| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055126 | A. Building<br>B. Wing | 06/12/2026 |

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

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility was free of five percent or greater medication error rate. ˆThe facility had three total medication errors in 33 opportunities for errors yielding a total of 9.09 percent error rate during medication pass (process through which medication is administered [the act of giving a treatment, such as a drug, to a patient]) for one of five sampled residents (Resident 43) when:ˆ 1. Licensed Vocational Nurse (LVN) 3 did not administer a delayed release (a drug that does not dissolve or release its active ingredient right away when swallowed) aspirin (ASA, a medication used to treat mild to moderate pain) to Resident 43.2. LVN 3 did not administer Resident 43's lamotrigine (a medication used to treat seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] disorders) per physician orders when Resident 43 swallowed the medication whole instead of chewing it. 3. LVN 3 did not measure Resident 43's diclofenac (a powerful pain killer used to treat mild to moderate pain, swelling, and joint stiffness) topical gel prior to administration. These failures resulted in Resident 43 receiving an inaccurate dosage of diclofenac and had the potential to result in compromised absorption and therapeutic effect (the desired, beneficial effect of a medical treatment or intervention) of ASA and Lamictal for Resident 43. Findings: During a review of Resident 43's Face Sheet (FS, admission record), the FS indicted Resident 43 was re-admitted to the facility on [DATE] with diagnoses including seizures and fibromyalgia (a long-term condition that causes widespread pain). During a review of Resident 43's History and Physical (H&P), dated 5/13/2026, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS, a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 43's cognitive (the ability to think and process information) skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 43 required partial/moderate assistance (helper does less than half the work) with toileting, showering, upper and lower body transfers, and sit to stand position. During a review of Resident 43's Order Summary Report (OSR), dated active as of 6/12/2026, the OSR indicated the following medications were ordered on 5/11/2026: 1. ASA 81 [mg-a unit of measurement] oral tablet delayed released, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA - stroke, loss of blood flow to a part of the brain) prophylaxis (a medication used to prevent the onset or spread of a disease). ˆ 2. Lamotrigine oral tablet 25 mg, give 3 tablets by mouth one time a day for absence seizure disorder (a seizure characterized by brief episodes of blanking out or staring into space). The order indicated to chew 3 tablets daily. 3. Diclofenac Sodium External Gel 1%, apply to bilateral (both sides) shoulders topically (applying a medication directly onto the skin) two times a day (BID) for pain management, apply 2 grams (gm - unit of measurement) bilaterally. Duringˆa medication pass observation on 6/12/2026 at 9:02 AM with LVN 3, LVN 3 was observed preparing Resident 43's medications. LVN 3 placed one tablet from Resident 43's ASA bottle labeled, chewable aspirin into a medicine cup (MC). LVN 3 took three tablets from Resident 43's Lamotrigine 25 mg bubble pack (a customized monthly pill organizer where medications are sorted into individual, sealed compartments) which indicated, Chew three<br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | tablets daily and placed them into the same MC. LVN 3 proceeded to squeeze an unmeasured amount of diclofenac ointment into another MC. LVN 3 walked to Resident 43's bedside and handed Resident 43's ASA and lamotrigine tablets to the resident. Resident 43 swallowed all tablets in the MC without chewing the tablets. LVN 3 proceeded to scoop the diclofenac ointment from the MC and applied the ointment to Resident 43's shoulders. During an interview on 6/12/2026 at 9:32 AM with LVN 3, LVN 3 stated Resident 43 did not chew the aspirin and lamotrigine tablets per pharmacy instructions on the medication labels. LVN 3 stated the facility should follow pharmacy instructions so the medications could be correctly absorbed. LVN 3 stated LVN 3 was supposed to administer 2 grams of diclofenac. LVN 3 stated LVN 3 did not know how much diclofenac LVN 3 administered to Resident 43. LVN 3 stated it was important to give the correct amount of diclofenac [2 grams] to avoid overdosing Resident 43. During an interview on 6/12/2026 at 4:02 PM with the Director of Nursing (DON), the DON stated it was important to follow physician orders and pharmacy instructions to ensure proper absorption of medications and to ensure the medications' therapeutic effects were met. ˆ ˆDuring a review of the facility's policy and procedure (P&P) titled Administering Medications, revised April 2019, the P&P's policy statement indicated, Medications are administered in a safe and timely manner, and as prescribed. The P&P's policy interpretation and implementation indicated, Medications are administered in accordance with prescriber orders . The individual administering the medication checks the label THREE times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in one of one kitchen (Kitchen 1) when the following was observed: On 6/9/2026, an open container, filled with a white flaky powder substance, was unlabeled and undated in Kitchen 1's cooking area. On 6/9/2026, [NAME] (CK) 1 was not wearing a beard cover while preparing food in Kitchen 1. On 6/11/2026, one of two sampled sanitizing solution buckets (Solution Bucket, SB 1) did not haveˆthe correct concentration required to effectively kill bacteria (microscopic single-celled organisms some can make people sick) and organisms from kitchen surfaces in accordance with the facility's policy and procedure (P&P) titled, Sanitizing Equipment and Surfaces. These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) or foodborne illness (a sickness caused by eating or drinking food and beverages contaminated with harmful germs, parasites, or toxic chemicals) to the residents consuming the facility's food. Findings: 1. During an observation on 6/9/2026 at 8:38 AM in Kitchen 1, there was an open, half full, container in Kitchen 1's cooking area. The container had a white flaky powdery substance and was unlabeled and undated. During an interview on 6/11/2026 at 1:22 PM with the Dietary Supervisor (DS), the DS stated all food items must be properly labeled and dated to ensure accurate identification of the product being served and to prevent the distribution of expired food to the residents (in general). During an interview on 6/12/2026 at 11:37 AM with the Facility Dietician (FD), the FD stated food should be labeled and dated to prevent expired food from being served to the residents. During a review of the facility's undated P&P titled, Storage of Canned and Dry Goods, the P&P's policy indicated, Food and supplies will be stored properly and in a safe manner. The P&P's procedure indicated, Remove food from packaging boxes upon delivery to minimize pests. The P&P indicated loose items like cookies, crackers, sugar packets, etc. should be placed in containers or bins. The P&P indicated bins will be dated, labeled, and covered. ˆ2. During an observation on 6/9/2026 at 8:45 AM in Kitchen 1's food preparation area, CK 1 had a beard and mustache and was not wearing a beard cover. During an interview on 6/9/2026 at 8:46 AM with CK 1, CK 1 stated a beard net cover should be worn to prevent hair follicles from falling into the residents' food. During an interview on 6/11/2026 at 1:22 PM with the DS, the DS stated beard nets were required to prevent hair from contaminating residents' food. The DS stated contaminated foods could result in residents getting sick. During an interview on 6/12/2026 at 11:37 AM with the FD, the FD stated beard nets were used [by kitchen staff] for food safety purposes and to prevent cross-contamination. Additionally, the FD stated bacteria grew in hair and if ingested could get the residents sick. During a review of the facility's undated P&P titled, Sanitation and Infection Control, the P&P's policy indicated, Food service employees will follow infection control policies to ensure the department operates under sanitary conditions at all times. The P&P's procedures indicated, [NAME] and/or mustaches should be closely trimmed or must be covered at all times. 3. During a concurrent observation and interview on 6/11/2026 at 12:28 PM with Dietary Aid (DA) 1, in Kitchen 1, SB 1 was tested in the dishwashing area by DA 1, the concentration in SB 1 read 100 parts per million (ppm, unit of measurement). DA 1 stated the sanitizing solution should be within the correct range (200 - 400 ppm) to avoid cross-contamination. During an interview on 6/11/2026 at 1:22 PM with the DS, the DS stated the sanitizing solution should between 200 - 400 ppm. The DS stated the sanitizing solution should be within the correct range to ensure food preparation surfaces were clean. During an interview on 6/12/2026 at 11:37 AM with the FD, the FD stated the sanitizing solution should be within the correct range. The FD stated the sanitizing solution was used to remove bacteria [from Kitchen 1 surfaces] that could be harmful to the residents. ˆ During a review of the facility's Quat Sanitizer Log, (QSL), dated June 2026, the QSL indicated the quat level (the concentration of quaternary ammonium<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | compounds [chemicals used to eliminate bacteria] in a sanitizing solution) should be at least 200 - 400 ppm. During a review of the facility's undated P&P titled, Sanitizing Equipment and Surfaces, The P&P's policy indicated, Sanitizing solution will be used to sanitize equipment and surfaces after each use or as often as needed. The P&P's procedure indicated, Dietary staff will check for appropriate sanitizer levels using the test strip into the bucket of solution, the test strip should read 200 - 400 ppm. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection (the invasion and growth of germs in the body) prevention and control practices by failing to ensure:a.Personal care items found inside the shared restrooms for five of five sampled residents (Residents 37, 2, 107, 48, and 75) were labeled and stored properly.b. The lint screen/trap and base (bottom) for three of three sampled commercial laundry dryers (CLD 1, CLD 2, CLD 3) were free of dense accumulation of lint (a thick, cottony pad [about the thickness of a felt sheet or small quilt] that completely hides the screen).c. One of two sampled [NAME] & [NAME] restrooms (JJR 1 [a shared restroom situated between two bedrooms with direct access from both rooms], specifically the restroom between rooms [ROOM NUMBERS] shared by Residents 33, 53, 59, 61, 65, and 73 ) was in a clean and sanitary condition when fecal matter was observed on the floor and sink area. These deficient practices had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections to the residents including Residents 2, 33, 37, 48, 53, 59, 61, 65, 73, 75, and 107. Additionally, the deficient practice had the potential to result in a damp environment leading to mold and bacterial growth in the dryer and the spread of microorganisms throughout the facility and the potential for increased fire risk.<br><br>Findings:<br><br>a. During a review of Resident 37's Face Sheet (FS-admission record), the FS indicated Resident 37 was admitted to the facility on [DATE] with diagnoses including acute (sudden) kidney failure, unspecified, and unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with agitation (a feeling of extreme restlessness, tension, or anxious energy).<br><br>During a review of Resident 37's History and Physical Examination (H&P), dated 12/14/2025, the H&P indicated Resident 37 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool), dated 3/23/2026, the MDS indicated Resident 37's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 37 required from partial/moderate assistance (helper does less than half the effort) to setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves)<br><br>During a review of Resident 2's FS, the FS indicated Resident 2 was admitted to the facility on [DATE] with diagnoses including personal history of other infections and parasitic diseases (an illness caused by tiny organisms that live on or inside the body) and type 2 diabetes mellitus (DM II – a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications.<br><br>During a review of Resident 2's History and Physical (H&P), dated 4/10/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were intact (decisions consistent/reasonable). The MDS indicated Resident (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2 was dependent (helper does all of the effort) with ADLs.<br><br>During a review of Resident 2' Order Summary Report (OSR), active orders as of 6/9/2026, the OSR indicated an order on 4/13/2026 for Enhanced Barrier Precautions (EBP - an infection-control practice to prevent the spread of bacteria in nursing homes).every shift.<br><br>During a review of Resident 2's Care Plan (CP - provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), titled Resident is at risk for COVID-19 (Coronavirus Disease of 2019 - a highly contagious respiratory illness caused by the SARS-CoV-2 virus) infection., date initiated 4/13/2026, the CP indicated an intervention of continuing infection control practices to prevent the spread of infection.<br><br>During a review of Resident 107's FS, the FS indicated Resident 107 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection), unspecified organism, and DM II with hyperglycemia (high blood sugar).<br><br>During a review of Resident 107's H&P, dated 6/3/2026, the H&P indicated Resident 107 had the capacity to understand and make decisions.<br><br>During a review of Resident 107' OSR, active orders as of 6/9/2026, the OSR indicated an order on 6/03/2026 for EBP.<br><br>During a review of Resident 48's FS, the FS indicated Resident 48 was admitted to the facility on [DATE] with diagnoses including urinary tract infection (UTI – an infection in the bladder/urinary tract), site not specified, and essential (primary) hypertension (HTN – high blood pressure).<br><br>During a review of Resident 48's H&P, dated 3/17/2026, the H&P indicated Resident 48 had the capacity to understand and make decisions.<br><br>During a review of Resident 48's CP titled Resident is at risk for COVID-19 infection., date initiated 3/17/2026, the CP indicated one of the interventions was to continue infection control practices to prevent the spread of infection.<br><br>During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 48 required substantial/maximal assistance (helper does more than half the effort) to supervision or touching assistance with ADLs.<br><br>During a review of Resident 75's FS, the FS indicated Resident 75 was admitted to the facility on [DATE] with diagnoses including essential (primary) HTN, and UTI, site not specified.<br><br>During a review of Resident 75's H&P, dated 2/15/2026, the H&P indicated Resident 75 could make needs known but could not make medical decisions.<br><br>During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 75 required partial moderate assistance to setup or clean-up assistance with ADLs.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 6/9/2026 at 9:18 AM, Resident 37 and Resident 2's shared room had an EBP signage posted and a white trimmed colored 3-drawer PPE (personal protective equipment – clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart outside of Resident 37 and Resident 2's shared room.<br><br>During a concurrent observation and interview on 6/9/2026 at 9:25 AM with Licensed Vocational Nurse (LVN) 2, in Resident 37 and Resident 2's shared restroom, an unlabeled gray colored wash basin was observed with two (2) unlabeled urinals inside, stored on top of the toilet tank. LVN 2 stated the unlabeled gray colored wash basin with 2 unlabeled urinals inside, stored on top of the toilet tank, should not be there. LVN 2 stated it was important to label the gray colored wash basin and the two urinals with Resident 37 and Resident 2's name and to store them at Resident 37 or Resident 2's bedside to know who the gray colored wash basin and urinals belonged to and to prevent cross contamination.<br><br>During a concurrent observation and interview on 6/9/2026 at 10:50 AM with Certified Nursing Assistant (CNA) 1, in Resident 3, Resident 48 and Resident 75's shared restroom, an opened, unlabeled eight (8) fl oz (fluid ounce – a measurement of volume) bottle of Remedy Essentials (brand name) Cleanse Spray Cleanser (for cleansing and conditioning hair and skin) was observed stored on the sink. CNA 1 stated the cleanse spray cleanser should be labeled with the resident's (in general) name and should be stored in the resident's drawer. CNA 1 stated labeling and storing properly was important because anybody could use or even drink the cleanse spray cleanser. Additionally, CNA 1 stated since Resident 75 was independent and could grab (any personal care items left inside the shared restroom) it was important to ensure the resident's personal care items were stored properly.<br><br>During an interview on 6/12/2026 at 8:27 AM with the Infection Preventionist (IP), the IP stated labeling personal care items with the resident's name and room number and storing properly, in their nightstand, were important for infection control, to prevent cross contamination and other residents from using the personal care items.<br><br>During a review of the facility's Policy and Procedure (P&P) titled, Personal Property, revised March 2023, the P&P's policy statement indicated, Residents are permitted to retain and use personal possessions. The P&P's policy interpretation and implementation indicated, The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary.<br><br>b. During a concurrent observation and interview on 6/12/2026 at 11:53 AM with the Laundry (LD) and the EVS Supervisor (EVSS), inside the Laundry Room, CLD 1, CLD 2 and CLD 3 were in use and had a dense accumulation of lint on the lint screen/trap and moderate amount of lint on the base below the lint screen/traps. The LD stated the lint screen/traps were checked and cleaned every 2 hours. The EVSS stated the facility did not keep a log of how often the facility's CLDs were checked and cleaned for lint. The EVSS stated the dense accumulation of lint was a fire hazard. The EVSS stated cleaning the lint screen/traps was important for the safety of the residents and staff.<br><br>During a review of the facility's undated P&P titled, Maintenance of the Laundry Room and Laundry Equipment, the P&P's procedure indicated, Clean lint filters after each use of washer or dryer every three (3) hours. The Maintenance Supervisor vacuums areas under and around machines at least monthly, or as need[ed], to remove all collected lint.<br><br>c.During a review of Resident 65's FS, the FS indicated the facility admitted Resident 65 on<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2/5/2025, with diagnoses including seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a mental illness characterized by excessive, persistent, and irrational worry or fear that can interfere with daily life).<br><br>During a review of Resident 65's Minimum Data Set (MDS, a resident assessment tool), dated 4/20/2026, the MDS indicated Resident 65's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 65 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance (helper does less than half the effort) with mobility.<br><br>During a review of Resident 65's CP titled Behaviors, revised 1/10/2026, the CP indicated Resident 65 engaged in stool and urine handling, including rectal digging and occasional throwing of stool/urinal. The CP's interventions indicated, Assess what may cause behavior and what may trigger behavior; attempt to reduce/eliminate those triggers if possible. During an observation on 6/9/2026 at 09:30 AM in JJR 1, fecal matter was observed smeared on the floor adjacent to the toilet and inside the sink.<br><br>During an observation on 6/9/2026 at 1:39 PM in JJR 1, dried fecal matter was observed on the floor adjacent to the toilet and inside the sink.<br><br>During an interview on 6/11/2026 at 11:30 AM with Registered Nurse (RN) 1, RN 1 stated Resident 59 had behaviors of digging for feces and, at times, throwing stool. RN 1 stated staff should have been conducting purposeful rounding (staff intentionally check on residents at regular intervals to anticipate and address needs such as pain, position, personal needs, and safety), particularly for residents with these behaviors, to promptly identify and address such incidents. The RN stated allowing fecal matter to remain (on the floor and inside the sink) in a shared restroom was unsanitary and created an infection control risk for residents, staff, and visitors.<br><br>During an interview on 6/11/2026 at 03:18 PM with the Infection Preventionist (IP), the IP stated fecal matter on environmental surfaces (the surfaces of resident-care equipment and housekeeping areas such as floors, walls, bed rails, doorknobs, light switches, and bathroom fixtures) was a significant infection control concern because it could result in cross contamination. The IP Nurse stated residents with known fecal smearing behaviors required interventions and close oversight to minimize environmental contamination and reduce the risk of exposure to other residents, staff, and visitors.<br><br>During a review of the facility's P&P titled, Policies and Practices – Infection Control, revised April 2023, the P&P's purpose indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The P&P's policy interpretation and implementation indicated, The objectives of our infection control policies and practices are to: maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 77), was free from abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) when Resident 86, who had a history of sexual inappropriate behavior, touched Resident 77 on the left breast on 5/30/2026.This deficient practice resulted in Resident 77 getting startled, upset, and screaming for help and had the potential to result in psychosocial (relates to how a person's mental health and social environment [relationships, community] affect each other) harm to Resident 77.Findings:During a review of Resident 77's Face Sheet (FS, admission record), the FS indicated Resident 77 was originally admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with other behavioral disturbance, and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), unspecified.During a review of Resident 77's Care Plan (CP), initiated 8/11/2025, the CP indicated, I, [Resident 77] have been made aware that the facility has stable systems to prevent not only abuse.I shall not be subject to abuse by anyone., the CP's goal indicated Resident 77 would be free from abuse (verbal abuse, sexual abuse, mental abuse, neglect, misappropriation of resident property).During a review of Resident 77's History and Physical (H&P), dated 3/16/2026, the H&P indicated Resident 77 did not have the capacity to understand and make decisions.During a review of Resident 77's Minimum Data Set (MDS - a resident assessment tool), dated 5/5/2026, the MDS indicated Resident 77's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 77 did not have psychosis (a severe mental condition in which thought and emotions are so affected that contact with reality is lost) behavior such as hallucinations (perceptual experiences in the absence of real external sensory stimuli) or delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated Resident 77 required substantial/maximal assistance (helper does more than half the effort) to 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.During a review of Resident 77's COC/Interact Assessment (Change of Condition), dated 5/30/2026, timed at 1:50 PM, the COC indicated on 5/30/2026 at approximately 1:15 PM, Certified Nursing Assistant (CNA) 6 witnessed Resident 86 make an inappropriate physical contact with Resident 77 by grabbing Resident 77's left breast while Resident 77 and Resident 86 were in the hallway.During a review of Resident 86's FS, the FS indicated Resident 86 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, with other behavioral disturbance, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs).During a review of Resident 86's CP, initiated 5/21/2026, the CP indicated, I [Resident 86] exhibit the following behavior: exhibit sexual advances towards others, the CP's interventions indicated to assess what may cause behavior and what may trigger behavior; and attempt to reduce/eliminate the triggers if possible.During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86's cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 86 did not have psychosis behavior such as hallucinations or delusions. During a review of Resident 86's COC, dated 5/30/2026, timed at 2:59 PM, the COC indicated on 5/30/2026 at approximately 1:15 PM, while CNA 6 was feeding a resident (unidentified), CNA 6 heard Resident 77 scream. The COC indicated CNA 6 witnessed Resident 86 made inappropriate physical contact with Resident 77 while Resident 77 and Resident 86 were in the hallway. The COC indicated<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | CNA 6 witnessed Resident 86 grab Resident 77's left breast. The COC indicated when Resident 86 was interviewed by Licensed Vocation Nurse (LVN) 1, Resident 86 stated, if she's [Resident 77] here, he will initiate sexual advances to her.During a review of Resident 86's Order Summary Report (OSR), active orders as of 6/9/2026, a physician's order, dated 6/8/2026, the order indicated to admit Resident 86 to a secure unit (a specialized, enclosed environment designed for residents with Alzheimer's disease or dementia, its purpose is resident safety).During an interview on 6/11/2026 at 8:59 AM with CNA 5, CNA 5 stated Resident 77 was friendly and so sweet, and got loud when Resident 77 expressed a need. CNA 5 stated Resident 86 had tried to intentionally grab staff (in general) inappropriately multiple times.During an interview on 6/11/2026 at 9:46 AM with CNA 2, CNA 2 stated Resident 86 should not have been left alone with other female residents unmonitored to prevent the incident since staff knew of Resident 86's behavior. CNA 2 stated, CNA 7 who only worked part time might not have been aware of Resident 86's behavior when CNA 7 transported Resident 86 via wheelchair and left Resident 86 next to Resident 77 in the hallway. During an interview on 6/11/2026 at 10:48 AM with Resident 77, in the presence of the Restorative Nursing Assistant (RNA - nurse assistants with extra training to help residents regain or maintain mobility, strength, and independence with activities of daily living), Resident 77 was confused and unable to answer questions asked.During an interview on 6/11/2026 at 10:58 AM with Resident 86 in the presence of the RNA, Resident 86 stated, Resident 86 touched ladies (in general) because the ladies wanted to be touched. Resident 86 stated, Resident 86 might have touched a female resident at the facility because Resident 86 and the female resident were boyfriend-girlfriend. Resident 86 stated Resident 86 used to touch Resident 86's mother. Resident 86 stated, Resident 86 liked to touch women as long as the women allowed Resident 86. During an interview on 6/11/2026 at 11:06 AM with the RNA, the RNA stated prior to the incident, Resident 86 liked touching the girls [female staff]. The RNA stated Resident 77 should not have been left alone with Resident 86 in the hallway and Resident 86 should have been kept away from other female residents to prevent Resident 86 from [inappropriately] touching female residents.During an interview on 6/11/2026 at 11:18 AM with the Director of Nursing (DON), the DON stated, prior to the incident, the staff (in general) were aware of Resident 86's grabbing behavior and [the facility did] not assign female CNAs to Resident 86.During an interview on 6/11/2026 at 12:05 PM with LVN 1, LVN 1 stated LVN 1 remembered reassigning CNA 2 to Resident 86 because Resident 86 made inappropriate comments and touched females inappropriately. LVN 1 stated Resident 86 should not have been left alone with other [female] residents because Resident 86 could touch them (other residents) inappropriately, unwanted touching, and for resident safety.During a concurrent interview and record review on 6/11/2026 at 12:11 PM with the Administrator, a clip of the facility's Surveillance Video (SV), timestamp (the embedded date and time displayed on the SV footage) 5/30/2026 starting at 12:55 PM was reviewed. The SV indicated Resident 77 was sitting alone in a wheelchair in the North [NAME] hallway. The ADM stated CNA 7 wheeled, Resident 86 in a wheelchair [to the Northwest area hallway] and placed Resident 86 next to Resident 77. The SV indicated CNA 7 left after transporting and placing Resident 86 next to Resident 77. The ADM stated, the SV indicated Resident 86 attempted to touch Resident 77's left side three times with Resident 86's right hand. The SV indicated Resident 77 got startled, appeared upset, and tried to stop Resident 86 each time Resident 86 attempted to touch Resident 77. The ADM stated knowing Resident 86's behavior, Resident 86 should not have been placed next to Resident 77 to avoid Resident 86 from touching Resident 77. The ADM stated CNA 7 was a new staff and the ADM did not think Resident 86's behavior was discussed with CNA 7.During an interview on 6/11/2026 at 1:25 PM with CNA 6, CNA 6 stated Resident 86 was admitted to the facility's locked unit. CNA 6 stated, Resident 77 was friendly and screamed Resident 77 did not like something. CNA 6 stated the incident between Resident 77 and Resident 86 happened on 5/30/2026 a little bit after 1:00 PM. CNA 6 stated CNA 6 was feeding a resident (unidentified) next to the DON's office when CNA 6 heard Resident 77 scream and motioned CNA 6 to go over to Resident 77. CNA 6 stated as CNA 6 was<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | approaching towards Resident 77, CNA 6 saw Resident 86 scooted closer to Resident 77 and Resident 86 grabbed Resident 77's left breast. CNA 6 stated Resident 86 should not have been placed next to Resident 77 because of Resident 86's behavior [history]. During a concurrent observation and interview on 6/12/2026 at 12:21 PM with the Facility Dietician (FD), inside the North Nursing Station, Resident 86 was sitting in a wheelchair by LVN 1 for close monitoring. Resident 86 attempted to touch the FD's butt. The FD stated, Resident 86 had tried that before, twice.During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, the P&P indicated, residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This included but was not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse. The P&P indicated, to protect residents from abuse by anyone including other residents, to implement measures to address factors that may lead to abusive situations such as adequately preparing staff for caregiving responsibilities.During a review of the facility's P&P titled, Identifying Types of Abuse, revised September 2022, the P&P indicated abuse of any kind against residents was strictly prohibited. During a review of the facility's undated P&P titled, Resident Rights, the P&P indicated federal and state laws guaranteed certain basic rights to all residents of the facility including the resident's right to be free from abuse, neglect, misappropriation of property, and exploitation. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete and transmit the Minimum Data Set (MDS, a resident assessment tool) discharge assessment in a timely manner for one of two sampled residents (Resident 14) as indicated in the Centers for Medicare and Medicaid Service's (CMS, a federal agency that manages health care programs in the United States) Resident Assessment Instrument (RAI, a tool used by nursing homes to assess the needs, strengths, and preferences of residents, mandated by CMS) Manual.This deficient practice resulted in a late completion and transmission of Resident 14's discharge MDS to CMS' Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System (an MDS record that passes CMS' standard edits and is accepted into the system) which had the potential to affect the accuracy of Resident 14's clinical information used for care planning and quality reporting.Findings:During a review of Resident 14's Face Sheet (FS-admission record), the FS indicated Resident 14 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (irregular heartbeat), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and hypertension (HTN-high blood pressure).During a review of Resident 14's History and Physical (H&P) dated 1/23/2026, the H&P indicated Resident 14 did not have the capacity to understand and make decisions.During a review of Resident 14's Physicians Orders (PO), the PO indicated Resident 14 was discharged from the facility on 2/23/2026. During a review of Resident 14's Minimum Data Set (MDS, a resident assessment tool), dated 2/23/2026, the MDS's type of assessment indicated, Discharge assessment - return not anticipated.During an interview and concurrent record review on 6/10/2026 at 4:04 PM with the Minimum Data Sheet Nurse (MDSN) Resident 14's medical record was reviewed. The MDSN stated Resident 14 was discharged from the facility on 2/23/2026. The MDSN stated Resident 14's discharge MDS was not completed or submitted. The MDSN stated Resident 14's MDS must be submitted on time to ensure CMS is informed of Resident 14's location, condition, and the care the resident was receiving.During a review of the facility's CMS Submission Report (CMSSR) dated 6/11/2026, the CMSSR indicated Resident 14's discharge MDS, with a target date of 2/23/2026, was not transmitted until 6/11/2026, more than 14 days past the required submission timeframe.During an interview on 6/12/2026 at 2:49 PM with the MDSN, the MDSN stated the facility should follow the RAI rules and regulations regarding the MDS.During a review of the facility's policy and procedure (P&P) titled MDS Completion and Submission Timeframes, revised July 2017, the P&P's policy statement indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The P&P's policy interpretation and implementation indicated, Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual [RAI Manual].During a review of CMS's RAI Version 3.0 Manual, Chapter 2: Assessments for the RAI, (RAI Manual) dated October 2025, the RAI Manual indicated the discharge assessment with a return not anticipated should have a completion date no later than 14 calendar days after the discharge date . |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the Minimum Data Set (MDS, a resident assessment tool) accurately reflected the resident's condition for two (2) of 2 sampled residents (Resident 12 and Resident 79) by:Coding Resident 12 as receiving limb restraints when the resident was not using limb restraints.Coding Resident 79 as not having a serious mental illness when the resident had diagnosis of schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). This failure had the potential to result in an inaccurate representation of Resident 12's and Resident 79's clinical status, inappropriate care planning and interventions, and inaccurate quality measure reporting that may have impacted resident care.A. During a review of Resident 12's FS, the FS indicated the facility admitted Resident 12 on 1/22/2020, and readmitted the resident on 4/4/2026, with diagnoses which included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), schizophrenia (a mental illness that is characterized by disturbances in thought), and dementia (a progressive state of decline in mental abilities).<br><br>During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 2 required partial/moderate assistance with ADL and with mobility. Additionally, Section P of the MDS indicated Resident 2 was coded as using limb restraints less than daily.<br><br>During a review of the facility's Resident Matrix (RM), dated 6/9/2026, the RM indicated Resident 12 had physical restraints.<br><br>During an observation on 6/9/2026 at 9:39 AM, Resident 12 was observed seated in a wheelchair with no signs or symptoms of anxiety, agitation, or distress. No physical restraints were in use at the time of observation.<br><br>During a concurrent interview and record review on 6/11/2026 at 11:30 AM, Resident 12's MDS Section P was reviewed with Registered Nurse 1 (RN1)/MDS Assistant (MDSA). RN1/MDSA confirmed that Resident 12 had not required or utilized physical restraints. RN1/MDSA stated that the facility's practice was to implement and exhaust least restrictive measures before considering the use of physical restraints and that Resident 12 had not exhibited behaviors or clinical indications warranting such interventions. RN1/MDSA stated the MDS was coded inaccurately. RN1/MDSA stated accurate MDS documentation was important, as inaccurate coding misrepresented the resident's condition and care needs, impacted care planning and quality measures, and created an inaccurate representation of the resident's overall clinical status.<br><br>B. During a review of Resident 79's Face Sheet (FS), the FS indicated Resident 79 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, bipolar type, and major depressive disorder.<br><br>During a review of Resident 79's History and Physical (H&P), dated 3/15/2026, the H&P indicated Resident 79 had fluctuating capacity to understand and make decisions, but could make immediate need known.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 79's MDS, dated [DATE], the MDS indicated Resident 79's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 79 required partial/moderate assistance (helper does less than half the effort to complete the activity) to setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 79 had active diagnoses of anxiety disorder, depression (other than bipolar) and schizophrenia (e.g., schizoaffective and schizophreniform disorders) and was taking antidepressant medications. Section A1500 Preadmission Screening and Resident Review (PASRR - used to ensure individuals who have a mental disorder or intellectual disabilities are placed in the most appropriate setting and receive the services they need in those settings) of the MDS indicated Resident 79 is currently not considered by the state level II PASRR process to have serious mental illness.<br><br>During a concurrent interview and record review on 6/10/2026 at 2:43 PM with the MDS Nurse (MDSN), Resident 79's Individualized Determination Report (IDR) from DHCS (California Department of Health Care Services), dated 4/25/2025, and the MDS Section A1500 in PCC (Point Click Care – electronic health record) were reviewed. The IDR indicated a PASRR II was conducted on 4/24/2025 and indicated Resident 79 had a significant medical condition with mental stressors. The IDR indicated Resident 79 required nursing facility services due to a medical and/or mental health condition and specialized add-on services were needed. The MDS Section A1500 indicated a No answer to the question, Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? The MDSN stated, the answer should have been a Yes and the No answer was a coding error, just human error. The MDSN stated, an MDS was the total assessment of a resident (in general) and was submitted upon resident's admission to the facility, every quarter, annually, when there was a change of condition, upon discharge or transfer. The MDSN stated, Resident 79's MDS was last submitted on 4/3/2026. The MDSN stated, coding correctly and submitting an accurate MDS was important so facility would know how to provide the individualized care and needs of the resident.<br><br>During an interview on 6/11/2026 at 11:18 AM with the Director of Nursing (DON), the DON stated, the MDS was the assessment of a resident and identified the specific care needed and to be provided for the resident and it was important to submit an accurate MDS since the plan of care was based on the resident assessment.<br><br>During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, revised 11/2019, the P&P indicated, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment.<br><br>During a review of the facility's P&P titled, Resident Assessments, revised 3/2022, the P&P indicated, All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. The P&P indicated the resident assessment coordinator was responsible for ensuring that the interdisciplinary team conducted timely and appropriate resident assessments and reviews. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a baseline care plan for one of seven sampled residents (Resident 106) within 48 hours of the resident's admission.This deficient practice had the potential for Resident 106 not receiving necessary care and services.During a review of Resident 106's Face Sheet (FS), the FS indicated Resident 106 was admitted to the facility on [DATE] with diagnoses which included unsteadiness on feet and tobacco use. The FS indicated Resident 106 did not have any other diagnosis.During a review of Resident 106's History and Physical (H&P), dated 6/7/2026, the H&P indicated, Resident 106 lacked capacity to independently make and understand complex medical decisions due to schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and cognitive impairment (problems with mental functions like memory, thinking, learning, and decision-making).During an interview on 6/10/2026 at 1:58 PM with the Minimum Data Set (MDS - a resident assessment tool) Coordinator, the MDS Coordinator stated the baseline care plan for Resident 106 was initiated by the admitting nurse (unidentified) on 6/5/2026 but the baseline care plan had not been completed.During an interview on 6/10/2026 at 3:38 PM with the MDS Coordinator, the MDS Coordinator stated the baseline care plan was not completed and the MDS Coordinator had been working on completing it now.During a review of the facility's policy and procedure (P&P) titled, Baseline Care Plan, undated, the P&P indicated, Baseline care plan is required to be completed within 48 hours from the time of admission. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview, and record review, the facility failed to provide appropriate interventions to prevent the development or worsening of existing pressure injuries (PI, lesion/wound caused by unrelieved pressure usually over a bony area that results in damage of underlying tissue) for one of two sampled residents (Resident 2) when Resident 2's, who had a PI, low air loss mattress (LALM, special type of mattress used for both the prevention and treatment of PI, prioritizes moisture control and temperature regulation to prevent skin breakdown) was not set to the correct setting.This failure had the potential to result in delayed wound healing, worsening of Resident 2's PI, and the development of new PI's or skin breakdown to Resident 2.Findings:During a review of Resident 2's Face Sheet (FS-admission record), the FS indicated the facility admitted Resident 2 on 4/9/2026 with diagnoses including quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), mild protein-calorie malnutrition (not getting enough nutrients and calories, leading to weight and muscle loss), pressure ulcer (PU-localized damage to the skin and/or underlying tissue usually over a bony prominence), and muscle weakness.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated Resident 2's cognition (the ability to think and process information) was intact. The MDS indicated Resident 2 was dependent (helper does all of the effort) with activities of daily living (AOL, term used in healthcare that refers to self-care activities) and was dependent on mobility.During a review of Resident 2's Order Summary Report (OSR), dated active as of 6/12/2026, the OSR indicated Resident 2 had a physician's order for a LALM for wound care management to be set at 160 pounds (lbs.-a unit of weight).During a review of Resident 2's Care Plan (CP) titled Pressure Sore, initiated 4/17/2026, the CP indicated Resident 2 was at risk to develop pressure sores. The CP's interventions indicated, Staff will provide pressure relieving device/interventions as ordered [LALM] mattress.During a review of Resident 2's Weight Summary Report (WSR), dated 6/10/2026, the WSR indicated Resident 2 weighed 143 lbs. on 6/10/2026.During an observation on 6/10/2026 at 4:37 PM in Resident 2's room, Resident 2 was observed lying on Resident 2's right side on a LALM. The LALM control unit indicated the pressure dial was set to 200 lbs.During a concurrent interview and observation on 6/11/2026 at 9:45 AM with Licensed Vocational Nurse (LVN) 1, in Resident 2's room, Resident 2's LALM pressure dial was observed to be set at 200 lbs. LVN 1 stated the importance of setting the LALM correctly was to ensure the resident received appropriate pressure redistribution to prevent worsening of existing wounds and reduce the risk of additional skin breakdown. During a review of the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, revised March 2023, the P&P's purpose indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The P&P's preparation indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The P&P's prevention indicated, Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice.During a review of the facility's undated Operation Manual (LALM manual), the LALM manual's weight/pressure set up indicated, users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055126 | A. Building<br>B. Wing | 06/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Chino Valley Health Care Cente | 2351 S Towne Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four residents' (Resident 4) environment remained as free of accident (any unexpected or unintentional incident, which results or may result in injury or illness to a resident) hazards as possible when Resident 4 was observed biting and chewing on a towel.This deficient practice had the potential to cause teeth or gum damage, jaw strain and/or choking to Resident 4 risking Resident 4's overall physical health.Findings:During a review of Resident 4's Face Sheet (FS-admission record), the FS indicated Resident 4 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (a condition where the brain is temporarily confused or impaired), unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, with other behavioral disturbance, and dysphagia, oropharyngeal phase (difficulty initiating a swallow due to problems in the mouth or throat).During a review of Resident 4's History and Physical (H&P), dated 2/4/2026, the H&P indicated Resident 4 had fluctuating capacity to understand and make decisions, but could make immediate needs known.During a review of Resident 4's Care Plan (CP), titled Altered behavior patterns related to impulse control disorder.Noted biting his blanket and biting his elbow/hand splints, revised date 3/3/2026, the CP indicated interventions including to provide reality awareness and redirection as needed.During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 4/27/2026, the MDS indicated Resident 4's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 4 was dependent (helper does all of the effort) with activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a concurrent observation and interview on 6/9/2026 at 12:54 PM with Certified Nursing Assistant (CNA) 2, in Resident 4's room, Resident 4 was observed in bed with the head of bed flat. Resident 4 was observed groaning while biting down and chewing on a towel. CNA 2 stated Resident 4 usually bites. CNA 2 stated the towel should not have been left with Resident 4 to prevent Resident 4 from choking. CNA 2 stated a staff (unnamed) might have forgotten to remove the towel after cleaning Resident 4.During an interview on 6/9/2026 at 1:01 PM with Licensed Vocation Nurse (LVN) 3, LVN 3 stated Resident 4 did not eat and had a gastrostomy tube (GT- a surgical opening fitted with a device to allow feedings and/or medications to be administered directly to the stomach common for people with swallowing problems). LVN 3 stated Resident 4 was always biting down and chewing on a towel.During an interview on 6/12/2026 at 11:42 AM with the Director of Nursing (DON), the DON stated Resident 4 was confused and had a habit of obsessive- compulsive behavior (a mental disorder in which you have thoughts [obsessions] and rituals [compulsions] over and over) and was purposely provided a blanket (to bite down/chew on), not a towel, and should have been monitored to prevent Resident 4 from choking. The DON stated the facility should have addressed the use and approval of a towel with Resident 4's family (unnamed) during the Interdisciplinary Team (IDT- a group of healthcare professionals from various disciplines who collaborate, assess, coordinate, and manage each resident's comprehensive health care, including his or her medical, psychological, social, and functional needs) meeting.During a review of the facility's policy and procedures (P&P) titled, Safety and Supervision of Residents, revised July 2017, the P&P indicated the facility strived to make the environment as free from accident hazards as possible. The P&P indicated resident safety and supervision and assistance to prevent accidents were facility-wide priorities. The P&P indicated the facility's individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055126 | A. Building<br>B. Wing | 06/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Chino Valley Health Care Cente | 2351 S Towne Avenue<br>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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of seven sampled residents (Resident 106) when Resident 106's Face Sheet (FS-admission record) did not indicate a complete cumulative diagnosis list (a complete list of a resident's active medical diagnoses).This deficient practice resulted in incomplete documentation for Resident 106 and had the potential to result in Resident 106's medical needs not being addressed.Findings:During a review of Resident 106's FS, dated 6/10/2026, timed at 9:43 AM, the FS indicated Resident 106 was admitted to the facility on [DATE]. The FS's diagnosis information indicated unsteadiness on feet and tobacco use.During a review of Resident 106's History and Physical (H&P), dated 6/7/2026, the H&P indicated Resident 106 lacked capacity to independently make and understand complex medical decisions due to chronic (persistent or long-lasting) schizophrenia (a mental illness characterized by disturbances in thought), dementia (the loss of the ability to think, remember, and reason that affect daily life and activities), and cognitive (the ability to think and process information) impairment. The H&P indicated major healthcare decisions should involve Resident 106's responsible party and designated surrogate decision-maker.During a concurrent interview and record review on 6/10/2026 at 1:58 PM with the Minimum Data Set Nurse (MDSN), Resident 106's FS was reviewed. The MDSN stated Resident 106's FS did not indicate a complete cumulative diagnosis list for Resident 106. The MDSN stated the cumulative diagnosis list should be completed as soon as possible.During a review of the facility's policy and procedure (P&P) titled, Cumulative Diagnosis List Policy and Procedures, revised 9/20/2022, the P&P's purpose indicated, [The] Cumulative Diagnosis list is intended to incorporate all active diagnoses including primary diagnosis and conditions that are part of the resident's current plan. It is to be completed within 72 hours of admission by the licensed nurse and authenticated by the attending physician with the signature. The list serves as a communication tool for healthcare professionals.to identify.diagnoses.in addition to generating an.accurate picture of the resident's current health status.During a review of the facility's P&P titled, Charting and Documentation, revised July 2017, the P&P's policy statement indicated. All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P's policy interpretation and implementation indicated, Documentation in the medical record will be . complete and accurate. |