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	01/31/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation of abuse that occurred between Residents 1 and 2 on 1/18/2025 per the facility's Policy and Procedure (P&P) titled, Abuse, Neglect and Exploitation, by failing to obtain a statement/information from Resident 3 who identified herself as a witness. This failure had the potential to omit possible evidence in the allegation of abuse between Residents 1 and 2. Findings: During a review of Resident 1's Admission Record, (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (damage or disease that affects the brain) and type 2 diabetes (disorder characterized by difficulty in blood sugar control). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 1/2/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, reason, plan) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying as resident completes activity) for bathing and toileting. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy and dementia (a progressive state of decline of mental abilities.) During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 had severely impaired cognition and required substantial or maximum assistance (helper does more than half the effort) for toileting and bathing. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes and immunodeficiency (decreased ability of the body to fight infections and other diseases.) During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3 had intact cognition and was dependent (helper does all of the effort) for toileting and bathing. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/30/2025 at 10:00 AM with Resident 3 in Resident 3's room, Resident 3 stated Resident 3 was a roommate of Resident 1 and Resident 3 witnessed Resident 2 enter Resident 1's room and approached Resident 1. Resident 3 stated, there were no staff present during the interaction between Residents 1 and 2 on 1/18/2025 and Resident 2 left the room without staff intervention. During an interview on 1/30/2025 at 4:33 PM with Registered Nurse Supervisor (RNS), RNS stated RNS watched Resident 2 enter Resident 1's room and redirected Resident 2 out of Resident 1's room. During a concurrent interview and record review on 1/31/2025 at 1:46 PM with the Administrator (ADM), the P&P titled, Abuse, Neglect and Exploitation, dated 12/19/2022 was reviewed. The P&P indicated under V. The investigation of alleged abuse, neglect and exploitation B. Written procedures for investigations include: 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. The ADM stated there was no need to interview Resident 3 as a witness because the RNS was already a witness to the abuse allegation and had not witnessed any abuse between Residents 1 and 2. The ADM stated the ADM did not feel the need to interview additional people including Resident 3 and stated a complete investigation had been made.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to develop and implement a comprehensive Care Plan (CP - document created to identify a patient's needs) in a timely manner to address wandering into resident rooms for one of seven sampled residents (Resident 2). This deficient practice had the potential to leave Resident 2's wandering behavior unaddressed and potentially affecting the safety of Resident 2, other facility residents, and their families. Findings: During a review of Resident 2's Admission Record, (AR), the AR indicated Resident 2 was admitted on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (damage or disease that affects the brain) and dementia (a progressive state of decline of mental abilities.) During a review of Resident 2's Elopement Risk, (ER) dated 1/8/2025, the ER indicated Resident 2 had goal directed wandering behavior. During a review of Resident 2's Minimum Data Set, (MDS - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 2 had severe cognitive impairment (ability to think, reason, plan) and required substantial or maximum assistance (helper does more than half the effort) for toileting and bathing. During a review of Resident 2's Progress Notes, (PN) dated 1/15/2025 at 2:52 AM, the PN indicated Resident 2 had been wandering in and out of residents' rooms and was aggressive when staff attempted to redirect Resident 2. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted on [DATE] with diagnoses including acute respiratory failure (occurs when the lungs cannot release enough oxygen into the blood) and immunodeficiency (decreased ability of the body to fight infections and other diseases.) During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact cognition and required maximal assistance (helper does more than half of the effort) for toileting and bathing. During an interview on 1/30/2025 at 3:09 PM with Resident 5, Resident 5 stated Resident 2 started entering Resident 5's room about two weeks prior. Resident 5 stated the facility staff (unidentified) was aware of Resident 2's wandering and behavior of entering other residents' rooms. Resident 5 stated, staff (in general) stated they could not do anything about Resident 2 entering other residents' rooms because Resident 2 had dementia. Resident 5 stated, Resident 5 felt it was unsafe because Resident 2 had entered Resident 5's room often and Resident 5 felt the need to protect Resident 5's non-verbal roommates who could not speak for themselves. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's AR, the AR indicated Resident 6 was admitted on [DATE] with diagnoses including dementia and functional quadriplegia (the complete inability to move due to severe disability.) During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort) from staff for toileting, hygiene and bathing. During an interview on 1/31/2025 at 11:16 AM with Resident 6's Family Member 2 (FM 2), FM 2 stated FM 2 was startled on 1/17/2025 when Resident 2 hit FM 2 on the shoulder without provocation in the resident's hallway. FM 2 stated Resident 2 entered another resident's room afterwards and staff redirected Resident 2 back to Resident 2's room. FM 2 stated the facility staff was aware of Resident 2's wandering behavior but did not address the problem timely because Resident 2 continued to enter other people's rooms before staff intervention. During a concurrent interview and record review on 1/31/2025 at 1:00 PM with the facility's Director of Nursing (DON), Resident 2's CP for risk for elopement/ wandering dated 1/21/2025 was reviewed. The DON stated a CP to address Resident 2's risk for elopement/wandering should have been created on admission. The DON stated, if staff observed a resident's behavior of wandering into other residents' rooms, a CP should be created or an existing CP should be updated. The DON stated Resident 2's existing CP should have been updated when the staff implemented close monitoring before the one-to-one monitoring was implemented. During a review of the facility's Policy and Procedure (P&P) titled, Accidents and Supervision, dated 2022, the P&P indicated under 3. Implementation of interventions - using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes d. Documenting interventions (e.g. care plans for the individual resident.)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48729 Based on interview and record review, the facility failed to accurately document in the resident's clinical record when close monitoring and one-to-one supervision was implemented for one of seven sampled residents (Resident 2.) This failure had the potential to result in inconsistency of care for Resident 2. Findings: During a review of Resident 2's Admission Record, (AR), the AR indicated Resident 2 was admitted on [DATE] and readmitted on [DATE] with diagnoses including metabolic encephalopathy (damage or disease that affects the brain) and dementia (a progressive state of decline of mental abilities.) During a review of Resident 2's Minimum Data Set, (MDS - a resident assessment tool) dated 1/13/2025, the MDS indicated Resident 2 had severe cognitive impairment (ability to think, reason, plan) and required substantial or maximum assistance (helper does more than half the effort) for toileting and bathing. During an interview on 1/31/2025 at 1:00 PM with the facility's Director of Nursing (DON), the DON stated a sitter was provided for one-to-one monitoring for Resident 2 on 1/20/2025 for wandering behavior. During a review of Resident 2's Care Plan (CP - document created to identify a patient's needs) for elopement risk/wandering dated 1/21/2025, the CP indicated the intervention for 1:1 supervision will be rendered by staff dated 1/28/2025. During a review of the facility's Nursing Staffing Assignment and Sign-In Sheet (NSA), dated 1/20/2025 for 7:00 AM, 3:00 PM and 11:00 PM for North and South Station, there was no documentation of a sitter (person who provides direct care and supervision to a resident), or one-to-one monitoring provided to Resident 2. During a review of the Resident 2's Progress Notes (PN), dated 1/20/2025, the PN did not indicate a sitter, or one-to-one monitoring was provided to Resident 2. During a review of the facility's Policy and Procedure (P&P) titled, Accidents and Supervision, dated, 2022, the P&P indicated under 3. Implementation of interventions - using specific interventions to try to reduce a resident's risk from hazards in the environment. The process includes communicating the interventions to relevant staff, assigning responsibility and documenting interventions.