STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055282	A. Building B. Wing	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomona Vista Care Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 42307 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 2) was free from physical abuse from Resident 3 who had just hit another resident (Resident 1) by failing to provide a 1:1 (providing one to one continuous nursing or observation care to an individual patient with behavioral problems for a period of time) supervision to Resident 3, in accordance with Resident 3'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 The resident has a behavior problem . This deficient practice resulted in Resident 3 hitting Resident 2 after an incident involving Resident 3 who had hit Resident 1 the previous day. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with multiple diagnoses including spinal stenosis (abnormal narrowing), site unspecified and unspecified dementia (a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons), unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 1's History and Physical (H&P), dated 1/26/24, the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screening tool), dated 4/24/24, the MDS indicated, Resident 1's BIMS (Brief Interview for Mental Status) Score indicated severely impaired cognition (ability to think and process information) status. During a review of Resident 1's Progress Notes (PN), dated 5/16/24, at 7:15 a.m., the PN, indicated, Resident 1 was tapped on the shoulder by Resident 3. The PN, indicated, Resident 3 denied tapping Resident 1 on the shoulder but Resident 1 was So scared to what have happened. (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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Change in Condition (COC), dated 5/16/24, at 7:16 a.m., the COC, indicated, Resident 1 stated, Resident 1 was hit in the arm by her roommate (Resident 3) next to Resident 1's bed. During a review of Resident 1's PN, dated 5/16/24, at 8:30 a.m., the PN, indicated, a rehab staff (unidentified) reported to charge nurse that Resident 1 was hit on the arm by Resident 3. During a review of Resident 1's Change in Condition (COC), dated 5/16/24, at 10:45 a.m., the COC, indicated, Resident 1 complained to the charge nurse (unidentified) that roommate (Resident 3) also hit Resident 1 in the head. During a review of Resident 1's Care Plan, initiated on 5/16/24, the CP, indicated, assessment revealed suspected abuse. During a review of Resident 2's AR, the AR indicated, Resident 2 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including muscle weakness (generalized) and dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. During a review of Resident 2's H&P, dated 6/29/23, the H&P indicated, Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated, Resident 2's BIMS Score indicated Resident 2 was moderately impaired cognitively. During a review of Resident 2's PN, dated 5/17/24, at 6:45 a.m., the PN, indicated, Resident 2 claimed Resident 2 was tapped on the left outer wrist by roommate, Resident 3. The PN, indicated, the incident started when Resident 3 tried to get personal belongings from Resident 2's cabinet. Resident 2 shouted at Resident 3 to stop getting in Resident 2's cabinet but Resident 3 went to Resident 2's bedside and tapped Resident 2 on the upper left outer wrist and stated, Shut up! The PN indicated, charge nurse (unidentified) placed a 1:1 CNA (Certified Nursing Assistant, unidentified) in the room. During a review of Resident 2's COC, dated 5/17/24, at 6:45 a.m., the COC, indicated, Resident 2 got tapped on the left upper wrist by roommate, Resident 3. During a review of Resident 2's CP, date initiated 5/17/24, the CP, indicated, assessment revealed suspected abuse. During a review of Resident 3's AR, the AR indicated, Resident 3 was newly admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and unspecified psychosis not due to a substance or known physiological condition. During a review of Resident 3's PN, dated 5/11/24, timed at 1:59 a.m., the PN, indicated, Resident 3 had history of dementia (wandering around). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's PN, dated 5/11/24, timed at 3:11 p.m., the PN, indicated, Resident 3 was ambulatory and wandered, walked all over the facility, wandered off to other resident's room and took other resident's belongings. During a review of Resident 3's H&P, dated 5/13/24, the H&P indicated, Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Resident 3's BIMS Score indicated Resident 3 was severely impaired cognitively. The MDS indicated, Resident 3 exhibited other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and significantly intruded on the privacy or activity of others and disrupted care or living environment. The MDS indicated, Resident 3 had a behavior of wandering daily that significantly intruded on the privacy or activities of others. During a review of Resident 3's CP, date initiated 5/15/24, the CP, indicated, Resident 3 had a behavior problem. The CP, indicated one of the interventions initiated on 5/16/24 included a 1:1 supervision as needed. During a review of Resident 3's PN, dated 5/16/24, timed at 3:27 p.m., the PN, indicated, Resident 3 was monitored at this time due to s/p (status post) incident of hitting roommate on the arm and head. During a review of Resident 3's PN, dated 5/17/24, at 3:20 p.m., the PN, indicated, Resident 3 was monitored for behavior of hitting Resident 3's roommate on the arm and other roommate on the left wrist and getting belongings from other residents and still having episode of hitting other residents. During an interview on 5/21/24 at 10:24 a.m. with Resident 1, Resident 1 stated, roommate, Resident 3 hit Resident 1 on the head. Resident 1 stated, Resident 1 cried, and a staff (unidentified) got Resident 3 out of the room. Resident 1 stated, Resident 1 had pain but now no more. During a concurrent observation and interview on 5/21/24 at 11:12 a.m., with CNA 1, Resident 3 was in bed. CNA 1 stated, CNA 1 was doing a 1:1 supervision since Resident 3 gets into things and had hit a resident. Resident 3 denied hitting a resident, became uncooperative and got slightly restless (inability to rest or relax) during the interview. During a concurrent observation and interview on 5/21/24 at 11:24 a.m. with Resident 2, Resident 2 had a small reddish colored bruise on the left wrist. Resident 2 stated, roommate, Resident 3 was slamming the closet doors and going thru everybody's clothes then approached Resident 2 and hit Resident 2's left wrist. Resident 2 stated, Resident 2 screamed and woke the other roommate up and the staff came. Resident 2 stated, Resident 2 had some pain and tenderness on the left wrist but did not notify staff. During an interview on 5/21/24 at 1:04 p.m. with the Occupational Therapy Assistant (OTA), the OTA stated, Resident 3 was confused and had days where Resident 3 had some irritation, agitation, and impulsive tendencies. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/21/24 at 3:24 p.m., with the Registered Nurse (RN), the facility's Census and Staff Assignment (SA), were reviewed. The SA indicated, on 5/16/24 during the evening shift (3:00 p.m. to 11:00 p.m.) and night shift (11:00 p.m. to 7:00 a.m.), there was no 1:1 staff supervision assigned to Resident 3. RN stated, 1:1 meant the CNA was specifically assigned to the resident and to focus on the resident 1:1. RN stated, based on the SA schedule on 5/16/24, there was no 1:1 staff supervision assigned to Resident 3. During an interview on 5/22/24 at 9:04 a.m. with CNA 3, CNA 3 stated, CNA 3 worked on the night shift of 5/16/24. CNA 3 stated, CNA 3 had four resident rooms assigned including the room where Resident 3 was. CNA 3 stated, CNA 3 was assigned to Resident 3 but was not assigned as a 1:1 supervision to Resident 3. CNA 3 stated, a 1:1 supervision was to watch the patient properly, maybe the patient has behavior problems and to keep the residents safe. During an interview on 5/22/24 at 9:21 a.m. with Resident 2, Resident 2 stated, there was no staff assigned as 1:1 supervision to Resident 3 or staff assigned to the room only. Resident 2 stated, Resident 3 got a 1:1 after she hit me. During an interview on 5/22/24 at 9:29 a.m. with the Licensed Vocational Nurse (LVN), the LVN stated, there was no documented evidence that a 1:1 supervision was provided to Resident 3. During an interview on 5/22/24 at 10:20 a.m. with the Director of Nursing (DON), the DON stated, Resident 3 had history of dementia and unspecified psychosis. The DON stated agitation was the most common behavior for residents with dementia. The DON stated, agitation could potentially lead to a lot, might be hitting other people. The DON stated, a 1:1 supervision was not provided to Resident 3 right away because the DON did not expect Resident 3 to hit another resident. During an interview on 5/22/24 at 11:05 a.m. with CNA 1, CNA 1 stated, there was no specific documentation for 1:1 supervision and was just communicated with the CNA staff assigned to the room. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, date revised 12/19/22, the P&P indicated, it was the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The P&P indicated, the facility would make efforts to ensure all residents were protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation that included but not limited to increased supervision of the alleged victim and residents. During a review of the facility's P&P, titled Accidents and Supervision, date revised 12/19/22, the P&P indicated, each resident will receive adequate supervision to prevent accidents that include implementing interventions. The P&P indicated the facility would provide adequate supervision to prevent accidents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Residents 1, Resident 2) were free from physical abuse from Resident 3 by failing to ensure Resident 3 who was newly admitted to the facility and diagnosed with dementia (a general term to describe a group of symptoms related to loss of memory, judgment, language, complex motor skills, and other intellectual function, caused by the permanent damage or death of the brain's nerve cells, or neurons) was provided and received the appropriate treatment (specific treatment?) and services to attain or maintain Resident 3 ' s highest practicable physical, mental, and psychosocial well-being. This deficient practice resulted in Resident 1 and Resident 2 being physically abused by Resident 3. Findings: During a review of Resident 1 ' s Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE] with multiple diagnoses that included spinal stenosis (abnormal narrowing), site unspecified and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic (disconnection from reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 1 ' s History and Physical (H&P), dated 1/26/24,the H&P indicated, Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s most recent Minimum Data Set (MDS, an assessment and screening tool), dated 4/24/24, the MDS indicated, Resident 1 ' s BIMS (Brief Interview for Mental Status) Score indicated Resident 1 had severely impaired cognition (ability to think and process information) status. During a review of Resident 1 ' s Progress Notes (PN), dated 5/16/24, at 7:15 a.m., the PN, indicated, Resident 1 was tapped on the shoulder by Resident 3. The PN, indicated, Resident 3 denied tapping Resident 1 on the shoulder but Resident 1 was Soscared to what have happened. During a review of Resident 1 ' s Change in Condition (COC) form, dated 5/16/24, at 7:16 a.m., the COC, indicated, Resident 1 stated, Resident 1 was by hit by Resident 3. During a review of Resident 1 ' s PN, dated 5/16/24, timed at 8:30 a.m., the PN, indicated, Resident 1 was hit on the arm by Resident 3. During a review of Resident 1 ' 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), date initiated 5/16/24, the CP, indicated, assessment revealed suspected abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s AR, the AR indicated, Resident 2 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses that included muscle weakness (generalized) and dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. During a review of Resident 2 ' s H&P, dated 6/29/23, the H&P indicated, Resident 2 had fluctuating capacity to understand and make decisions. During a review of Resident 2 ' s MDS, dated [DATE], the MDS indicated, Resident 2 ' s BIMS Score indicated moderately impaired cognition status. During a review of Resident 2 ' s PN, dated 5/17/24, at 6:45 a.m., the PN, indicated, Resident 2 claimed Resident 2 was tapped on the left outer wrist by roommate, Resident 3. The PN, indicated, the incident started when Resident 3 tried to get personal belongings from Resident 2 ' s cabinet. Resident 2 shouted at Resident 3 to stop getting in Resident 2 ' s cabinet but Resident 3 went to Resident 2 ' s bedside and tapped Resident 2 on the upper left outer wrist and stated, Shut up! The PN indicated, the charge nurse (unidentified) placed a 1:1 (providing one to one continuous nursing or observation care to an individual patient with behavioral problems for a period of time) CNA (Certified Nursing Assistant, unidentified) in the room. During a review of Resident 2 ' s COC, dated 5/17/24, at 6:45 a.m., the COC, indicated, Resident 2 got tapped on the left upper wrist by roommate, Resident 3. During a review of Resident 2 ' s CP, date initiated 5/17/24, the CP, indicated, assessment revealed suspected abuse. During a review of Resident 3 ' s AR, the AR indicated, Resident 3 was newly admitted to the facility on [DATE] with multiple diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic (a mental disorder characterized by disconnection from reality) disturbance, mood disturbance, and anxiety and unspecified psychosis not due to a substance or known physiological condition. During a review of Resident 3 ' s H&P, dated 5/13/24, the H&P indicated, Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3 ' s MDS, dated [DATE], the MDS indicated, Resident 3 ' s BIMS Score indicated severely impaired cognition status. The MDS indicated, Resident 3 exhibited other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing,or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) and significantly intrude on the privacy or activity of others and disrupt care or living environment. The MDS indicated, Resident 3 had a behavior of wandering daily that significantly intruded on the privacy or activities of others. During a review of Resident 3 ' s PN, dated 5/11/24, at 1:59 a.m., the PN, indicated, Resident 3 had a history of dementia (wandering around). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3 ' s PN, dated 5/11/24, at 3:11 p.m., the PN, indicated, Resident 3 was ambulatory and wandered, walked all over the facility, wandered off to other resident ' s room and took other resident ' s belongings. During a review of Resident 3 ' s CP, date initiated 5/15/24, the CP, indicated, Resident 3 had a behavior problem. During a review of Resident 3 ' s PN, dated 5/16/24, at 3:27 p.m., the PN, indicated, Resident 3 was monitored at this time due to s/p (status post) incident of hitting roommate on the arm and head. During a review of Resident 3 ' s PN, dated 5/17/24, at 3:20 p.m., the PN, indicated, Resident 3 was monitored for behavior of hitting roommate on the arm and other roommate on the left wrist and getting belongings from other residents and still having episode of hitting other residents. During an interview on 5/21/24 at 10:24 a.m. with Resident 1, Resident 1 stated, roommate, Resident 3 hit Resident 1 on the head. Resident 1 stated, Resident 1 cried, and a staff (unidentified) got Resident 3 out of the room. Resident 1 stated, Resident 1 had pain but now no more. During a concurrent observation and interview on 5/21/24 at 11:12 a.m., with CNA 1, Resident 3 was in bed. CNA 1 stated, CNA 1 was doing a 1:1 supervision since Resident 3 gets into things and had hit a resident. Resident 3 denied hitting a resident, became uncooperative and got slightly restless (inability to rest or relax) during the interview. During a concurrent observation and interview on 5/21/24 at 11:24 a.m. with Resident 2, Resident 2 had a small reddish colored bruise on the left wrist. Resident 2 stated, roommate, Resident 3 was slamming the closet doors and going thru everybody ' s clothes then approached Resident 2 and hit Resident 2 ' s left wrist. Resident 2 stated, Resident 2 screamed and woke the other roommate up and the staff came. Resident 2 stated, Resident 2 had some pain and tenderness on the left wrist but did not notify staff. During an interview on 5/21/24 at 1:04 p.m. with the Occupational Therapy Assistant (OTA), the OTA stated, Resident 3 was confused and had days where Resident 3 had some irritation, agitation, and impulsive tendencies. During an interview on 5/22/24 at 10:20 a.m. with the Director of Nursing (DON), the DON stated, Resident 3 had a history of dementia and unspecified psychosis. The DON stated agitation was the most common behavior for residents with dementia. The DON stated, agitation could potentially lead to a lot, might be hitting other people. The DON stated, the facility was required to have an IDT (Interdisciplinary Team, a group of health care professionals with various areas of expertise who work together toward the goals of their patients) to be able to provide better care, but the incidents (physical abuse) had already happened prior to doing the IDT. The DON stated, residents admitted with dementia had the same needs as the rest of the residents and there is no difference in assessment and care provided to residents who had dementia and residents who did not have dementia. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 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, Dementia Care, date revised 12/19/22, the P&P indicated, it was the policy of the facility to provide the appropriate treatment and services to every resident who displays signs of, or is diagnosed with dementia, to meet his or her highest practicable physical, mental, and psychosocial well-being. The P&P indicated, the facility will assess, develop, and implement care plans through an IDT approach that includes the resident, their family, and/or resident representative, to the extent possible.