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	08/09/2024

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on observation, interview, and record review, the facility failed to protect a resident's right to remain free from physical abuse (willful infliction of injury, deliberate aggressive or violent behavior with the intention to cause harm) for one of two sampled residents (Resident 2) by failing to protect Resident 2 from being hit by Resident 3. On 8/6/2024, Resident 3 hit Resident 2 on Resident 2's chest. This failure had the potential to result in Resident 2 feeling afraid and not safe while under the care of the facility. Findings: 1. During a review of Resident 2's Admission Record (AR), the AR indicated, the facility admitted Resident 2 to the facility on [DATE], with diagnoses including hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) of the right side, personal history of cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain), and muscle weakness. During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 6/3/2024, the MDS indicated, Resident 2 had no impairment in cognitive skills (ability to make daily decisions). The MDS indicated, Resident 2 required setup or clean-up assistance from staff for eating, toileting, and oral and personal hygiene. During a review of Resident 2's, SBAR (Situation-Background-Assessment-Recommendation) Communication Form (SBAR), dated 8/6/2024, timed at 5 pm, the SBAR indicated on 8/6/2024, untimed, while Resident 2 was sitting in his wheelchair next to his room, Resident 3 tried to go inside Resident 2's room. The SBAR indicated, Resident 3 came very fast and tried to push his (Resident 2's) w/c (wheelchair) and (Resident 2) tried to stop his w/c and Resident 3 was upset and he (Resident 3) swing his hand very fast, and his hand hit on (Resident 2's) chest. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 3's AR, the AR indicated, the facility originally admitted Resident 3 to the facility on [DATE], and readmitted Resident 3 on 6/10/2024, with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning) with behavioral disturbance, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), and chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). During a review of Resident 3's MDS, dated [DATE], the MDS indicated, Resident 3 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated, Resident 3 required supervision or touching assistance from staff for dressing, toileting, bathing, and walking 150 feet. During a review of Resident 3's, SBAR, dated 8/6/2024, timed at 5:30 p.m., the SBAR indicated on 8/6/2024, untimed, Resident 3 had a change of condition when Resident 3 exhibited Physical aggression and Agitation/Angry towards resident and staff. The SBAR indicated, Resident 3 swung his hand very fast and hit Resident 2 on Resident 2's chest. During a review of Resident 3's care plan titled, Aggressive behavior ., initiated 4/6/2024, the care plan indicated Resident 3 had a history of hitting staff. During an interview on 8/8/2024 at 10:41 a.m. with the Activities Assistant (AA) 1, AA 1 stated AA 1 was conducting an activity with residents (in general) in the hallway outside Resident 2's room. AA 1 stated Resident 2 was sitting in his w/c in the hallway next to Resident 2's room. AA 1 stated Resident 3 was a confused resident. AA 1 Stated Resident 3 was trying to walk into Resident 2's room so AA 1 tried to redirect Resident 3 away from Resident 2's room. AA 1 stated Resident 3 was trying to push Resident 2's w/c. AA 1 stated AA 1 was redirecting Resident 3 from pushing Resident 2's w/c. AA 1 stated Resident 3 became upset because AA 1 was trying to redirect Resident 3. AA 1 stated AA 1 did not see Resident 3 hit Resident 2 because it happened so fast. During an observation and interview on 8/8/2024 at 11:10 a.m. with Resident 2, Resident 2 stated Resident 3 was a confused resident who walked in the hallways. Resident 2 stated Resident 3 was lost. Resident 2 stated Resident 3 hit Resident 2 on Resident 2's chest. Resident 2 demonstrated that Resident 3 had a closed fist when Resident 3 hit Resident 2 on the chest. Resident 2 stated it was like Resident 3 was trying to pat Resident 2 like a dog but that the patting action was hard. During an observation and interview on 8/8/2024 at 3:04 p.m. with Certified Nursing Assistant (CNA) 1, Resident 3 was lying in bed. CNA 1 stated CNA 1 was the 1:1 (staff person with resident at all times) CNA assigned to Resident 3. CNA 1 stated Resident 3 could get physically aggressive sometimes. CNA 1 stated Resident 3 had punched and kicked CNA 1 in the past. CNA 1 stated Resident 3 was confused. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/8/2024 at 3:08 p.m. with CNA 2, CNA 2 stated on 8/6/2024, CNA 2 was assigned as the 1:1 CNA to Resident 3. CNA 2 stated Resident 3 required 1:1 monitoring/supervision because Resident 3 wandered in the hallways and was confused. CNA 2 stated Resident 3 might pick something up and put it in Resident 3's mouth. CNA 2 stated on 8/6/2024, unable to recall time, Resident 3 was wandering the hallways and stopped at Resident 2's room. CNA 2 stated Resident 2 was blocking the entry into Resident 2's room since Resident 2 was sitting in front of the doorway. CNA 2 stated Resident 3 tried to move Resident 2 out of the way by grabbing Resident 2's w/c. CNA 2 stated Resident 3 then swung his arm at Resident 2 and struck Resident 2 in the chest. CNA 2 stated the incident happened fast. CNA 2 stated Resident 3's hand was closed in a fist. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 12/19/2022, the P&P indicated, It is the policy of this 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, physical abuse, includes, but is not limited to hitting, slapping, punching, biting, and kicking. The P&P indicated, the facility would make efforts to ensure all residents were protected from physical and psychosocial harm.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to report an allegation of abuse to the California Department of Public Health (the Department), the Ombudsman (an official appointed to investigate individuals' complaints against maladministration), and to the local law enforcement, within two hours, in accordance with the facility's policy and procedure (P&P), titled Abuse, Neglect and Exploitation, dated 12/19/2022, for one of two sampled residents (Resident 1). This failure resulted in the delay of notification to the Department and other officials and had the potential for Resident 1 to be subjected to potential further abuse. Findings: During a review of Resident 1's Admission Record (AR), the AR indicated, the facility admitted Resident 1 to the facility on [DATE], with diagnoses including metabolic encephalopathy (brain disease that alters brain function or structure), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and dementia (a group of thinking and social symptoms that interferes with daily functioning). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 7/2/2024, the MDS indicated, Resident 1 had severely impaired (never/rarely made decisions) cognitive skills (ability to make daily decisions). The MDS indicated, Resident 1 required setup or clean-up assistance from staff for eating and personal hygiene. During an interview on 8/7/2024 at 9:40 a.m. with Resident 1's Responsible Party (RP), RP stated on the morning of 7/4/2024, Resident 1 informed RP that a resident (unidentified) at the facility punched Resident 1 in the face earlier that morning. RP stated RP informed a nurse at the facility. RP stated RP did not remember who the nurse was. During an interview on 8/8/2024 at 11:18 a.m. with Resident 1, Resident 1 stated there was a time at the facility when a woman (unidentified) hit Resident 1 on Resident 1's right shoulder. Resident 1 stated Resident 1 responded by hitting the woman. Resident 1 stated Resident 1 told RP about the incident. During an interview on 8/8/2024 at 12:35 p.m. with the Administrator (ADM), the ADM stated RP informed the ADM that someone hit Resident 1's shoulder. The ADM stated the ADM did not report the allegation of someone hitting Resident 1 on the shoulder to the Department and other officials because the ADM determined it was not possible that someone had hit Resident 1 on the shoulder. During an interview on 8/8/2024 at 1:03 p.m. with the Director of Nursing (DON), the DON stated Resident 1 informed the DON that a guy (unidentified) tried to pat Resident 1 on the arm and that Resident 1 hit the guy back. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Abuse, Neglect and Exploitation, dated 12/19/2022, the P&P indicated, the facility designated an Abuse Prevention Coordinator in the facility who was responsible for reporting allegations of suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The P&P indicated, reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involved abuse or result in serious bodily injury.