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	05/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 40913 Based on observation, interview, and record review, the facility failed to provide privacy during assistance with personal care and during treatment procedures for two of two sampled residents (Resident 45 and Resident 202). This deficient practice had the potential to affect Resident 45 and Resident 202's feelings of self-worth and self-esteem. Findings: a. During a review of Resident 45's Admission Record (AR), the AR indicated the facility admitted Resident 45 on 12/28/2017, with diagnoses that included Alzheimer's disease (irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually the ability to carry out the simplest tasks) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 45's Minimum Data Set (MDS - a resident assessment tool) dated 1/27/2025, the MDS indicated Resident 45 rarely/never understood verbal content and rarely/never able to express ideas and wants. The MDS indicated Resident 45 was dependent on staff for all activities of daily living. During an observation on 4/29/2025 at 2:25 PM, Certified Nursing Assistant (CNA) 8 and CNA 14 transferred Resident 45 back to bed from the geriatric (medical care for older adults) chair then closed Resident 45's privacy curtain from both sides. CNA 8 and CNA 14 did not completely close Resident 45's privacy curtain all the way to the front of Resident 45's bed. Resident 45 was visible to any staff or resident who entered Resident 45's room and restroom located across Resident 45's bed. CNA 14 then changed Resident 45's incontinence pad and positioned Resident 45 on Resident 45's back. During an interview on 4/29/2025 at 2:29 PM with CNA 14, CNA 14 stated CNA 14 needed to completely close Resident 45's privacy curtain to protect Resident 45's privacy. b. During a review of Resident 202's AR, the AR indicated the facility admitted Resident 202 on 4/28/2025, with diagnoses that included cardiomegaly (enlarged heart) and chronic respiratory failure with hypoxia (respiratory failure occurs when the lungs cannot adequately provide oxygen to the body). (continued on next page)

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
	055126	A. Building B. Wing	05/01/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/29/2025 at 1 PM, Resident 202's rooms door was closed. After knocking and upon opening Resident 202's room door, the Treatment Nurse (TN) was observed inside Resident 202's room with Resident 202's privacy curtain opened. Resident 202 was not covered with a blanket and Resident 202's gown was pushed upward to Resident 202's chest exposing Resident 202's incontinence brief. Resident 202 was visible from the doorway. During an interview on 4/29/2025 at 2:30 PM with the TN, the TN stated the TN was performing Resident 202's assessment because Resident 202 was a new admission. The TN stated the TN just closed the door but not the privacy curtain. The TN stated the TN needed to close Resident 202's privacy curtain during the assessment because Resident 202 was exposed. During a review of the facility's policy and procedure (P&P) titled, Dignity, revised February 2021, the P&P indicated, Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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	05/01/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 47) was free from verbal abuse as indicated by the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program. This deficient practice resulted in verbal abuse to Resident 47 and had the potential to lead to psychosocial harm to Resident 47. Cross Reference F609 Findings: During a review of Resident 23's Admission Record (AR), the AR indicated the facility admitted Resident 23 on 8/26/2020, and readmitted the resident on 9/21/2024, with diagnoses including impulse disorder (a group of behavioral conditions that make it difficult to control your actions or reactions), dementia (a progressive state of decline in mental abilities), and unspecified mood disorder (a mental health condition that causes significant and persistent changes in a person's emotional state, energy levels, and behavior). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 23's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 23 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance with mobility. During a review of Resident 47's Admission Record (AR), the AR indicated the facility admitted Resident 47 on 5/21/2024, and readmitted the resident on 10/9/2024, with diagnoses including dementia, restlessness and agitation, and anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life). During a review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/17/2025, the MDS indicated Resident 47's cognition was moderately impaired. The MDS indicated Resident 47 required partial/moderate assistance (helper does less than half the effort) with ADLs and required partial/moderate assistance with mobility. (continued on next page)

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	05/01/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/29/2025 at 12:07 PM, while conducting routine investigative tasks, the surveyor was in the conference room located in the Northeast corridor of the facility. Loud yelling was heard that came from the Northwest side of the facility. Upon exiting the conference room to assess the source of the disturbance, the surveyor observed Certified Nursing Assistant (CNA) 8 wheeling Resident 47 from the Northwest area through the Northeast corridor. Resident 47 appeared visibly scared and emotionally distressed. Resident 47's body was tense and Resident 47 clutched the armrest of her wheelchair. Resident 47 audibly stated, I'm scared. Resident 23 was standing in the doorway of room [ROOM NUMBER] and appeared angry; Resident 23's face was red, and his body language was tense. Upon seeing the surveyor, Resident 23 immediately yelled, I want my fu**ing lunch tray! in a loud and angry tone. Resident 23 proceeded to direct a racial slur and profanity toward Resident 47, shouting, Get that fu**ing ni**er b**ch away from me! The language was overheard by Resident 47, CNA 9, and other residents (unidentified). CNA 9 immediately intervened and in a firm but calm voice, told Resident 23, You may not speak to other residents like that. That is not respectful! During an interview on 4/30/2025 at 8:15 AM, with CNA 8, CNA 8 confirmed being on duty on 4/29/2025, the day of the incident involving Resident 23 and Resident 47. CNA 8 stated at approximately 12 PM, CNA 8 heard loud yelling coming from the Northwest area of the facility. CNA 8 stated CNA 8 observed Resident 23 and Resident 47 outside of room [ROOM NUMBER] (Resident 23's room). CNA 8 stated Resident 23 was angry, was yelling, and was demanding food and was red in the face. CNA 8 stated Resident 47 was in her wheelchair outside room [ROOM NUMBER] and Resident 47 appeared scared and distressed. CNA 8 stated Resident 47 was active in Resident 47's wheelchair, frequently took strolls down the hallway, and never caused trouble. CNA 8 stated CNA 8 had heard Resident 23 use racial slurs and obscenities in the past, sometimes directed toward staff or other residents. CNA 8 stated this [behavior] usually occurred when Resident 23 was frustrated, such as when he did not receive what he wanted right away, especially food or care. CNA 8 stated Resident 23 got loud, started yelling, and used curse words. CNA 8 stated the altercation between Resident 23 and Resident 47 could have been avoided if there had been more staff monitoring the hallway, especially around lunchtime. CNA 8 stated the facility was aware of Resident 23's behavior history, and lunchtime was a high-risk period for Resident 47, due to similar behavior being observed in the past. CNA 8 stated if staff had been nearby or had eyes on Resident 23, they might have been able to intervene before the situation escalated. During an interview on 4/30/2025 at 3:25 PM, with the Administrator (ADM), the ADM stated the facility had maintained clear policies regarding resident-to-resident interactions involving inappropriate, offensive, or abusive language. The ADM stated the facility took such behaviors seriously. The ADM stated had the ADM been made aware of the incident at the time it occurred, the ADM would have initiated the appropriate steps [to address the incident]. The ADM stated considering what had reportedly been said, the incident did indicate verbal abuse toward another resident. The ADM stated language of that nature was offensive, discriminatory, and emotionally harmful, and should have been addressed promptly and thoroughly [by following] the facility's internal protocols. (continued on next page)

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	05/01/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 5/1/2025 at 9:16 AM, with CNA 9, CNA 9 stated CNA 9 was walking through the Northwest corridor of the facility on 4/29/2025 around 12:00 PM. CNA 9 stated Resident 23 used both profanity and a racial slur directed at Resident 47. CNA 9 reported Resident 23 yelled, Get that ni**er b**ch away from me. CNA 9 described the statement as loud, aggressive, and directed at Resident 47. CNA 9 stated CNA 9 told Resident 23 not to speak to Resident 47 in that way because it was not respectful. CNA 9 stated CNA 9 attempted to calm Resident 23 and de-escalate the situation. CNA 9 stated CNA 9 reminded Resident 23 that his lunch tray was coming out shortly. CNA 9 stated using that kind of language constituted verbal abuse and emphasized that no one should be spoken to in that manner, especially not by another resident. CNA 9 stated Resident 47 did not deserve that treatment because Resident 47 was simply in the hallway and the incident clearly shook-up Resident 47. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revision dated 4/2021, the P&P indicated residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.

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	05/01/2025

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** 50016 Based on observation, interview, and record review, the facility failed to report verbal abuse within two hours that involved one of one sampled resident (Resident 47) as indicated in the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating. This deficient practice prevented timely investigation and implementation of appropriate measures, which could potentially allowed continued abuse to Resident 47. Cross Reference F600 Findings: During a review of Resident 23's Admission Record (AR), the AR indicated the facility admitted Resident 23 on 8/26/2020, and readmitted the resident on 9/21/2024, with diagnoses including impulse disorder (a group of behavioral conditions that make it difficult to control your actions or reactions), dementia (a progressive state of decline in mental abilities), and unspecified mood disorder (a mental health condition that causes significant and persistent changes in a person's emotional state, energy levels, and behavior). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 23's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 23 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance with mobility. During a review of Resident 47's AR, the AR indicated the facility admitted Resident 47 on 5/21/2024, and readmitted the resident on 10/9/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), restlessness and agitation, and anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life). During a review of Resident 47's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/17/2025, the MDS indicated Resident 47's cognition was moderately impaired. The MDS indicated Resident 47 required partial/moderate assistance (helper does less than half the effort) with ADLs and required partial/moderate assistance with mobility. (continued on next page)

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	05/01/2025

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	During an observation on 4/29/2025 at 12:07 PM, there was loud yelling heard from the Northwest side of the facility. Certified Nursing Assistant (CNA) 8 was wheeling Resident 47 from the Northwest area through the Northeast corridor. Resident 47 appeared visibly scared and emotionally distressed. Resident 47's body was tense and Resident 47 clutched the armrest of her wheelchair. Resident 47 stated, I'm scared. Resident 23 was standing in the doorway of room [ROOM NUMBER] and appeared angry; Resident 23's face was red, and his body language was tense. Resident 23 yelled, I want my fu**ing lunch tray! in a loud and angry tone. Resident 23 proceeded to direct a racial slur and profanity toward Resident 47, shouting, Get that fu**ing ni**er b**ch away from me! During an interview on 4/30/2025 at 3:25 PM, with the Administrator (ADM), the ADM stated the ADM had not been made aware of any incident involving verbal abuse or an altercation between Resident 23 and Resident 47. The ADM stated the incident should have been reported immediately. The ADM stated, any time there was a situation involving racial slurs or verbal abuse, staff were expected to notify their supervisor right away, and the ADM should be informed as well. The ADM stated, the facility had maintained clear policies regarding resident-to-resident interactions involving inappropriate, offensive, or abusive language. The ADM stated the facility took such behaviors seriously. The ADM stated had the ADM been made aware of the incident at the time it occurred, the ADM would have initiated the appropriate steps [to address the incident]. The ADM stated language of that nature was offensive, discriminatory, and emotionally harmful, and should have been addressed promptly and thoroughly [by following] the facility's internal protocols. During an interview on 4/30/2025 at 4:06 PM, with the Director of Nursing (DON), the DON stated the DON had not been notified of any incident involving verbal abuse, racial slurs, or an altercation between Resident 23 and Resident 47. The DON stated staff were expected to notify their immediate supervisors, the DON, and the ADM immediately when any incident occurred that may be considered abuse, including verbal altercations or racial slurs. The DON stated timely reporting was essential so the facility could initiate an internal investigation and report to the state agency as required. During a telephone interview on 5/1/2025 at 9:16 AM, with CNA 9, CNA 9 stated CNA 9 had not reported the incident as thoroughly as CNA 9 should have. CNA 9 recalled CNA 9 may have told the Infection Preventionist (IP) Nurse there was yelling, but CNA 9 did not explain exactly what was said. CNA 9 stated because of the severity of the language used-including the racial slur and the profanity-the incident should have been reported immediately to the DON or the ADM so an internal investigation could be initiated. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating revision dated 9/2022, the P&P indicated 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. The P&P indicated, reporting Allegations to the Administrator and Authorities included, 1. 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. (continued on next page)

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	05/01/2025

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	2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. 3. Immediately is defined as: a. Within two hours of an allegation involving abuse or result in serious bodily injury; or b. Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via special carrier, fax, e-mail, or by telephone. 5. Notices include, as appropriate: a. The resident's name; b. The resident's room number; c. The type of abuse that is alleged (i.e., verbal, physical, sexual, neglect, etc.); d. The date and time the alleged incident occurred; e. The name(s) of all persons involved in the alleged incident; and f. What immediate action was taken by the facility. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.

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	05/01/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 Based on interview and record review, the facility failed to enter a diagnosis of schizophrenia (a serious mental health condition that affects how people think, feel, and behave, characterized by prominent delusions [a belief or altered reality that is persistently held despite evidence or agreement to the contrary], and hallucinations [false perception of objects or events involving the senses]) in the the Minimum Data Set (MDS - a standardized assessment and screening tool) for one of one sampled residents (Resident 15). This deficient practice resulted in Resident 15's MDS not accurately reflecting Resident 15's clinical status, and had the potential to impact care planning, quality measures, and resource allocation for Resident 15. Findings: During a review of Resident 15's Admission Record (AR), the AR indicated the facility admitted Resident 15 on 12/26/2023, and readmitted the resident on 6/1/2024, with diagnoses including urinary tract infection (UTI-an infection in the bladder/urinary tract), paranoid, and chronic kidney disease (CKD- a condition where the kidneys don't function properly over a long period). During a review of Resident 15's History and Physical (H&P), dated 6/2/2024, the H&P indicated Resident 15 had a diagnosis of Schizophrenia. During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 15 had severe cognitive (the ability to think and process information) impairment. During a review of Resident 15's MDS, dated [DATE], the MDS indicated that the checkbox under Section 16000 - Psychiatric/Mood Disorders: Schizophrenia - was not marked to reflect Resident 15's current diagnosis. During a concurrent interview and record review on 4/29/2025 at 3:49 PM, Resident 15's MDS, dated [DATE] and resident's H&P, dated 6/2/2024, were reviewed with the MDS Coordinator (MDSC), the MDSC stated Resident 15's MDS, did not indicate or reflect Resident 15's medical diagnosis of schizophrenia. The MDSC stated the diagnosis was present in the medical record and should have been coded on the MDS to accurately represent Resident 15's condition. The MDSC stated accurate coding ensured proper care planning, supported the use of necessary psychotropic medications, and prevented inaccurate quality measure reporting. The MDSC stated schizophrenia was an exclusion for antipsychotic tracking, if not coded correctly on the MDS, the facility may have appeared non-complaint. The MDSC stated the risks of incorrect coding impacted care planning, quality measures, and resource allocation. (continued on next page)

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	05/01/2025

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/1/2025 at 1:38 PM, with the Director of Nursing (DON), the DON stated it was important to accurately code a resident's (in general) diagnosis on the MDS. The DON stated accurate coding ensured appropriate care planning, supported proper treatment, and helped reflect the resident's true clinical status. The DON stated incorrect or missing diagnoses could lead to inadequate care, affect quality measures, and impact resident outcomes. During a review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Chapter 3, Section I, Version 3.0, dated October 2024, the manual indicated failure to code an active diagnosis can result in inaccurate assessments and improper care planning.

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chino Valley Health Care Cente	2351 S Towne Avenue Pomona, CA 91766

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 40913 Based on observation, interview, and record review, the facility failed to implement the plan of care to prevent aspiration (when something swallowed enters the airway or lungs) and/or choking (blockage of the upper airway by food or other objects) for one of one sampled resident (Resident 32) who was assessed as being at risk for aspiration and choking. This deficient practice had the potential to result in aspiration and/or choking for Resident 32. Findings: During a review of Resident 32's Admission Record (AR), the AR indicated the facility admitted Resident 32 on 1/22/2016, with diagnoses that included mood affective disorder (mental health condition that affects a person's emotional state), dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and dysphagia (difficulty swallowing). During a review of Resident 32's Change of Condition (COC) dated 4/5/2025, timed at 12:30 PM, the COC indicated Resident 32 was noted with delayed swallowing with episodes of coughing on liquids. The COC indicated Resident 32's physician was notified and ordered to change Resident 32's diet to a puree (smooth, creamy substance made of liquidized or crushed food) texture with nectar/mildly thick consistency diet. During a review of Resident 32's Care Plan (CP) titled, Aspiration, dated 4/5/2024, and revised on 3/8/2025, the CP indicated Resident 32 was at risk for coughing, shortness of breath, choking and lung infections due to food and fluids swallowing problems. The CP interventions included for staff to monitor Resident 32's tolerance to diet and fluids, assess for signs and symptoms of aspiration (coughing, shortness of breath, respiration changes), and speech therapy (assessment and treatment of communication problems and swallowing disorders) as indicated. During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool) dated 4/16/2025, the MDS indicated Resident 32 rarely/never understood verbal content and rarely/never able to express ideas and wants. The MDS indicated Resident 32 was dependent on staff for activities of daily living. During an observation on 4/28/2025 from 1:02 PM, Certified Nursing Assistant (CNA) 13 was assisting Resident 32 with Resident 32's lunch meal while Resident 32 was sitting up in a geriatric chair (geri chair - specialized chair designed for older adults or individual with limited mobility). There was pureed food and nectar thickened water on Resident 32's lunch tray. During an observation on 4/28/25 at 1:05 PM, Resident 32 coughed while CNA 13 was feeding Resident 32. (continued on next page)

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chino Valley Health Care Cente	2351 S Towne Avenue Pomona, CA 91766

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 04/28/25 at 1:06 PM, Resident 32 coughed while CNA 13 was feeding Resident 32. CNA 13 gave Resident 32 thickened water from a cup to drink. Resident 32 coughed shortly after drinking. During an observation on 4/28/25 at 1:07 PM, Resident 32 coughed three times then stopped. CNA 13 continued to feed Resident 32 brown colored pureed food using a spoon. During an observation on 4/28/25 at 1:08 PM, Resident 32 coughed five times. CNA 13 continued to feed Resident 32 pureed food using a spoon. Resident 13 coughed eight more times. CNA 13 then gave Resident 32 thickened water using a cup. During an observation on 4/28/25 at 1:09 PM, Resident 32 coughed a total of 11 times. During an observation on 4/28/25 at 1:10 PM, CNA 13 gave Resident 32 thickened milk from a cup. Resident 32 then coughed eight times. During an observation on 4/28/25 at 1:11 PM, Resident 32 coughed a total of six times. CNA 13 stopped feeding Resident 32 then positioned Resident 32's geri chair by the side of Resident 32's bed. There were food items left on Resident 32's lunch tray that included 2 spoonful of brown colored pureed food on the plate, a half cup of milk, pureed dessert, and pureed coleslaw. During an interview on 4/28/2025 at 1:13 PM with CNA 13, CNA 13 stated when Resident 32 started coughing, CNA 13 gave Resident 32 water to see if the coughing would stop. CNA 13 stated CNA 13 stopped feeding lunch when Resident 13 continued to cough. During an observation on 4/28/2025 at 1:29 PM, while Resident 32 was in occupational therapy (OT- use of self-care and work activities to increase independent function, enhance development, and prevent disability) session, Resident 32 coughed six times. During an interview on 5/1/2025 at 4:48 PM with the Registered Nurse Supervisor (RNS), the RNS stated signs and symptoms of aspiration would be coughing. The RNS stated when a resident (in general) would start coughing during meals, the CNA needed to stop feeding and notify the nurse because the resident needed to be monitored by a Speech Therapist (ST- a healthcare professional who specializes in diagnosing and treating communication and swallowing disorders). During an interview on 5/1/2025 at 5:15 PM with the Director of Nursing (DON), the DON stated when a resident (in general) coughed during meals, the resident's diet might need to be changed. The DON stated the staff did not notify the DON about Resident 32 coughing during meals. The DON stated Resident 32 needed to be assessed by a ST to check Resident 32's swallowing function. (continued on next page)

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	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chino Valley Health Care Cente	2351 S Towne Avenue Pomona, CA 91766

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Dysphagia - Clinical Protocol, revised September 2017, the P&P indicated the staff and physician will identify individuals with a history of swallowing difficulties or related diagnoses such as dysphagia, as well as individuals who currently have difficulty chewing or swallowing food. Based on the information collected and correlated by various disciplines, the staff and practitioner, in conjunction with the SLP (speech-language pathologist), will define the situation carefully (for example, differentiate coughing, choking, wheezing, and aspirating; identify circumstances, details and frequency and severity of any episodes .) and whether the situation needs additional evaluation and clarification. The P&P indicated the staff and physician will first try to identify and implement simple interventions to manage the situation, for example, cutting food into smaller pieces, allowing the individual to eat more slowly .

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	05/01/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 24) who spoke primarily Mandarin had a communication board at bedside. This failure had the potential to result in Resident 24 having unmet needs and emotional distress. Findings: During a review of Resident 24's Admission Record (AR), the AR indicated Resident 24 was admitted on [DATE] with multiple diagnoses including osteoporosis (condition that weakens bones, making them more prone to fractures) and chronic pulmonary edema (condition where fluid accumulates in the lungs over an extended period.) The AR further indicated Resident 24's primary language was Chinese (Mandarin). During a review of Resident 24's History and Physical (H&P), dated 2/4/2025, the H&P indicated Resident 24 had the capacity to understand and make decisions. During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool) dated 2/5/2025, the MDS indicated Resident 24 required partial or moderate assistance (helper does less than half of the effort) for toileting hygiene and bathing. During a review of Resident 24's Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) titled, Language Barrier, date initiated 2/3/2025 and revised on 3/9/2025, the CP indicated Resident 24 was at risk for communication difficulties due to speaking Mandarin. The interventions included in the CP indicated staff (general) will provide/utilize communication boards in the preferred language. During a concurrent observation and interview on 4/28/2025 at 3:39 PM with the Treatment Nurse (TN), the TN stated, the facility utilized communication boards to provide residents with language barriers, a visual method for the residents to communicate their needs and preferences. The TN stated Resident 24 should always have a communication board accessible to Resident 24. The TN stated, the TN was unable to locate a communication board in Resident 24's room. During an interview on 5/1/2025 at 1:38 PM with the Director of Nursing (DON), the DON stated any resident who cannot communicate in English or has difficulty expressing themselves verbally should have a communication board. The DON further stated Resident 24 would benefit from a communication board at bedside to support effective communication which is important during times without a translator, family member or bilingual staff present. The DON stated the communication board helps the resident express basic needs, discomfort, or concerns when verbal communication is limited. The DON stated, It's essential for their (the residents') safety, comfort, and quality of care. (continued on next page)

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	05/01/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs Related to Communication Deficit, undated, the P&P indicated communication needs will be identified and appropriate interventions including care planning, will be developed in order to accommodate the needs of the resident.

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	05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 3), who was cognitively impaired (refers to difficulties with thinking, learning, remembering, and using judgment, among other mental abilities) and was assessed at risk for elopement (the act of leaving a facility unsupervised and without prior authorization) did not elope from the facility's secured unit (specialized healthcare setting that restricts patient/resident movement and access to promote safety with measures such as locked doors and surveillance) on 4/24/2025, at 7: 06 PM by failing to ensure: 1. Certified Nursing Assistant (CNA) 6 closed/locked the door when CNA 6 exited the facility's secured unit and ascertained (make sure of) Resident 3 did not follow CNA 6 out of the secured unit. 2. Receptionist (RC) 1 clocked and set the alarm on the front door located in the facility's lobby to prevent Resident 3 from leaving the facility without supervision. 3. CNA 7 implemented Resident 3's Care Plan (CP) titled, Elopement Risk, indicating to monitor Resident 3 and to follow the facility's visual check protocol (to check the resident where about with the naked eyes) [Q (every) 15-minute monitoring]. These deficient practices resulted in Resident 3's elopement on 4/24/2025 at 7:06 PM, placing Resident 3 at risk for vehicular accidents due to the facility is located in a busy street with many cars driving by, negative outcome from not receiving Resident 3's medication, and exposure due to extreme temperatures (heat during the day and cold during the night) that could lead to serious injury, serious harm, or death. On 4/28/2025 at 5:20 PM, while onsite at the facility, the State Survey Agency (SSA) identified an Immediate Jeopardy situation (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The IJ was called in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to ensure the doors to the secured unit were closed after CNA 6 walked out of the secured unit, the front lobby's door was locked and alarmed, Resident 3 was monitored/checked every 15 minutes, and to prevent the elopement of Resident 3 on 4/24/2025. On 4/29/2025 at 3:24 PM, while onsite at the facility, the ADM provided an acceptable IJ Removal Plan (IJRP, a detailed plan that includes interventions to immediately correct the deficient practices in the IJ) for the facility's failure to ensure Resident 3 did not elope from the facility on 4/24/2025 at 7:06 PM. The SSA verified and confirmed the facility's full implementation of the IJRP through observations, interviews, and record reviews, and determined the IJ situation regarding Resident 3's elopement due to lack of supervision, unlocked secured unit door, and no alarm on the front lobby door, were no longer present. The SSA removed the IJ on 4/29/2025 at 5 PM in the presence of the ADM. The acceptable IJRP included the following summarized actions: (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A. Immediate Corrective Actions: 1. On 4/24/2025, the DON provided a verbal one-on-one in-service (education given to one staff by one educator) via phone regarding the elopement policy to CNA 6, following a disciplinary Performance Correction on 4/25/2025. 2. On 4/25/2025, 4/26/2025, and 4/27/2025, the Registered Nurse Supervisor RNS 1 had contacted the nearby hospitals, and local police department to locate Resident 3. On 4/25/2025 the ADM contacted the private investigators (PI) who were also utilized to find Resident 3. A flyer of the missing resident was also provided by the PI. 3. On 4/28/2025, the local police found Resident 3 and dropped Resident 3 off at Clinic 1. at approximately 6:30 AM. The DON communicated with Clinic 1's Nurse (CN) 1 who confirmed Resident 3 was currently in Clinic 1 with stable (normal) vital signs (VS, measuring the basic functions of your body temperature, blood pressure, pulse, and respirations). The DON notified Resident 3's Primary Physician/Medical Doctor (MD 1) who instructed to transfer Resident 3 back to the facility. 4. On 4/28/2025, two CNA's (CNAs 1 and 2) picked up Resident 3 from Clinic 1 and brought Resident 3 back to the facility at 4:35 PM. 5. On 4/28/2025, RNS 1 conducted a comprehensive assessment of Resident 3 upon Resident 3's return to the facility. Resident 3's VS were stable, no signs or symptoms of major injury were noted. MD 1 ordered to transfer Resident 3 to a General Acute Care Hospital (GACH) for further evaluation on 4/29/2025. Facility staff notified Resident 3's conservator regarding Resident 3 was found. 6. On 4/28/2025, the DON posted a virtual alert sign at secured unit exit areas, reminding staff to keep doors closed before walking away from all secured exit areas, as ongoing safety education. 7. Effective 4/28/2025, the facility assigned a staff member to the reception area to assist with visitation and supervise individuals entering and exiting the facility. 8. On 4/28/2025, and 4/29/2025, the DON and the Director of Staff Development (DSD) provided in-services to staff members regarding the elopement policy, covering the following topics: a. Supervise and redirect residents who are close to the exits, to mitigate the risk of elopement. b. While entering or existing the secured unit, staff members must check/confirm that no resident is existing from the secured unit before walking away from the exit doors. c. The importance of conducting rounds every 15 minutes in the secured unit and as needed for adequate supervision. d. The importance of supervision in the front lobby and the activation of the front lobby gate alarm to enhance overall supervision. e. Elopement Trainings is as follows: (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e1. As of 4/29/2025, 7 out of 8 RNs, 14 of 14 Licensed Vocational Nurses (LVNs), 36 of 42 CNA's, 20 of 20 department managers and assistants, 4 of 4 activity assistants, 7 of 7 housekeeping and laundry employees, 10 of 11 dietary service staff received the in-service training for elopement. e2. 8 staff need to complete the in-service regarding elopement upon returning to work and prior to providing resident/resident care. e3. 7 staff were not working due to medical, emergency leaves, vacation, and leave of absence will complete their in-services upon their return. e4. The ADM notified the Medical Director of the IJ findings in the IJ template. The Medical Director assisted in developing the IJ removal plan. 9. On 4/29/2025, the facility also installed a new door keypad for safety in the front lobby. B. Identification of other Residents: 1. On 4/28/2025, there were 48 residents residing in the secured unit. 2. On 4/28/2025 and 4/29/2025, the ADM, the DON, and the DSD made rounds, observed staff members entering/exiting the secured unit. No issues were identified. 3. On 4/27/2025, 4/28/2025, and 4/29/2025. the maintenance supervisor inspected all exit doors, gate, and door/gate alarms. No issues were noted. C. Systematic Change: 1. Effective 4/29/2025, the DON would repeat the in-service regarding Elopement policy to staff members every month, for 3 months. The in-services would cover the following topics: a. Supervise and redirect residents who are close to the exits, to mitigate the risk of elopement. b. While entering or exiting the secured unit, staff members must check/confirm that no residents are exiting the secured unit before walking away from the exit doors. c. The importance of conducting rounds every 15 minutes and as needed for adequate supervision. d. The importance of supervision in the front lobby and the activation of the front lobby gate alarm to enhance overall supervision. 2. The DON developed an Elopement Monitoring Log, which included supervision and redirection, precautions for entering/exiting the secured unit, and monitoring of the front gate alarm to prevent elopement. 3. Effective 4/29/2025, the facility would conduct a head count at every shift on the secured unit station for 3 months, using the current day's census to enhance supervision. D. Monitoring Performance: (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 05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The DON, the DSD or the RNS 1 would conduct daily rounds to observe staff entering/exiting the secured unit to ensure compliance and document the monitoring findings/actions in the monitoring log. 2. The ADM and the DON developed a Quality Assurance and Performance Improvement (QAPI, data driven and a proactive approach to quality improvement) for elopement to address the deficient practice in the IJ findings. Findings: During a review of Resident 3's Admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included paranoid (when a person feels distrustful and suspicious of other people) schizophrenia (a serious mental health condition that affects how people think, feel, and behave, characterized by prominent delusions [a belief or altered reality that is persistently held despite evidence or agreement to the contrary] and hallucinations [false perception of objects or events involving the senses]), anxiety disorder (persistent feeling of dread or panic that can interfere with daily life), unspecified convulsions (a sudden, violent, irregular movement of a limb [arm or leg] or of the body), epilepsy [a disorder in which nerve cell activity in the brain is disturbed, causing seizures (a sudden burst of electrical activity in the brain)], cognitive communication deficit (difficulties with communication affecting the ability to understand), and diabetes mellitus (a disease that results in elevated levels of glucose in the blood). During a review of Resident 3's CP, titled Elopement Risk, initiated 8/21/2023 (no revision date indicated), the CP indicated Resident 3 sometimes left the facility without authorization/permission. The CP's interventions indicated for staff to continue to provide frequent visual checks (every 15 minutes) of Resident 3's where abouts (the place or general locality where a person is) in the secured unit, and to follow the protocol for visual checks (check the resident every 15 minutes). During a review of Resident 3'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), dated 8/30/2024, the COC indicated on 8/30/2024 at 8 AM, Resident 3 showed exit seeking behaviors and increased delusions that someone was waiting for Resident 3 outside of the facility. The COC indicated (on 8/30/2024) at 10 AM, Resident 3 was noted to be walking up and down the hallways looking hypervigilant (being excessively or abnormally alert to potential danger or threat), looking to get out [of the facility], screaming and shouting I need to get out of here now. During a review of Resident 3's Physician Orders (POs) for the month of September 2024, the POs indicated the following orders: 1. Admit Resident 3 to the secured unit, dated 9/9/2024. 2. Humalog Injection Solution [a rapid-acting insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) that starts working faster and works for a shorter period of time than regular/short-acting insulin] 100 unit milliliter (ml, unit of measurement) to inject as per sliding scale (a scale followed, dose of insulin varies based on blood sugar levels), dated 9/20/2024. (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Lantus Solostar [a long-acting (a type of insulin that works throughout the day and night to provide residents/patients with low levels of insulin all the time) man-made-insulin used to control high blood sugar] subcutaneous (to administer medications between skin and muscle) solution pen-injector inject (a device that provides a nonelectrically-powered, mechanically-operated method of accurately injecting medication/insulin) 100 unit/ml, administer 15 units at bedtime for diabetes mellitus with hyperglycemia (high blood sugar), check finger stick blood sugar (FSBS, a little poke is make in the finger, and a little teeny, tiny drop of blood is withdrawn to test the blood sugar/glucose) before administration, dated 9/9/2024. 4. Tegretol (carbamazepine, medication used to treat seizures) tablet, 200 milligrams (mg, unit of measurement) administered by mouth, three times a day, dated 9/9/2024. 5. Zyprexa (Olanzapine, medication used to treat schizophrenia) tablet, 10 mg, give 1 tablet by mouth, one time a day, for paranoid schizophrenia manifested by delusion that a judge ordered Resident 3 to take the medication. During a review of Resident 3's History and Physical (H&P), dated 9/10/2024, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Elopement Risk Assessments ([NAME]), dated 9/26/2024, 12/24/2024 and 3/18/2025, the [NAME] indicated Resident 3 was assessed at risk for elopement due to Resident 3 wandered aimlessly (to move around or go to different places without having a particular purpose or direction), had verbally expressed the desire to go home, packed belongings to go home, and stayed near an exit door. During a review of Resident 3's Minimum Data Set (MDS- a resident assessment and care screening tool), dated 3/18/2025, the MDS indicated Resident 3 had moderate impaired cognition (ability to think, remember, and reason). The MDS indicated Resident 3 needed supervision (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completed the activity and may be provided throughout the activity or intermittently) with oral hygiene, toileting, and personal hygiene. During a review of Resident 3's Police Report (PR), dated 4/24/2025, the PR indicated on 4/24/2025 at approximately 9:48 PM, Resident 3 was reported missing. The PR indicated (on 4/24/2025) at around 8 PM, facility staff looked through the entire facility and were unable to locate Resident 3. The PR indicated the facility's surveillance video footage captured Resident 3 walking in the [facility's] hallway (on 4/24/2025) at approximately 6 PM and at 7 PM, Resident 3 was seen standing by the secured unit's double doors. The PR indicated, A medical staff [CNA 6] opened the locked door and walked through the door. The PR indicated Resident 3 held the door open, walked behind CNA 6, then opened the front entrance door, and walked toward the north bound on [T Avenue, street located in front of the facility]. The PR indicated Resident 3 was diagnosed with several medical conditions, required constant medical attention, took prescribed medication, and was unable to care for herself. The PR indicated Resident 3 was a Critical missing person. The PR indicated Resident 3 left the health care facility without anyone [staff] noticing. During an observation on 4/28/2025 at 10:37 AM of the facility's premises. There was double glass doors located at the front of the facility's lobby. The double doors were pushed open to exit the facility. Past the double doors, there was a busy street with multiple cars moving along the road. (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent observation of the facility's surveillance video, dated 4/24/2025, time at 7:06 PM and interview with the DON, on 4/28/2025 at 12:13 PM, the facility's surveillance video indicated Resident 3 exited the facility on 4/24/2025, at 7:06 PM and walked toward the left side of the facility. The video indicated there were multiple cars driving by on the major street located in front of the facility. The DON stated, the facility's surveillance video dated 4/24/2025, timed at 7:06 PM, indicated Resident 3 was in the secured unit's hallway, standing next to the exit door. The DON stated, CNA 6 opened the facility's locked door and walked out of the secured unit. The DON stated, Resident 3 placed Resident 3's hand between the double doors to prevent the doors from closing. The DON stated Resident 3 pushed the double doors open, walked into the facility's lobby, and walked out of the facility. The DON stated there were no staff visible past the secured unit door or in the facility's lobby. The DON stated Resident 3 walked out of the facility's main door, Like a visitor, and the facility located on a busy street with cars constantly driving by. The DON stated the facility's main lobby door was unlocked and no alarm or blinking lights were heard or observed visible in the surveillance video. The DON stated there should have been a staff member (receptionist) at the front desk monitoring who entered or left the facility. The DON stated the front doors should always be locked and the alarm should have turned on [sounded] to alert facility staff when people (staff, residents and or visitors) attempted to enter or exit the facility, as a safety measure to prevent residents (in general) from eloping. During a concurrent observation of the facility's surveillance video, dated 4/24/2025, at 7:06 PM, and an interview with the ADM on 4/28/2025 at 3:06 PM, the surveillance video indicated Resident 3 exited the facility on 4/24/2025, at 7:06 PM. The ADM stated, per the surveillance video, CNA 6 walked out of the facility's secured unit into the facility's lobby. The ADM stated Resident 3 walked behind CNA 6, pushed the lobby front doors open, walked out of the facility, and walked toward the busy street in front of the facility. The ADM stated, according to the surveillance video, no staff were seen at the front desk on 4/24/2025, since 6:30 PM, and the facility's staff members were unaware of Resident 3's elopement (on 4/24/2025, at 7:06 PM). During a review of Resident 3's 3 PM to 11 PM Resident Check (PMRC) log, dated 4/24/2025, completed by CNA 7, the PMRC log indicated Resident 3's where abouts were to be monitored by CNA 7 every 15 minutes. The PMRC log indicated Resident 3's slots on 4/24/2025, from 6:45 PM to 11 PM were left blank (no indication of Resident 3's location). During a review of Resident 3's PMRC log, dated 4/24/2025 and an interview with CNA 7, on 4/28/2025 at 3:33 PM, The PMRC log indicated Resident 3's slots on 4/24/2025, from 6:45 PM to 11 PM were left blank. CNA 7 stated all residents resided in the secured unit (including Resident 3) were to be monitored/checked every 15 minutes. CNA 7 stated CNA 7 was supposed to monitor and document the time and location of each resident assigned to CNA 7. CNA 7 stated, on 4/24/2025, (from 3 pm to 11 pm shift) CNA 7 was the primary CNA assigned to care for Resident 3. CNA 7 stated CNA 7 documented Resident 3's where abouts as being in the hallway on 4/24/2025, at 6 PM, 6:15 PM, and at 6:30 PM. CNA 7 stated CNA 7 last saw Resident 3 (on 4/24/2025), at 6:30 PM just before the scheduled smoke break for the smokers (residents who smoke) which lasted until 7 PM. CNA 7 stated it was unrealistic to monitor (check and document the residents [all assigned residents including Resident 3'] location every 15 minutes because CNA 7 was busy assisting and providing care to other residents. (continued on next page)

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	05/01/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the DSD, on 4/28/2025 at 3:43 PM, the DSD stated CNA 6 was in-serviced (educated) on the necessary safety steps to take when staff entered and exited the facility's secured units (prior to Resident 3's elopement). The DSD stated, after exiting the secured unit, CNA 6 needed to ensure the secured door was closed shut and residents did not follow CNA 6 or attempted to exit the secured unit. The DSD stated, when these steps [closed the door and made sure residents did not leave the secured unit without supervision] were not taken, residents could elope from the facility and could walk onto the busy street and get hurt. During a telephone interview with CNA 6 on 4/28/2025 at 3:54 PM, CNA 6 stated, on 4/24/2025 at around 7 PM, CNA 6 unlocked the secured unit doors and exited the secured unit. CNA 6 stated CNA 6 did not check if the door closed shut behind CNA 6 upon exiting the secured unit or ensure there were no residents standing close to the doors. CNA 6 stated it was important to ensure the doors were closed shut and locked, upon exiting the secured unit, so the resident (Resident 3) did not elope. During a review of Resident 3's PMRC log, dated 4/24/2025 and an interview with the DON on 4/29/2025 at 3:30 PM, The PMRC log indicated Resident 3's slots on 4/24/2025, from 6:45 PM to 11 PM were left blank. The DON stated Resident 3 was discovered missing on 4/24/2025, between 8:40 PM to 9 PM. During an interview with LVN 4, on 4/29/2025 at 3:40 PM, LVN 4 stated, on 4/24/2025, LVN 4 was the person in charge of the secured unit. LVN 4 stated Resident 3 was observant, smart, and aware of Resident 3's surroundings. LVN 4 stated on 4/24/2025, at around 9 PM, CNA 6 informed LVN 4 Resident 3 was missing. LVN 4 stated the assigned CNA (CNA 6) was responsible for monitoring the whereabouts of Resident 3 every 15 minutes. During a review of the facility's undated policy and procedures (P&P) titled, Missing Resident, the P&P indicated The facility's objective was to prevent possible injury or death to a resident and for wanderers (exit seeking residents) to be checked on a regular basis. During a review of the facility's P&P titled, Safety and Supervision of Residents, revised 7/2017, the P&P indicated Resident safety, supervision and assistance to prevent accidents are facility wide priorities. The P&P indicated systems approach to safety included, facility-oriented and resident-oriented approaches to safety are used together to implement a system's approach to safety, which considers the hazards identified in the environment and individual resident risk factors. The P&P indicated to adjust interventions accordingly. During a review of the facility's P&P titled, Wandering and Elopements, revised 3/2019, the P&P indicated The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents.

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	05/01/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on observation, interview and record review, the facility staff failed to ensure Certified Nurse Assistants (CNAs) 8 and 9 know how to recognize verbal abuse and implement the facility's policy on abuse for two of two residents (Residents 23 and 47) on 4/29/2025. These deficient practices had the potential to expose other residents in the facility to abuse and cause distress, fear and nervousness. Findings: a. During a review of Resident 23's Admission Record (AR), the AR indicated Resident 23 was admitted on [DATE], and readmitted on [DATE], with diagnoses including impulse disorder (having a hard time resisting urges or impulses, often leading to unwanted behaviors), dementia (a progressive state of decline in mental abilities), and mood disorder (a mental health condition that causes significant and persistent changes in a person's emotional state, energy levels, and behavior). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 23's cognition (ability to understand and process information) was moderately intact. The MDS indicated Resident 23 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required supervision or touching assistance with mobility. b. During a review of Resident 47's AR, the AR indicated Resident 47 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including dementia, restlessness and agitation, and anxiety disorder (mental health conditions characterized by excessive and persistent worry and fear, often leading to physical symptoms and difficulties in daily life). During a review of Resident 47's MDS, dated [DATE], the MDS indicated Resident 47's cognition was severely impaired. The MDS indicated Resident 47 required partial/moderate assistance (helper does less than half the effort) with ADL, and required partial/moderate assistance with mobility. During an observation on 4/29/2025 at 12:07 PM, Resident 23 was observed in the doorway of Resident 23's room with tense posture, clenched fists and red face yelling a racial slur and profanity towards Resident 47. Resident 47 was observed in a wheelchair moving away from Resident 23 with eyes widened and audibly stated Resident 47 was scared. During an interview on 4/30/2025 at 8:15 AM with CNA 8, CNA 8 stated CNA 8 recalled at the time of the incident Resident 47 frequently strolls down the resident hallway and Resident 23's face was red. CNA 8 stated, CNA 8 had not heard the use of profanity or racial slurs but Resident 23 use them in the past, sometimes directed toward staff or other residents. (continued on next page)

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	05/01/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2025 at 3:25 PM with the Administrator (ADM), the ADM stated the ADM was not made aware of any incident involving verbal abuse or altercation between Residents 23 and 47. The ADM stated that anytime an incident/altercation involves racial slurs or verbal abuse, the staff (in general) are expected to notify their supervisor right away and the incident (between Residents 23 and 47) should have been reported immediately. The ADM stated the incident indicated verbal abuse toward another resident and the language used was offensive, discriminatory and emotionally harmful and should have been addressed promptly and thoroughly through the facility's internal protocol. During an interview on 4/30/2025 at 4:06 PM with the Director of Nursing (DON), the DON stated the DON was not notified of any incident involving verbal abuse or racial slurs between Residents 23 and Resident 47. The DON stated staff are expected to notify their immediate supervisors, the DON and the ADM immediately when any incident/altercation occurs. The DON stated timely reporting was essential so the facility's administrative staff could initiate investigation and repot the incident to the state as required. During a telephone interview on 5/1/2025 at 9:16 AM with CNA 9, CNA 9 stated CNA 9 had been on duty at the time of the incident and recalled Resident 23 had used profanity and a racial slur directed at Resident 47. CNA 9 stated the statements were loud and aggressive. CNA 9 stated CNA 9 had immediately intervened and attempted to de-escalate the situation but did not report the incident as thoroughly as CNA 9 should have. CNA 9 stated the incident should have been reported immediately to the DON or ADM so an investigation could have been initiated. During an interview on 5/1/2025 at 4:02 PM with Director of Staff Development (DSD), the DSD stated after learning about the incident between Residents 23 and 47, the DSD had identified CNA 9 other staff (in general) who required re-enforcement of when to implement action for potential abuse. The DSD stated the incident that occurred between Residents 23 and 47 should have been reported to the DON or ADM when it occurred initially. The DSD stated a delayed report could mean continued verbal altercations and affect other residents and could cause distress, fear or nervousness to residents involved and other residents. During a review of the facility's policy and procedure (P&P) titled, Abuse & Mistreatment of Residents, dated 1/3/2023 the P&P indicated 2. Verbal Abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 3/2023, the P&P indicated 1. 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. 3. Immediately is defined as: a. within two hours of an allegation involving abuse or result in seriously bodily injury.

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	05/01/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40913 Based on observation, interview, and record review, the facility failed to ensure food items in one of one kitchen were stored and distributed in a sanitary manner by failing to: a. Ensure expired dry food items were not kept in storage in one of one kitchen (Kitchen 1). b. Ensure proper ice handling practices by one of one kitchen staff (Dietary Aide 1) during lunch tray line. These deficient practices had the potential to expose 97 of 97 residents to food borne illness (any illness resulting from eating/drinking contaminated foods) and could negatively affect the health of the residents at the facility. Findings: a. During an observation on [DATE] at 8:55 AM with the Dietary Manager (DM), in the dry storage area of Kitchen 1, there was one (1) pack of hamburger bun with a used by date of [DATE] and 1 can of pork and beans with a use by date of ,d+[DATE]. During an interview on [DATE] at 9:10 AM with the DM, the DM stated the expired hamburger bun and pork and beans would be thrown away. The DM stated the kitchen staff follow the first in, first out (valuation method where the oldest items are sold or used first) process. The DM stated these items could have been missed. During a review of the facility's undated policy and procedure (P&P) titled, Storage of Canned and Dry Goods, the P&P indicated no food item that is expired or beyond the best buy date are in stock. 45553 b. On [DATE] at 11:56 a.m., during a kitchen tray line inspection, Dietary Aide (DA) 1, who was assisting the dietary lunch team with preparing residents' drinks, was observed touching the ice in the tray used to keep the milk cups cold for the residents' lunches with bare hands. DA 1 was then observed going to the trash can and touched the plastic lining of the trash can with DA 1's bare hands as DA 1 threw away an item in the trash can. DA 1 did not wash her hands after touching the trash can then proceeded to touch the milk cups and ice as DA 1 arranged the milk cups in the tray of ice. During an interview on [DATE] at 11:58 a.m. with the Dietary Supervisor (DS), the DS stated DA 1 should wash her hands after touching the trash can because DA 1 could spread germs and place the residents at risk for a food-borne illness due to cross-contamination. (continued on next page)

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	05/01/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 1:02 p.m. with DA 1, DA 1 stated DA 1 should have washed DA 1's hands after touching the trash can, but DA 1 was in a hurry to get milk cups on the residents' food cart. DA 1 stated DA 1 needed to wash DA 1's hands after touching the trash can because DA 1 can transfer germs to any food item DA 1 touched next, which could make the residents sick with vomiting or diarrhea. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control, undated, the P&P indicated, Policy: Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. The P&P further indicated, Hand Washing: Before starting work in the kitchen; Before and after handling foods; After handling any waste and waste products. Use of Disposable Gloves: 1. Disposable gloves will be worn when handling food directly with bare hands to prevent food borne illnesses; 2. Disposable gloves are a single use item and should be discarded after each use, or when damaged or soiled; 3. Hands are to be washed when entering the kitchen and before putting on disposable gloves; 5. Wash hands when changing gloves. Change disposable gloves when: *Gloves get ripped or torn; *After coughing or sneezing into hands, use of handkerchief or tissue, smoking touching hair or face, and using the toilet; *After handling waste; *During food preparation, as often as necessary when it gets soiled and when changing task to prevent cross contamination. During a review of the U.S. Food and Drug Administration Food Code, dated 2017, the food code indicated, , d+[DATE].11 - Preventing Contamination from Hands. (A) Food Employees shall wash their hands as specified under S ,d+[DATE].12. (B) Except when washing fruits and vegetables as specified under S, d+[DATE].15 or as specified in (D) and (E) of this section, Food Employees may not contact exposed, READY-TO-EAT FOOD with their bare hands and shall use suitable UTENSILS such as deli tissue, spatulas, tongs, single-use gloves, or dispensing EQUIPMENT. (C) Food Employees shall minimize bare hand and arm contact with exposed FOOD that is not in a READY-TO-EAT form.

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50016 Based on observation, interview, and record review the facility failed to maintain its infection prevention and control program, for one of two sampled residents (Resident 2), as indicated by the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions The facility failed to wear appropriate personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while providing care and having direct physical contact with Resident 2 who was under Enhanced Barrier Precautions (EBP, an approach that entails the use of PPE to reduce transmission of multidrug-resistant organism [MDRO, bacteria that are resistant to three or more classes of antimicrobial drugs]). This deficient practice had the potential to result in the transmission of infectious microorganisms and increase the risk of infection for Resident 2 and other residents residing at the facility. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility admitted Resident 2 on 11/28/2003, and readmitted the resident on 4/6/2024, with diagnoses including encounter for attention to colostomy (a doctor's visit or other healthcare interaction related to a stoma (artificial opening) created during colostomy [a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body]) surgery, melena (black, tarry stools caused by digested blood from the upper digestive tract), and cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance with mobility. During a review of Resident 2's History and Physical (H&P), dated 4/12/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a record review of Resident 2's Order Summary Report, dated active as of 5/1/2025, the report indicated Resident 2 had a physician's order for EBP for colostomy, dated 6/27/2024. During an observation on 4/28/2025 at 10:03 AM, there was signage indicating EBP located outside of Resident 2's room. Certified Nursing Assistant (CNA) 9 entered Resident 2's room without donning (putting on) a gown and provided personal care to Resident 2. CNA 9 had direct physical contact with Resident 2. During an interview on 4/28/2025 at 10:10 AM, CNA 9 stated CNA 9 forgot to put on a gown prior to entering Resident 2's room, who was on EBP. CNA 9 stated it was a requirement to wear gloves and a gown before performing any personal care and having direct physical contact with Resident 2. CNA 9 stated wearing a gown was important because it (continued on next page)

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	05/01/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	protected both the staff and the resident from infections. CNA 9 stated gowning helped prevent contact with bodily fluids and reduced the risk of spreading germs between residents. CNA 9 stated following proper PPE protocols was about keeping everyone safe. During an interview on 5/1/2025 at 9:33 AM, with the Infection Preventionist (IP), the IP stated staff were expected to wear gowns when providing high-contact care to residents on EBP. The IP stated proper use of PPE was necessary to prevent the transmission of infectious microorganisms and to reduce the risk of infections to residents. During a review of the facility's P&P titled, Enhanced Barrier Precautions revised 8/2022, the P&P indicated EBPs are utilized to prevent the spread of MDROs to residents. The P&P indicated: 1. EBPs are used as an infection prevention and control intervention to reduce the spread of MDROs to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. Dressing, b. Bathing/Showering, c. Transferring, d. Providing hygiene, e. Changing linens, f. Changing briefs or assisting with toileting, g. Device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.), and h. Wound care (any skin opening requiring a dressing).

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	05/01/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 48729 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 rooms with more than one resident. Seven rooms had two residents per room and twenty rooms had three beds per room. These deficient practices had the potential to result in the rooms were not having enough space for nursing staff to provide resident hygiene care, or the ability to permit the use of resident care devices. Findings: During a review of the facility's Client Accommodation Analysis (CAA), dated 4/30/2025 the CAA indicated the following rooms were less than 80 sq. ft. per resident: Room: No. of Beds: Room Size: Floor Area: 102 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 103 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 104 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 105 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 106 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 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. (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 05/01/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	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. 125 2 150.9 sq. ft 13.5 x 11 ft. 3 x 0.8 ft. 126 3 223.3 sq. ft. 19.4 x 11.3 ft. (continued on next page)

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	05/01/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	5.10 x 0.8 ft. 127 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 128 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 129 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 130 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 131 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. 132 3 223.3 sq. ft. 19.4 x 11.3 ft. 5.10 x 0.8 ft. 133 3 227.08 sq. ft. 19.4 x 11.5 ft. 5.10 x 0.8 ft. During a review of the facility's room waiver request letter, dated 4/30/2025, the letter indicated there are no unnecessary pieces of furniture or devices that could cause congestion. The letter further indicated the residents in these rooms benefit from the familiarity of environment and are comfortable with adequate pieces of furniture to meet their needs. During an interview on 4/28/2025 at 10:14 AM with Resident 74, Resident 74 stated there was enough space in the room to be comfortable and had no complaints about the room. During an interview on 5/1/2025 at 3:30 PM with Licensed Vocational Nurse (LVN) 6, LVN 6 stated none of the rooms in the facility have interfered with LVN 6's ability to perform their duties and LVN 6 is able to carry out all assigned tasks without issue or limitation. 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.

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	05/01/2025

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 40913 Based on observation, interview, and record review, the facility failed to ensure gnats (a group of tiny, winged flies) were not found inside the kitchen area. This deficient practice had the potential for gnats to multiply and fly to other areas of the facility or contaminate food. Findings: During an observation on 4/28/2025 at 8:25 AM, there were 4 tiny black colored flying insects below the sink area. The [NAME] stated the flying insects were gnats. During an interview on 5/1/2025 at 5:11 PM with the Dietary Manager (DM), the DM stated food particles could attract gnats, so the staff cleaned the kitchen thoroughly after the gnats were found. The DM stated the facility needed to ensure there were no gnats present inside the kitchen because the flying insects could go to the food and contaminate the food which could affect food safety. During a review of the facility's policy and procedure (P&P) titled, Pest Control Policy, the P&P indicated the facility shall maintain an on-going pest control program to ensure that the building is kept free of insects and rodents.