

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2024
NAME OF PROVIDER OR SUPPLIER Pomona Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 651 N Main St Pomona, CA 91768	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198</p> <p>Based on interview and record review, the facility failed to readmit Resident 1 back to the facility from the General Acute Care Hospital (GACH) 2 as indicated in the facility's policy and procedure titled, Readmission to Facility.</p> <p>This deficient practice violated Resident 1's right to return to the facility.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated, the facility initially admitted Resident 1 to the facility on [DATE] and readmitted Resident 1 on 3/19/2024, with diagnoses that included cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), epilepsy (a brain condition that causes repeated seizures), and dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/6/2023, the MDS indicated, Resident 1 had the ability to understand others and was understood by others. The MDS indicated, Resident 1 required setup or clean-up assistance (helper set up or cleaned up; helper assisted only prior to or following the activity) with eating and oral hygiene and required supervision or touching assistance (helper provided verbal cues and touching/steadying as resident completed activity) with toileting, dressing, and putting on/taking off footwear.</p> <p>During a review of Resident 1's Physician's Order (PO), dated 4/28/2024, timed at 12:12 am, the PO indicated an order to send Resident 1 to GACH 1 for further evaluation and treatment for psychosis (a mental disorder characterized by disconnection from reality) and physical altercation causing injury to another resident.</p> <p>During a review of Resident 1's Nurses Progress Note (NPN), dated 4/28/2024 at 3:20 am, the NPN indicated, the transport personnel picked up Resident 1 and Resident 1 left the facility at 3 am.</p> <p>During a review of Resident 1's Notice of Proposed Transfer/Discharge (NPT), dated 4/28/2024, untimed, the NPT indicated, Resident 1 was transferred to GACH 1. The NPT indicated, the transfer/discharge was necessary for the resident's welfare and the resident's needs cannot be met in the facility.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's clinical record, the clinical record indicated there was no bed-hold documented for Resident 1.</p> <p>During an interview on 5/1/2024 at 4:55 pm with the Director of Case Management (DCM) from GACH 2, DCM stated Resident 1 was currently at GACH 2 (transferred from GACH 1). The DCM stated GACH 2's case manager contacted the facility on 4/29/2024 to transfer Resident 1 back to the facility and the facility declined to accept Resident 1 back. DCM stated GACH 2's case manager had to start looking for another facility for Resident 1 to go to.</p> <p>During an interview on 5/1/2024 at 5:04 pm with the Director of Business Development (DBD), the DBD stated he spoke to GACH 2's case manager on 4/29/2024 and the DBD informed GACH 2's case manager that the facility was not going to accommodate Resident 1 back to the facility. The DBD stated when he spoke to GACH 2's case manager, the facility decided they were not going to readmit Resident 1.</p> <p>During an interview on 5/1/2024 at 5:04 pm with the Administrator (ADM), the ADM stated it was not safe to accept/readmit Resident 1 back to the facility.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Readmission to Facility, revised on 12/19/2022, the P&P indicated, the facility protected the resident's right to readmission by initiating a bed-hold and permitting each resident to return to the facility after they were hospitalized or placed on therapeutic leave, regardless of payment source. The P&P indicated, the facility initiated a bed-hold and permitted residents to return to the facility and resume residence after they were hospitalized or placed on therapeutic leave.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37198</p> <p>Based on interview and record review, the facility failed to perform neurological checks (neuro checks, an assessment tool that evaluated the brain and nervous system [the body's command center that included the brain, spinal cord, and nerves] functioning) as indicated in the facility's policy and procedure (P&P) titled, Head Injury, for one of two sampled residents (Resident 1), after a change in condition.</p> <p>This deficient practice had the potential to place Resident 1 at risk for any neurological (relating to disorders of the nervous system) issues not being identified.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated, the facility initially admitted Resident 1 to the facility on [DATE] and readmitted Resident 1 on 3/19/2024, with diagnoses that included cerebral infarction (stroke - damage to tissues in the brain due to a loss of oxygen to the area), epilepsy (a brain condition that causes repeated seizures), and dementia (the loss of the ability to think, remember, and reason to levels that affect daily life and activities).</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/6/2023, the MDS indicated, Resident 1 had the ability to understand others and was understood by others. The MDS indicated, Resident 1 required setup or clean-up assistance (helper set up or cleaned up; helper assisted only prior to or following the activity) with eating and oral hygiene and required supervision or touching assistance (helper provided verbal cues and touching/steadying as resident completed activity) with toileting, dressing, and putting on/taking off footwear.</p> <p>During a review of Resident 1's Nurse Progress Note (NPN), dated 3/16/2024, timed at 1 am, the NPN indicated, Resident 1 had been aggressively exit seeking (actively trying to leave an area) since last night. The NPN indicated, nothing was noted on Resident 1's head and face while asleep. The NPN indicated, the lump and redness on forehead and scratch on bridge of nose was noted this morning upon resident waking up (time not specified).</p> <p>During a review of Resident 1's eINTERACT Change in Condition Evaluation, (COC), dated 3/16/2024, timed at 9 am, the COC indicated at 7 am (on 3/16/2024), Resident 1 was noted with a lump with redness on the left side of the forehead, redness on top of the lump on the head, and a small scratch on the bridge of the nose. The COC indicated, staff notified Resident 1's physician and the physician ordered to monitor Resident 1 for 72 hours.</p> <p>During a review of Resident 1's clinical record, Resident 1's clinical record indicated there were no neuro checks done for Resident 1 after the change in condition on 3/16/2024.</p> <p>During an interview on 5/1/2024 at 3:47 pm with Registered Nurse 1 (RN 1), RN 1 stated neuro check needed to be done for Resident 1 to make sure there were no deficits (shortage in amount) or any changes in mental status (state of mind of a person). RN 1 stated staff needed to check if the head was affected, if motor skills (muscle movements people use daily) were affected, and if the resident had slurred speech (there is weakness in the muscles used for speaking).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/1/2024 at 5:12 pm with the Director of Nursing (DON), the DON stated the morning shift staff found Resident 1 with a bump on the forehead on 3/16/2024. The DON stated the NPN only indicated Resident 1 was exit seeking and nobody witnessed anything else. The DON stated neuro checks were done to check for any changes in mental status. The DON stated a neuro check should have been done for Resident 1.</p> <p>During a review of the facility's P&P titled, Head Injury, revised on 3/25/2024, the P&P indicated, the facility reported potential head injuries to the physician and implemented interventions to prevent further injury. The P&P indicated, assess resident following a known, suspected, or verbalized head injury. The P&P indicated, the assessment may include the following . neurological evaluation for changes in physical functioning, behavior, cognition, level of consciousness, dizziness, nausea, irritability, slurred speech or slow to answer questions . Any injuries to head, neck, eyes, or face, including lacerations, abrasions, or bruising . Perform neuro checks as indicated or as specified by the physician.</p>