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	03/18/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify one of four sampled residents' (Resident 1's) physician that Resident 1 was scared after being grabbed by Resident 4 in the hallway on 3/2/2026.This failure had the potential for Resident 1 not to receive care and treatment to address Resident 1's physical and psychosocial health after an incident which could negatively affect Resident 1's health and wellbeing.(Cross Reference F609 and F656)Findings:a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain), and other abnormalities of gait and mobility (abnormal walking patterns, including limping, shuffling, dragging feet, or instability).During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/2/2026, the H&P indicated that the resident had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and with moving around in bed. The MDS indicated Resident 1 was dependent on staff for transfers and walking.During a review of Resident 1's Progress Notes (PN), dated 3/3/2026 and timed at 2:57 PM, the PN indicated that the Social Services Director (SSD) requested psychology consultation for Resident 1 on 3/3/2026 because Resident 1 was having a hard time due to Resident 1's health challenges.b. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 4's H&P, dated 2/21/2026, the H&P indicated that the resident did not have the capacity to understand and make decisions.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was severely impaired in cognitive skills. The MDS indicated Resident 4 required substantial/maximal assistance with oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and with transfers and walking.During a review of Resident 4's PN, dated 3/2/2026 and timed at 10:38 AM, the PN indicated that Resident 4 was throwing objects at staff, hitting head against wall, and grabbing other residents on 3/2/2026 at 9:45 AM and was sent to General Acute Hospital (GACH) 1 on 3/2/2026 at 10:30 AM for further evaluation.During a review of Resident 4's SBAR Communication (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/2/2026, the SBAR (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that Resident 4 was agitated, yelling out, throwing objects at other people, and grabbing others.During an interview on 3/17/2026 at 10:46 AM with Resident 1, Resident 1 stated that Resident 1 was scared when another resident (Resident 4) grabbed Resident 1's left arm in the hallway.During an interview on 3/17/2026 at 12:42 PM with Physical Therapy Assistant (PTA) 2, PTA 2 stated Resident 4 grabbed Resident 1's arm in the hallway which scared Resident 1 on 3/2/2026. PTA 2 stated the Social Services Director (SSD) witnessed the incident and Licensed Vocational Nurse (LVN) 1 and a registered nurse (unknown) checked on Resident 1.During an interview on 3/18/2026 at 2:08 PM with the Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 4 grabbed Resident 1's arm in the hallway on 3/2/2026.During a concurrent interview and record review on 3/17/2026 at 3:14 PM with the SSD, Resident 1's PN, dated 3/3/2026, was reviewed. SSD stated Resident 1's doctor was not notified that Resident 1 was shaking and tearing after Resident 4 touched Resident 1 in the hallway on 3/2/2026. SSD stated SSD requested psychology consultation for Resident 1 on 3/3/2026 due to Resident 1 having a hard time due to health challenges. The SSD stated Resident 1's doctor should be notified whenever Resident 1's health condition had changed.During a concurrent interview and record review on 3/18/2026 at 11:42 AM with LVN 1, Resident 1's medical record was reviewed. LVN 1 stated that Resident 1's doctor was not notified and there were no progress notes or SBAR for Resident 1 after Resident 1's left upper arm was grabbed by Resident 4 on 3/2/2026. LVN 1 stated the resident's doctor should be notified whenever the resident had any change of condition.During a concurrent interview and record review on 3/18/2026 at 12:35 PM with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON stated there were no notes or SBAR regarding notifying Resident 1's doctor after Resident 1 was grabbed and scared by Resident 4 in the hallway on 3/2/2026. The DON stated that Resident 1's doctor was not made aware of the incident between Resident 1 and Resident 4 and that Resident 4 scared Resident 1 on 3/2/2026 when and after SSD requested a psychology consultation for Resident 1 on 3/3/2026. The DON stated that it was important to notify the physician and create an SBAR whenever residents had any change of condition and needed a psychology consultation.During a review of the facility's Policy and Procedure (P&P) titled, Notification of Changes, dated 12/19/2022, the P&P indicated, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include:1. Accidentsa. Resulting in injury.b. Potential to require physician intervention.2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 1) was provided with comfortable and homelike environment by failing to remove two boxes of canned soda, which did not belong to Resident 1, from Resident 1's nightstand.This deficient practice resulted in Resident 1 feeling upset and Resident 1's private privacy space being violated.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 which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain), and other abnormalities of gait and mobility (abnormal walking patterns, including limping, shuffling, dragging feet, or instability).During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/2/2026, the H&P indicated that the resident had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and with moving around in bed. The MDS indicated Resident 1 was dependent on staff for transfers and walking.During a concurrent observation and interview on 3/18/26 at 9:13 AM with Resident 1 in Resident 1's room, there were two boxes of canned soda in Resident 1's nightstand at bedside. Resident 1 stated that the canned soda was not Resident 1's and Resident 1 felt upset that someone violated Resident 1's private space.During a concurrent observation and interview on 3/18/26 at 9:22 AM with the Social Services Director (SSD) in Resident 1's room, there were two boxes of canned soda in Resident 1's nightstand at bedside. The SSD stated the nightstand was Resident 1's private space, and the facility should remove everything that did not belong to Resident 1 from the nightstand.During an interview on 3/18/2026 at 9:38 AM with the Infection Preventionist (IP), the IP stated the facility should not leave anything which did not belong to residents in resident's room including inside the nightstand and closet. The IP stated that the facility should remove things which did not belong to residents and ensure everything is clean in the residents' room.During an interview on 3/18/2026 at 12:35 PM with the Director of Nursing (DON), the DON stated the facility should not leave anything which did not belong to residents in residents' nightstand and closet. The DON stated it was residents' right to use the nightstand as their personal private space to place their own personal belongings.During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 12/19/2022, the P&P indicated the facility should ensure the resident has a right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings and clothing, as space permits. The P&P indicated that the facility should ensure the resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

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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 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** Based on interview and record review, the facility failed to report an allegation of abuse for one of four sampled residents (Resident 1) to the California Department of Public Health (the Department), the Ombudsman (an advocate for residents of nursing homes, board and care centers, and assisted living facilities), and to the local law enforcement in accordance with the facility's policy and procedure (P&P) titled, Abuse, Neglect, and Exploitation, dated 12/19/2022.This failure resulted in the delay of notification to the Department, the Ombudsman, and to the local law enforcement and had the potential to result in Resident 1 to be subjected to abuse while at the facility.(cross reference F580 and F656)Findings:a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain), and other abnormalities of gait and mobility (abnormal walking patterns, including limping, shuffling, dragging feet, or instability).During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/2/2026, the H&P indicated that the resident had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and with moving around in bed. The MDS indicated Resident 1 was dependent on staff for transfers and walking.During a review of Resident 1's Progress Notes (PN), dated 3/3/2026 and timed at 2:57 PM, the PN indicated that the Social Services Director (SSD) requested psychology consultation for Resident 1 on 3/3/2026 because Resident 1 was having a hard time due to Resident 1's health challenges.b. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 4's H&P, dated 2/21/2026, the H&P indicated that the resident did not have the capacity to understand and make decisions.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was severely impaired in cognitive skills. The MDS indicated Resident 4 required substantial/maximal assistance with oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and with transfers and walking.During a review of Resident 4's PN, dated 3/2/2026 and timed at 10:38 AM, the PN indicated that Resident 4 was throwing objects at staff, hitting head against wall, and grabbing other residents on 3/2/2026 at 9:45 AM and was sent to General Acute Hospital (GACH) 1 on 3/2/2026 at 10:30 AM for further evaluation.During a review of Resident 4's care plan (CP), initiated on 3/2/2026, the CP indicated Resident 4 was having a behavioral/psychotic episode by yelling out, throwing objects at staff, grabbing other residents and hitting head against wall.During a review of Resident 4's SBAR Communication Form (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/2/2026, the SBAR indicated that Resident 4 was agitated, yelling out, throwing objects at other people, and grabbing others and Resident 4 was sent out to the emergency room (ER- a specialized, 24/7 hospital unit designed to treat acute, life-threatening, or severe injuries and illnesses requiring immediate medical attention) for further evaluation.During an (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 3/17/2026 at 10:46 AM with Resident 1, Resident 1 stated Resident 1 was scared when another resident (Resident 4) grabbed Resident 1's left arm in the hallway.During an interview on 3/17/2026 at 12:42 PM with Physical Therapy Assistant (PTA) 2, PTA 2 stated Resident 4 grabbed Resident 1's arm in the hallway which scared Resident 1 on 3/2/2026. PTA 2 stated the Social Services Director (SSD) witnessed the incident and Licensed Vocational Nurse (LVN) 1 and a registered nurse (unknown) checked on Resident 1. PTA 2 stated Resident 4 grabbing Resident 1's arm should have been reported as an allegation of physical abuse to the Department, the Ombudsman, and to local law enforcement within two hours.During an interview on 3/18/2026 at 2:08 PM with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 4 grabbed Resident 1's arm in the hallway on 3/2/2026. CNA 4 stated abuse or allegations of abuse must be reported to the charge nurse, the administrator and to the Director of Nursing (DON) right away.During a concurrent interview and record review on 3/17/2026 at 3:14 PM with the SSD, Resident 1's PN, dated 3/3/2026, was reviewed. SSD stated Resident 1 was shaking and tearing after Resident 1 was touched by Resident 4 in the hallway on 3/2/2026. SSD stated SSD requested psychology consultation for Resident 1 on 3/3/2026 due to Resident 1 having a hard time due to health challenges. The SSD stated that the SSD should report any abuse and allegation of abuse to the Department, the Ombudsman, and to local law enforcement within two hours.During an interview on 3/18/2026 at 11:42 AM with LVN 1, LVN 1 stated staff (in general) should report unwanted grabbing as physical abuse to the Department, the Ombudsman, and to local law enforcement within two hours.During an interview on 3/18/2026 at 12:35 PM with the DON, the DON stated the facility did not report the incident to the Department, the Ombudsman, and to local law enforcement regarding Resident 4 grabbing Resident 1's arm which scared Resident 1 in the hallway on 3/2/2026. The DON stated the facility should report any abuse and allegation of abuse to the Department, the Ombudsman, and to local law enforcement within two hours.During an interview on 3/18/2026 at 1:35 PM with the Administrator, the Administrator stated that the facility did not report the incident to the Department, the Ombudsman, and to local law enforcement regarding Resident 4 grabbing Resident 1's arm which scared Resident 1 in the hallway on 3/2/2026.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 that Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse,. The P&P indicated that the facility must ensure 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: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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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** Based on interview and record review, the facility failed to ensure a person-centered care plan (a treatment plan that focused on the needs and preferences of a resident or individual) was developed and implemented for one of four sampled residents (Resident 1) to monitor Resident 1's physical and psychosocial well-being after Resident 1 was grabbed on the arm by Resident 4 on 3/2/2026 and Social Services Director (SSD) requested psychology consultation for Resident 1 on 3/3/2026.These deficient practices had the potential to place Resident 1 at risk of not receiving the individualized care services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.(cross reference F580 and F609)Findings:a. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (loss of blood flow to a part of the brain), and other abnormalities of gait and mobility (abnormal walking patterns, including limping, shuffling, dragging feet, or instability).During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/2/2026, the H&P indicated that the resident had the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 2/3/2026, the MDS indicated Resident 1 was mildly impaired in cognitive skills (ability to make daily decisions). The MDS indicated the resident required substantial/maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with toileting hygiene, showering/bathing self, lower body dressing, putting on/taking off footwear, and with moving around in bed. The MDS indicated Resident 1 was dependent on staff for transfers and walking.During a review of Resident 1's Progress Notes (PN), dated 3/3/2026 and timed at 2:57 PM, the PN indicated that the Social Services Director (SSD) requested psychology consultation for Resident 1 on 3/3/2026 because Resident 1 was having a hard time due to Resident 1's health challenges.During a review of Resident 1's medical record, there was no care plan to address that Resident 1 was shaking and tearing after Resident 1 was touched by Resident 4 in the hallway on 3/2/2026 and Resident 1's need for a psychology consultation.b. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 4's H&P, dated 2/21/2026, the H&P indicated that the resident did not have the capacity to understand and make decisions.During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was severely impaired in cognitive skills. The MDS indicated Resident 4 required substantial/maximal assistance with oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, and with transfers and walking.During a review of Resident 4's PN, dated 3/2/2026, the PN indicated that Resident 4 was throwing objects at staff, hitting head against wall, and grabbing other residents on 3/2/2026.During a review of Resident 4's care plan (CP), initiated on 3/2/2026, the CP indicated Resident 4 was having a behavioral/psychotic episode by yelling out, throwing objects at staff, grabbing other residents and hitting head against wall.During a review of Resident 4's SBAR Communication Form (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents), dated 3/2/2026, the SBAR indicated that Resident 4 was agitated, yelling out, throwing objects at other people, and grabbing others.During an interview on 3/17/2026 at 10:46 AM with Resident 1, Resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 stated that Resident 1 was scared when the other resident grabbed Resident 1's left arm in hallway.During an interview on 3/17/2026 at 12:42 PM with Physical Therapy Assistant (PTA) 2, PTA 2 stated Resident 4 grabbed Resident 1's arm in the hallway which scared Resident 1 on 3/2/2026.During an interview on 3/18/2026 at 2:08 PM with the Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 4 grabbed Resident 1's arm in the hallway on 3/2/2026.During a concurrent interview and record review on 3/17/2026 at 3:14 PM with the Social Service Director (SSD), Resident 1's medical record was reviewed. SSD stated the SSD was unable to find a care plan to address Resident 1 was shaking and tearing after Resident 1 was touched by Resident 4 in the hallway on 3/2/2026. SSD stated SSD requested psychology consultation for Resident 1 because Resident 1 was having a hard time due to health challenges on 3/3/2026 and there was no care plan for this psychology consultation request.During a concurrent interview and record review on 3/18/2026 at 11:42 AM with the Licensed Vocational Nurse (LVN) 1, Resident 1's medical record was reviewed. LVN 1 stated that there was no care plan for Resident 1 after Resident 1's left upper arm was grabbed by Resident 4 on 3/2/2026.During a concurrent interview and record review on 3/18/2026 at 12:35 PM with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON stated there was no care plan for Resident 1 after Resident 1 was grabbed and scared by Resident 4 in the hallway on 3/2/2026. The DON stated that there was no care plan for Resident 1 after SSD requested a psychology consultation due to health condition challenges. The DON stated that it was important to develop a care plan to monitor the residents' psychosocial well-being when the resident requested a psychology consultation.During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Care Plans, dated 12/19/2022, the P&P indicated that the facility should develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P indicated, The person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. The P&P indicated, The comprehensive care plan will describe, ., a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.