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Form Approved OMB
No. 0938-0391

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	06/07/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36924 Based on interview and record review, the facility failed to monitor and supervise one of three sampled residents (Resident 8) by failing to ensure Resident 8 did not wander (to go about from place to place usually without a plan or definite purpose) into other residents' rooms. This failure had the potential to result in resident-to-resident altercation involving Resident 8 and had the potential to cause injury/harm to Resident 8 and/or other residents. Findings: During a review of Resident 8's Admission Record (AR), the AR indicated the facility initially admitted Resident 8 to the facility on [DATE], and readmitted Resident 8 on 12/8/23, with diagnoses that included COVID-19 (minor to severe respiratory illness caused by a virus and spread from person to person), unspecified psychosis (mental disorder causing disconnection from reality), and unspecified dementia with other behavioral disturbance (a group of thinking and social symptoms that interfered with daily functioning). During a review of Resident 8's untitled Care Plan (CP) dated 10/10/23, the CP indicated Resident 8 was at risk for wandering/elopement (leaving the facility without notice) with episodes of going to another (resident's) room. The CP interventions indicated visual supervision will be rendered by staff at all times. During a review of Resident 8's History & Physical (H&P), dated 10/12/23, the H&P, indicated Resident 8 did not have the capacity to understand and make decisions. A review of Resident 8's Minimum Data Sheet (MDS, a standardized assessment and care planning tool), dated 4/15/24, the MDS indicated Resident 8 had severely impaired cognition (ability to think, learn, remember, use judgement, and make decisions) required supervision or touching assistance to walk 50 to 150 feet and was independent to walk 10 feet. During a review of Resident 8's untitled CP revised on 4/23/24, the CP indicated Resident 8 was an elopement risk and was a wanderer. The CP interventions indicated visual check for safety precaution. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/24 at 3:28 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 8 would go around the facility and look inside different residents' rooms. LVN 1 stated Resident 8 would sometimes get stuff of other residents and touch other residents' blanket. During an interview on 6/6/24 at 3:53 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 8 was a wandering resident who walked around the facility and needed redirection. CNA 1 stated CNA 1 had seen Resident 8 go inside other residents' rooms. CNA 1 stated Resident 8 would stand in other residents' rooms but did not take anything from other residents. CNA 1 stated there was no 1:1 sitter (one staff stayed and directly supervised one resident) for Resident 8. During an interview on 6/6/24 at 4:12 p.m. with LVN 2, LVN 2 stated Resident 8 was usually a wanderer and walked around the facility a lot. LVN 2 stated LVN 2 had seen Resident 8 go into other residents' rooms. LVN 2 stated Resident 8 usually walked in and out of other residents' rooms and other residents' bathrooms. LVN 2 stated Resident 8 was confused and at times would take things from his roommates, but Resident 8 would give it right back. LVN 2 stated Resident 8 would touch other residents' blankets and beds but had not heard any residents complain that Resident 8 touched them inappropriately. During an interview on 6/7/24 at 9:36 a.m. with Resident 12, Resident 12 stated Resident 8 wandered around the facility and into Resident 12's room and would use Resident 12's bathroom. During an interview on 6/7/24 at 3:13 p.m. with the Business Office Manager (BOM), the BOM stated the BOM had seen Resident 8 wandering around the facility a lot. The BOM stated the BOM had observed Resident 8 standing in front of other residents' room doors. During an interview on 6/7/24 at 3:14 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 8 had a history of wandering in the hallway and into different residents' rooms. The DSD stated the staff were aware Resident 8 wandered into other residents' room and knew to redirect Resident 8 when Resident 8 would go inside other residents' rooms. The DSD stated the facility did not provide a 1:1 sitter for Resident 8 but facility nurses were instructed to monitor and supervise Resident 8. The DSD stated Resident 8 had dementia. The DSD stated it was important to closely monitor dementia residents for safety and protection of residents. The DSD stated there was no specific monitoring or supervision schedule for Resident 8. During an interview on 6/7/24 at 3:40 p.m. with Resident 5, Resident 5 stated Resident 8 wandered all the time into his room and other residents' rooms. During an interview on 6/7/24 at 4:23 p.m. with the Social Services Director (SSD), the SSD stated Resident 8 was confused and wandered around the facility. The SSD stated the staff must monitor and redirect Resident 8 when he wandered inside other residents' rooms. The SSD stated at times, the SSD would hear other residents telling Resident 8 to get out of their rooms and Resident 8 would usually leave. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pomona Vista Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 651 N Main St Pomona, CA 91768	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/7/24 at 4:35 p.m. with LVN 1, LVN 1 stated Resident 8 was very confused and always wandered around the facility. LVN 1 stated residents would yell at Resident 8 and would ask Resident 8 to get out of their rooms. LVN 1 stated all facility staff including housekeeping and kitchen staff were aware of Resident 8's wandering behavior and would monitor Resident 8. LVN 1 stated some families had complained about Resident 8 going into their family member's rooms. LVN 1 stated the facility had not considered 1:1 supervision for Resident 8's wandering or dementia related behaviors. LVN 1 stated it was important to provide monitoring and supervision for residents with wandering and dementia related behaviors to prevent harm and ensure safety of residents. During a review of the facility's policy and procedure (P&P) titled Accidents and Supervision, dated 12/19/2022, the P&P indicated each resident received adequate supervision to prevent accidents. This included implementing interventions to reduce hazard(s) and risk(s). The P&P indicated adequacy of supervision: defined by type and frequency and based on the individual resident's assessed needs and identified hazards in the resident environment.