Refrigerator 1. LVN 3 was assigned to Medication Cart C.</p> <p>(continued on next page)</p>		

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<p>F 0813</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/1/2024 at 1:37 pm with LVN 4, LVN 4, who was assigned to Medication Cart A, stated she was not sure if the nurse assigned to Medication Cart A was responsible for checking Refrigerator 1. LVN 4 stated any food brought in by a residents' family had to be consumed within 24 hours and would be discarded after 24 hours. LVN 4 stated food brought in by the family should be labeled with the resident's name, date, and time to indicate when it was brought into the facility, and the resident and family would be informed food would be discarded after 24 hours.</p> <p>During an interview on 5/1/2024 at 1:42 pm with Registered Nurse 1 (RN 1), RN 1 stated food brought in by family was only kept for 24 hours. RN 1 stated unfinished food would be kept in Refrigerator 1 and would be labeled with a date and time the food was received and labeled with the resident's name and room number. RN 1 stated the resident, and their family would be informed food would be discarded after 24 hours.</p> <p>During an interview on 5/1/2024 at 1:50 pm with the Dietary Manager (DM), the DM stated when resident's family brought food in, the staff who received the food from the family took the food to the DM or any kitchen staff so they could label the food with a use-by-date. The DM stated foods that were not labeled with an expiration date, or a use-by-date were only good for 2 hours.</p> <p>During an interview on 5/1/2024 at 3:20 pm with the Administrator (ADM), the ADM stated, If food don't need refrigeration, then it will be put in a bag or container, label, and discard within 24 hours. The ADM provided two policies on how to handle residents' food.</p> <p>During an interview on 5/2/2024 at 1:30 pm with the Assistant Director of Staff Development (ADSD), the ADSD stated food brought in by family that were non-perishable (not needing refrigeration) and were unopened were kept and discarded after 24 hours, and food needing refrigeration must be labeled and discarded in 24 hours.</p> <p>During a review of the facility's policy and procedure (P&P), titled, Foods Brought by Family/Visitors, dated 3/2022, indicated, Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food .Non-perishable foods are stored in re-sealable containers with tight-fitting lids .Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item, and the use by date .The nursing staff will discard perishable foods on or before the use by date .Potentially hazardous foods that are left out for the resident without a source of heat or refrigeration longer than 2 hours are discarded .</p> <p>During a review of the facility's P&P titled, Resident's Refrigerator/Freezer Storage, undated, the P&P indicated, Leftover food or unused potions of packaged foods should be discarded. No food will be stored beyond 72 hours from received .</p>		

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<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729</p> <p>Based on observation, interview, and record review, the facility failed to ensure 27 out of 37 resident rooms (Rooms 102, 103, 104, 105, 106, 107, 108, 109, 111, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132 and 133) met the minimum requirement of 80 square feet (sq. ft. - unit of measure) per resident in multiple resident rooms. Seven rooms had two residents per room and twenty rooms had three beds per room.</p> <p>This deficient practice had the potential to result in not having enough space for nursing staff to provide resident care, inability to accommodate the resident's functional furniture or care devices, and not enough room for visitors.</p> <p>Findings:</p> <p>During a review of the facility's room waiver request letter, dated 2/12/2024, the letter indicated the purpose being an official request for a room waiver. The letter indicated there were no unnecessary pieces of furniture or devices that could cause congestion and indicated the floor areas were open and passable without obstruction. The letter indicated the residents in the rooms did not want to move and their needs were comfortably met.</p> <p>During a review of the facility's Client Accommodation Analysis (CAA), dated 4/30/2024 the CAA indicated the following rooms were less than 80 sq. ft. per resident:</p> <p>Room: No. of Beds: Room Size: Floor Area:</p> <p>102 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft.</p> <p>103 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft.</p> <p>104 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft.</p> <p>105 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft.</p> <p>106 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Chino Valley Health Care Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	107 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 108 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 109 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 111 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 116 2 143.00 sq. ft. 13 x 11 ft. 117 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 118 2 143.00 sq. ft. 13 x 11 ft. 119 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 120 2 150.6 sq. ft. 13.4 x 11 ft. 4 x 0.8 ft. 121 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 122 2 150.6 sq. ft. 13.4 x 11 ft. 4 x 0.8 ft. 123 2 150.9 sq. ft. 13.5 x 11 ft. 3 x 0.8 ft. 124 2 150.6 sq. ft. 13.4 x 11 ft. 4 x 0.8 ft. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055126	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0912</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>125 2 150.9 sq. ft. 13.5 x 11 ft.</p> <p>3 x 0.8 ft.</p> <p>126 3 223.3 sq. ft. 19.4 x 11.3 ft.</p> <p>5.10 x 0.8 ft.</p> <p>127 3 227.08 sq. ft. 19.4 x 11.5 ft.</p> <p>5.10 x 0.8 ft.</p> <p>128 3 223.3 sq. ft. 19.4 x 11.3 ft.</p> <p>5.10 x 0.8 ft.</p> <p>129 3 227.08 sq. ft. 19.4 x 11.5 ft.</p> <p>5.10 x 0.8 ft.</p> <p>130 3 223.3 sq. ft. 19.4 x 11.3 ft.</p> <p>5.10 x 0.8 ft.</p> <p>131 3 227.08 sq. ft. 19.4 x 11.5 ft.</p> <p>5.10 x 0.8 ft.</p> <p>132 3 223.3 sq. ft. 19.4 x 11.3 ft.</p> <p>5.10 x 0.8 ft.</p> <p>133 3 227.08 sq. ft. 19.4 x 11.5 ft.</p> <p>5.10 x 0.8 ft.</p> <p>During a concurrent observation and interview on 5/2/2024 at 11:44 AM with Certified Nursing Assistant (CNA) 2 in room [ROOM NUMBER], CNA 2 transferred a resident via wheelchair from the restroom to bed A. Resident 85 stated Resident 85 did not want to move rooms and there was enough space each the resident.</p> <p>During an interview on 5/2/2024 at 12:15 PM with CNA 2, CNA 2 stated, there was enough space in room [ROOM NUMBER] to be able to provide care to the residents without having to move any furniture.</p> <p>The waiver request is hereby recommended for rooms 102, 103, 104, 105, 106, 107, 108, 109, 111, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132 and 133.</p>