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	05/18/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure verbal complaints regarding moaning from a roommate was addressed and resolved promptly for one of one sampled resident (Resident 30).This deficient practice led to Resident 30 verbalizing being unable to sleep at night due to constant moaning. Findings:During a review of Resident 30's admission Record (AR), the AR indicated the facility admitted Resident 30 on 1/2/2025, with diagnoses that included acute respiratory failure with hypoxia (a condition where there is not enough oxygen in the body's tissues) and severe protein-calorie malnutrition (an extreme deficiency of dietary energy and protein).During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 12/30/2025, the MDS indicated Resident 30 had intact cognition (ability to think, learn, and process information) and was independent with bed mobility such as rolling left and right, sit to lying, sit to stand.During an observation on 5/17/2026 at 12:10 PM, Resident 30's roommate (Resident 44) was assisted back to the room from activities by unidentified staff. Resident 30, who was lying in bed, asked why Resident 44 was already back in the room, Resident 30 stated Resident 30 was trying to get some sleep because Resident 30 was not able to sleep last night from the constant moaning.During an interview on 5/17/2026 at 3:22 PM, Resident 30 stated that Resident 30's roommate (Resident 44) was restless in bed, and there was a constant moaning or humming sound coming from Resident 44.During an interview on 5/17/2026 at 3:30 PM, Resident 30 stated that Resident 30 reported to the Certified Nursing Assistants (CNAs) and some of the licensed nurses assigned to Resident 30 that Resident 30 had a problem sleeping at night because of the roommate's constant moaning. Resident 30 stated that Resident 30 made the CNA's and nurses know for weeks. During an interview on 5/17/2026 at 5:18 PM, the Social Services Director (SSD) stated that Resident 30's roommate (Resident 44), had repetitive moaning as a behavior, but Resident 30 never mentioned this complaint to the SSD. The SSD stated that when a resident (in general) would complain to the staff, the staff could file the grievance on behalf of the complainant so the concern could be addressed.During a review of the facility's policy and procedure (P&P), titled Resident and Family Grievances, revised on 2/22/2023, the P&P indicated it is the policy of the facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal. Grievances may be voiced in the following forums:a. Verbal complaints to a staff member or Grievance Official.b. Written complaint to a staff member or Grievance Official.c. Written complaint to an outside party.d. Verbal complaint during resident or family council meetings.e. Via the company toll free Customer Service Line (if applicable).The P&P indicated the facility will make prompt efforts to resolve the grievance.

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

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	05/18/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 23) was assessed prior to permitting self-administration of albuterol (a medication used to provide fast relief from symptoms such as wheezing, coughing, chest tightness, and shortness of breath) inhaler (handheld device that delivers medication in a measured dose while a person inhales) and did not ensure accurate documentation when Resident 23 self-administered .This deficient practice had the potential for Resident 23 to over-medicate and experience potential unwanted side effects (unintended consequences of medication/treatment).Findings:During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD, a progressive lung disease that damages airways and air sacs, making it hard to breathe), asthma (a chronic lung disease that causes the airways to become inflamed, swollen, and filled with extra mucus), and chronic respiratory failure (a condition that happens when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from the body).During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/16/2026, the MDS indicated Resident 23 had intact cognition and used a manual wheelchair but required supervision or touching assistance to transfer from a bed to a chair.During a review of Resident 23's Order Summary Report (OSR) with active orders as of 5/17/2026, the OSR indicated a physician order for albuterol sulfate hydrofluoroalkane (HFA) inhalation aerosol solution (a liquid medication formulated to be converted into a fine mist or aerosol) with instructions to inhale two (2) puffs orally every four hours as needed for asthma/shortness of breathing/wheezing. May self-administer and keep at bedside with start date of 4/17/2026.During an observation on 5/17/2026 at 1:49 PM at the facility's outside patio, Resident 23 was observed removing an inhaler from Resident 23's jacket pocket and self-administering two doses of the inhaler.During an interview and observation on 5/17/2026 at 1:55 PM with Resident 23 in the activities room, Resident 23 stated that Resident 23 used inhalers for years and liked to keep it on hand just in case it was needed quickly. The box indicated the medication was Albuterol.During an interview on 5/17/2026 at 2:27 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that Resident 23 requested to keep the inhaler on hand to be able to self-administer. LVN 3 stated LVN 3 would know if Resident 23 had used the inhaler by asking the resident at the end of the shift when and how many times it was used.During a review of Resident 23's Medication Administration Record (MAR) from 5/1/2026 to 5/31/2026, the MAR did not indicate Resident 23 had used the albuterol inhaler during the month of May 2026.During a concurrent observation and interview on 5/18/2026 at 11:33 AM with Resident 23, Resident 23's medication box containing albuterol inhaler was observed. The medication box indicated the albuterol inhaler had total of 200 metered dose inhalations. Resident 23 stated that the staff would not normally know when or how often Resident 23 used the inhaler and staff had not been asking Resident 23 when the inhaler was being used prior to 5/17/2026. Resident 23 stated the inhaler indicated how many doses were left by a counter on the inhaler but did not think the counter was accurate. The inhaler indicated 140 doses were left. Resident 23 stated the medication's box indicated that it should only be used every four hours as needed, but Resident 23 stated Resident 23 used it as often and whenever Resident 23 wanted. Resident 23 stated the medication could increase his blood pressure and heart rate. Resident 23 stated that Resident 23 is supposed to rinse their mouth after the medication administration, but Resident 23 does not want to and does not do so.During a review of Resident 23's Care Plan Report (CP, a form where one can summarize a person's health conditions, specific care needs, and current treatments) related to COPD and asthma and initiated on 1/13/2026, the CP's Interventions section indicated to give aerosol/inhalers or bronchodilators (a type of medication that makes breathing easier by relaxing the muscles in the lungs and widening the airways) as ordered. Monitor/document (continued on next page)

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	05/18/2026

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any side effects and effectiveness.During a review of Resident 23's Self-Administration of Medication (SAM), dated 5/17/2026, the SAM indicated Resident 23 could safely self-administer medication.During an interview on 5/18/2026 at 1:45 PM with the Director of Nursing (DON), the DON stated that it was the facility's protocol to obtain an order and perform an assessment prior to resident's self-administering medication. The DON stated the assessment had not been completed until 5/17/2026 because the nurse likely didn't know an assessment had to be completed. The DON stated it was important to perform an assessment prior to allowing the resident to self-administer because the resident may not know how to administer the medication, may over-medicate, and may not be able to verbalize adverse reactions (any unwanted undesirable and harmful effects of medications).During a review of the facility's policy and procedure (P&P), titled Resident Self-Administration of Medication, dated 12/19/2022, the P&P indicated a resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely. The P&P indicated upon notification of the use of bedside medication by the resident, the medication nurse records self-administration on the MAR.

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	05/18/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate documentation of the most recent Minimum Data Set (MDS - a federally mandated resident assessment tool) for two of two sampled residents (Resident 23 and Resident 1) by failing to: A. Ensure documentation of oxygen (a gas essential for life) therapy (an administration of supplemental oxygen) for Resident 23.B. Ensure documentation of use of anticonvulsant (a drug commonly used to prevent seizures [a sudden and uncontrolled electrical activity in the brain] or stabilize mood disorders) medication for Resident 1.This deficient practice had the potential for Resident 23 and Resident 1 not receiving treatment and/or services related to the oxygen therapy and anticonvulsant medication. Findings: A. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 2/28/2025, with diagnoses including acute respiratory failure (ARF - sudden inability to breathe adequately and maintain normal oxygen levels), bipolar disorder (a mental health condition causing episodes of mood changes, including depression and elevated or irritable moods), and chronic obstructive pulmonary disease (COPD, a progressive lung disease that damages airways and air sacs, making it hard to breathe). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognition (the ability to think and process information) was intact. The MDS indicated Resident 1 required setup or clean-up assistance (helper sets up or cleans up) with activities of daily living (ADL - a term used in healthcare that refers to self-care activities) and required setup or clean-up assistance with mobility. Section N0415 – High Risk Drug Classes (Use and Indication) of the MDS indicated Resident 1 was not taking an anticonvulsant (a drug commonly used to prevent seizures or stabilize mood disorders) medication during the assessment period. During a review of Resident 1's Medication Administration Record (MAR), dated 4/2026 (4/1/2026 to 4/30/2026) and 5/2026 (5/1/2026 to 5/31/2026), the MAR indicated that Resident 1 received Carbamazepine (an anticonvulsant medication commonly used to prevent seizures or stabilize mood disorders) oral tablet, 200 milligrams (mg - a measurement used to show the amount or strength of medication), daily, for bipolar disorder. The MAR indicated that the medication was administered during the MDS assessment reference period. During a review Resident 1's Medication Review Report (MRR), dated 5/18/2026, the MRR indicated that Resident 1 had an active physician order for Carbamazepine, 200 mg, to give by mouth one time a day, initiated on 4/10/2026, with a start date of 4/11/2026, for bipolar disorder. The order was still active, and the resident was still being administered the medication at the time of review. During an interview and concurrent record review on 5/18/2026 at 4:26 PM, Resident 1's MDS, MAR, and MRR was reviewed with the MDS nurse (MDSN), the MDSN stated that accurate completion of the MDS was important to ensure the Resident 1's clinical status, medications, and care needs were correctly reflected in the medical record. The MDSN stated inaccurate coding of medications could affect care planning, reimbursement, and the facility's ability to accurately assess and monitor the resident's needs. The MDSN further stated that anticonvulsant medications administered during the assessment reference period should be accurately coded on the MDS according to the medication's pharmacological classification. B. During a review of Resident 23's AR, the AR indicated Resident 23 was admitted to the facility on (continued on next page)

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	05/18/2026

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD, a progressive lung disease that damages airways and air sacs, making it hard to breathe), asthma (a chronic lung disease that causes the airways to become inflamed, swollen, and filled with extra mucus), and chronic respiratory failure (a condition that happens when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from the body). During a review of Resident 23's MDS, dated [DATE], the MDS indicated Resident 23 had intact cognition and required supervision or touching assistance to transfer from a bed to a chair. The MDS did not indicate Resident 23 used oxygen therapy. During a review of Resident 23's Order Summary Report (OSR), dated with active orders as of 5/17/2026, the OSR indicated a physician order for oxygen at two liters per minute, may titrate (gradual adjustment of the dose) oxygen to three (3) liters per minute to maintain SPO2 (Saturation of Peripheral Oxygen – a measure of the percentage of hemoglobin in the red blood cells that is carrying oxygen from lungs to the rest of the body) greater or equal to 92 percent every shift for SOB (shortness of breath)/COPD with start date of 1/12/2026. During an observation on 5/17/2026 at 10:39 AM in Resident 23's room, Resident 23 was observed sitting up in bed while using oxygen at two liters per minute via nasal cannula (a device that delivers extra oxygen through a tube and into the nose). During an interview on 5/17/2026 at 2:27 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that Resident 23 used oxygen via nasal cannula as needed but almost always uses it when out of bed. During an interview on 5/18/2026 at 10:46 AM with the MDSN, the MDSN stated that there was a discrepancy on the last completed MDS dated [DATE] and it was not marked that Resident 23 used oxygen. The MDSN stated that it was important for information on the MDS to be accurate to ensure Resident 23 received care related to oxygen use. During a review of the facility's policy and procedure (P&P), titled MDS 3.0 Completion, dated 12/19/2022, the P&P indicated: - Residents are assessed, using a comprehensive assessment process in order to identify care needs and to develop an interdisciplinary care plan. - All disciplines shall follow the guidelines in Chapter 3 of the current RAI manual for coding each assessment. - The facility has seven (7) days in which to encode the MDS data regarding the electronic completion of the MDS. - The assessment reference date is established as reference point for all staff participating in the assessment process. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period.

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	05/18/2026

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 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 develop a comprehensive care plan (CP) that included specific and measurable interventions for two of two sampled residents (Resident 7 and Resident 11) who were at risk for falls.This deficient practice had the potential to result in unmet individualized needs for Residents 7 and 11 and had the potential to affect the residents' physical and psychosocial well-being. Findings:A. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 10/24/2025, with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to aˆect a person's daily functioning)ˆandˆepilepsy (aˆbrain disorder in which a person has repeated seizuresˆ[a sudden, uncontrolled surge of electrical activity in the brain).ˆ During a review of Resident 7's Fall Risk-V4 assessment, dated 10/24/2025, the Fall Risk-V4 assessment indicated Resident 7 was At Risk for Falls. During a review of Resident 7's Minimum Data Set ˆ(MDS - a resident assessment tool), dated 10/28/2025, the MDS indicated Resident 7 had severe cognitive impairment (ability to think and make decisions) and was dependent (helper does all of the effort) with bed mobility such as rolling left and right, sit to lying, and lying to sitting. During a concurrent record review and interview on 5/18/2026 at 8:58 AM with the Minimum Data Set Nurse (MDSN), the MDSN stated Resident 7's CP Report, initiated 11/4/2025, indicated Resident 7 was at risk for falls. The MDSN stated the CP's interventions indicated frequent visual checks. The MDSN stated frequent visual checks included the angel rounds (high-level, administrative check-ins performed once a day by managers or assigned staff), certified nursing assistant (CNA) rounds [a practice of visually checking the resident's well-being], and licensed nurses' rounds. The MDSN stated angel rounds were completed once a day for specific assigned rooms. The MDSN stated CNAs and licensed nurses conducted rounds frequently. The MDSN could not define the specific frequency of frequent visual checks and stated frequent visual checks were not measurable or specific for Resident 7. B. During a review of Resident 11'sˆAR, the AR indicated the facility admitted Resident 11 on 11/5/2025 with diagnoses that included dementia and psychosis (a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality). During a review of Resident 11'sˆMDS, dated [DATE], the MDS indicated Resident 11 had severe cognitive impairement. The MDS indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort) for sit to lying, sit to stand, chair/bed to chair transfer, toilet transfer, and when walking 10 feet. During a review of Resident 11's Fall Risk-V4 assessment, dated 11/5/2025, the Fall Risk-V4 assessment indicated Resident 11 was At Risk for Falls. During a concurrent record review and interview on 5/18/2026 at 9:20 AM, Resident 11's CP, initiated 12/4/2025, was reviewed with MDSN. The CP Report's focus indicated Resident 11 had an actual fall on 12/4/2025. The CP Report's interventions indicated frequent visual checks. The MDSN stated frequent visual checks included angel rounds, CNA rounds, and licensed nurse's rounds. The MDSN stated angel rounds were completed once a day for specific assigned rooms. The MDSN stated CNAs and licensed nurses conducted rounds frequently. The MDSN stated frequent visual checks were not measurable or specific for Resident 11. During an interview on 5/18/2026 at 5:38 PM with the Director of Nursing (DON), the DON stated measurable and specific interventions for falls will help to measure the effectiveness of the interventions.ˆ During a review of the facility'sˆpolicy andˆprocedure (P&P), titled Comprehensive Care Plan, dated 12/19/2022, the P&P indicated it is the policy of the facility to develop and implement a comprehensive person-centered CP for each resident, consistent with resident rights, 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.ˆThe P&P indicated that the comprehensive CP will include measurable objectives and (continued on next page)

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	05/18/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.ˆThe P&P indicated that the objectives will be utilized to monitor the resident's progressˆand alternative interventions will be documented, as needed.

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	05/18/2026

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise a care plan (CP, a form where one can summarize a person's health conditions, specific care needs, and current treatments) and develop individualized interventions accordingly after an actual fall incident on 5/14/2026 at 2:50 AM to prevent repeated fall incident on 5/14/2026 at 7:20 PM for one of one sampled resident (Resident 53).This deficient practice had the potential for facility staff to be unaware of new fall prevention interventions for Resident 53.Findings: During a review of Resident 53's admission Record (AR), the AR indicated Resident 53 was admitted to the facility on [DATE] with multiple diagnoses including metabolic encephalopathy (when the brain has trouble working because of a chemical or metabolic problems in the body), dementia (a gradual decline in mental ability usually caused by a brain disease), and overactive bladder (sudden urges to urinate that may be hard to control).During a review of Resident 53's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/31/2026, the MDS indicated Resident 53 had impaired cognition (ability to understand and process information), required substantial/ maximal assistance (helper does more than half the effort) for oral and personal hygiene and for transferring from bed to chair, and was dependent (helper does all of the effort) for toileting hygiene and toilet transfer.During a review of Resident 53's Fall Risk-V4 (FR) forms, dated 3/15/2026 at 10:08 AM, 5/14/2026 at 2:50 AM, and 5/14/2026 at 7:20 PM, the FR indicated Resident 53 was at risk for falls.During a review of Resident 53's Care Plan Report (CP) related to actual falls and initiated on 3/15/2026 for an unwitnessed fall, the CP indicated Resident 53 had an unwitnessed fall on 5/14/2026 at 2:50 AM and witnessed fall on 5/14/2026 at 7:20 PM. The CP indicated revision date of 5/18/2026. CP did not indicate specific revision or interventions after the fall incident on 5/14/2026 at 2:50 AM.During a concurrent interview and record review on 5/17/2026 at 5:03 PM with Licensed Vocational Nurse (LVN) 4, Resident 53's CP related to actual falls initiated on 3/15/2026, was reviewed. LVN 4 stated Resident 53 was a fall risk and when a resident has a fall at the facility, part of the facility's fall protocol is to update the resident's CP on how the fall took place and include interventions to prevent another fall. LVN 4 stated Resident 53's CP included the fall on 5/14/2026 at 7:20 PM but did not indicate Resident 53's fall on 5/14/2026 at 2:50 AM.During an interview on 5/18/2026 at 10:50 AM with the Director of Nursing (DON), the DON stated CP interventions needed to be modified if they're proven to be ineffective and staff need to check what interventions are appropriate. The DON stated staff would know the efficacy of the interventions to prevent falls if there were no falls noted after three months. The DON stated Resident 53 fell once on 3/15/2026 and twice on 5/14/2026. The DON stated the care plan related to actual falls did not include the unwitnessed fall on 5/14/2026 at 2:50 AM. The DON stated that the CP needed to include all falls to ensure interventions are individualized to Resident 53's fall situation so they could be implemented.During a review of the facility's policy and procedure (P&P), titled Fall Prevention Program, dated 12/19/2022, and revised on 4/20/2026, the P&P indicated when any resident experiences a fall, the facility will:e. Review the resident's care plan and update as indicated.

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	05/18/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were followed for two of two sampled residents (Resident 10 and Resident 61) by failing to:A. Check Resident 10's Hemoglobin A1C (HgbA1C, a blood test that measures the average level of blood sugar levels over the past two to three months) on last Monday of March 2026.B. Check Resident 61's blood pressure (BP - is the amount of force blood uses to get through the arteries. Normal blood pressure reading for most adults is below 120/80 mm Hg) and heart rate (HR or PR refers to the number of times the heart beats per minute. The normal resting heart rate ranges from 60 to 100 beats per minute) prior administration of amlodipine (a medication used to treat high blood pressure and to prevent chest pain).These deficient practices had the potential to place Resident 61 at risk for the improper administration of amlodipine when clinical parameters indicated the medication should be held and Resident 10 at risk for uncontrolled blood sugar. Findings: A. During a review of Resident 10's admission Record (AR), the AR indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including Type 2 Diabetes Mellitus (a condition in which the body cannot properly store or use glucose [sugar], the body's main source of energy), metabolic encephalopathy (a brain dysfunction caused by chemical imbalances in the body), and peripheral vascular disease (a condition where narrowed or blocked blood vessels restrict blood flow to the limbs, organs, or brain). During a review of Resident 10's Minimum Data Set (MDS – a federally mandated resident assessment tool), dated 3/31/2026, the MDS indicated Resident 10 had impaired cognition (ability to understand and process information) and required set up or clean-up assistance with eating and substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. During a review of Resident 10's Medication Review Report (MRR), dated as of 5/18/2026, the MRR indicated a physician order to check HgbA1c on last Monday of September and March every year with the start date of 9/16/2025. During an interview on 5/18/2026 at 1:45 PM with the Director of Nursing (DON), the DON stated Resident 10's last HgbA1c result was from 9/2025. The DON stated checking the HgbA1c is important to be able to monitor Resident 10's blood sugar and if the HgbA1c is high, then Resident 10 might have consistently high blood sugar, and could experience more frequent urination, thirst, hunger or nerve pain. During a review of the facility's policy and procedure (P&P), titled Provision of Physician Ordered Services, revised on 5/15/2023, the P&P indicated the facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. B. During a review of Resident 61's AR, the AR indicated the facility admitted Resident 61 on 7/22/2024, with diagnoses that included severe protein calorie malnutrition (an extreme deficiency of dietary energy and protein) and functional quadriplegia (a complete inability to move due to severe disability or frailty caused by another condition without physical injury or damage to the spinal cord). During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61 rarely/never understands verbal content and rarely/never able to express ideas and wants. (continued on next page)

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	05/18/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 61's Medication Review Report (MRR), dated 4/1/2026 to 4/16/2026, the MRR indicated an order to administer amlodipine five milligrams (mg), one tablet, by mouth, one time a day for hypertension (high blood pressure) with an order date of 12/25/2025. The order indicated to hold if systolic blood pressure (SBP - the pressure when the heart actively beats) was below 100 or heart rate was (HR) less than 60. During a review of Resident 61's Medication Administration Record (MAR), dated 4/1/2026 to 4/30/2026, the MAR indicated amlodipine was administered from 4/1/2026 to 4/15/2026. The MAR indicated there was no BP or pulse documented on the MAR. During a review of Resident 61's Weights and Vitals Summary from 4/1/2026 to 4/16/2026, the blood pressure summary indicated there was no documented blood pressure from 4/1/2026 to 4/4/2026, from 4/7/2026 to 4/9/2026, and from 4/12/2026 to 4/15/2026 prior to hospitalization. During a review of Resident 61's Weights and Vitals Summary from 4/1/2026 to 4/16/2026, the pulse summary indicated no documented pulse from 4/13/2026 to 4/15/2026. During a review of Resident 61's Care Plan report (CP) for The resident has hypertension (HTN)/hyperlipidemia [HLD, a medical term for high levels of fats in the blood]), the Goal section indicated, The resident will remain free of complications related to hypertension. The CP indicated an intervention to observe blood pressure and or pulse monitoring parameters prior to medication administration. The CP indicated to monitor side effects such as orthostatic hypotension (a form of low blood pressure that happens when the person stands up), increased heart rate, and effectiveness. The CP indicated to monitor/document/report as needed any signs and symptoms of malignant hypertension (a life-threatening medical emergency characterized by a sudden, sever spike in blood pressure) including confusion, irritability, and seizure activity. During an interview on 5/18/2026 at 5:03 PM, Licensed Vocation Nurse 2 (LVN 2) stated on 4/16/2026, LVN 2 assessed Resident 61, Resident 61 was staring and mumbling, and the resident was transferred to the hospital for seizure like activity. LVN 2 stated LVN 2 checked Resident 61's vital signs during that change of condition. During an interview on 5/18/2026 at 5:35 PM, the Director of Nursing (DON) stated there was no documented evidence that the BP and PR was checked on 4/12/2026 to 4/15/2026. The DON stated the BP and PR was checked on 4/16/2026 when Resident 61 had a change of condition. The DON stated Resident 61's BP and HR needed to be checked prior to the administration of amlodipine in order to know if the administration parameters were met. The DON stated the BP and PR needed to be documented to indicate that there were checked. During a review of the facility's policy and procedure (P&P), titled Medication Administration, dated 12/19/2022, the P&P indicated to obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. During a review of the facility's P&P, titled Provision of Physician Ordered Services, revised on 5/15/2023, the P&P indicated medications will be administered following facility protocol, dosage guidelines, and documentation procedures.

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	05/18/2026

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 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. Based on observation, interview, and record review, the facility failed to prevent falls (unintentionally coming to rest on the ground, floor, or other lower level) for one of three sampled residents (Resident 11), as evidenced by:Resident 11's was not provided assistance when walking from the dining room back to Resident 11's room on 12/4/2025.Resident 11 was not provided assistance when getting up from bed to the bathroom on 1/1/2026.This deficient practice resulted in Resident 11 falling on 12/4/2025 and on 1/1/2026 and had the potential to result in harm and health decline. Findings:During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on 11/5/2025 with diagnoses that included dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning) and psychosis (severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality).During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 1/9/2026, the MDS indicated Resident 11 rarely/never understands verbal content and rarely/never able to express ideas and wants. The MDS indicated Resident 11 required substantial/maximal assistance (helper does more than half the effort) for sit to lying, sit to stand, chair/bed to chair transfer, toilet transfer, and when walking 10 feet.During a review of Resident 11's Fall Risk-V4 assessment, dated 11/5/2025, the Fall Risk assessment indicated Resident 11 was At Risk for Falls.a. During a review of Resident 11's SBAR Communication Form (SBAR - situation, background, assessment and recommendation, is a communication framework for sharing information with the team about the condition of a patient), dated 12/4/2025, the SBAR indicated Resident 11 was walking in the hallway, resident was stumbled and fell face down. The SBAR indicated Resident 11 sustained a cut above the left side of the upper lip.During a review of Resident 11's Care Plan Report (CP), initiated on 12/4/2025, the CP indicated Resident 11 had an actual fall on 12/4/2025. The CP indicated according to the Activity Staff (unidentified), Resident 11 was walking through the hallway, resident stumbled and took a fall face down. The CP indicated Resident 11 sustained a cut above the left side of the resident's upper lip. During an interview on 5/18/2026 at 11:40 AM, the Activity Assistant (AA) stated that the AA could not remember the exact date, but it was between 8:00 AM to 8:30 AM in December 2025 when Resident 11 fell. The AA stated that the AA saw residents walking out from the dining room due to dining room was being closed for cleaning. The AA stated residents were walking toward the AA and the AA witnessed Resident 11 was walking by herself, there was another resident in front of Resident 11, and then Resident 11's head disappeared from the AA's line of sight. The AA stated AA did not see how Resident 11 hit the ground but there was blood around.During a concurrent review of Resident 11's Physical Therapy Evaluation and Plan of Treatment (PTE/POT) notes, dated 11/7/2025, and interview on 5/18/2026 at 2:00 PM, the Physical Therapist (PT) stated that Resident 11 was initially evaluated by Physical Therapy on 11/7/2025, Resident 11 was able to walk 150 feet with partial/moderate assistance and requiring handheld assistance. The PT stated partial/moderate assistance would mean the resident would need help during ambulation. The PT stated Resident 11 had a balance deficit and decreased muscle strength. During a review of Resident 11's Physical Therapy Treatment Encounter Notes (PT/TEN), dated 12/4/2025, and interview on 5/18/2026 at 2:18 PM, the PT stated that Resident 11 walked 175 feet with handheld assistance of contact guard assistance which would mean Resident 11 needed assistance during ambulation.During an interview on 5/18/2026 at 5:42 PM, the Director of Nursing stated that when residents in general are provided with assistance during ambulation, we could lessen the severity of a fall, or we could prevent a fall.b. During a review of Resident 11's SBAR Communication Form, dated 1/1/2026, the SBAR indicated Resident 11's roommate called the assigned certified nursing assistant (CNA) and reported that Resident 11 fell in the bathroom and resident was transferred to the General Acute Care Hospital (GACH).During a review of Resident 11's (continued on next page)

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	05/18/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PT/TEN, dated 12/30/2025, and interview on 5/18/2026 at 2:28 PM, the PT stated Resident 11 walked 225 feet with handheld assistance. The PT stated Resident 11 needed contact guard assistance with transfers due to balance deficit and required maximum cueing or redirection due to cognition.During an interview on 5/18/2026 at 5:42 PM, the Director of Nursing (DON) stated Resident 11 just walks and did not call for assistance when resident went to the bathroom. The DON stated that for residents with dementia, the facility needed to provide close supervision and activities, but the fall happened after breakfast early in the morning. The DON stated the staff found Resident 11 in the bathroom.During an observation on 5/18/2026 at 5:45 PM, the DON stated Resident 11 was not placed in a room closer to the Nurse's station because there was no room available. During a review of Resident 11's CP, titled At Risk for Fall, initiated on 11/5/2025, and related to episodes of pacing and being unaware of safety needs, the CP did not have interventions regarding the level of assistance Resident 11 needed during ambulation and during transfers as indicated on the PT/TEN report. During a review of Resident 11's CP, initiated on 12/4/2025, the CP indicated Resident 11 had an actual fall on 1/1/2026. The CP indicated Resident 11's roommate reported to the CNA that Resident 11 was sitting on the bathroom floor and had swelling, discoloration, and pain in the right knee/lower extremity. The CP indicated 911 (universal emergency telephone number in the United States) was activated to send Resident 11 to the GACH. During a review of the facility's policy and procedure (P&P), titled Fall Prevention Program, revised on 4/20/2026, the P&P indicated that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The P&P indicated to provide additional interventions as directed by the resident's assessment, including but not limited to increased frequency of rounds, scheduled ambulation or toileting assistance, therapy services referral . The P&P indicated At Risk Protocols included providing interventions that address unique risk factors measured by the risk assessment tools: medication, psychological, cognitive status, or recent change in functional status.

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	05/18/2026

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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the nurse staffing data for one of three days (5/16/2026).This deficient practice failed to protect the rights of residents and their representatives to access nursing staffing data.Findings:During an observation on 5/16/2026 at 11:55 AM, there was a posted Census (the total number of residents staying in the building at that specific time) and Direct Care Service Hours Per Patient Day (the average number of hours a single resident receives hands-on care from the nursing staff in a 24-hour period), dated 5/15/2026. The data was posted near the Nursing Station close to the facility's entrance door.On 5/17/2026 at 11:01 AM, Licensed Vocational Nurse 1 (LVN 1)/Director of Staff Development (DSD) stated that posting the nursing hours was the LVN 1/DSD's responsibility and the Registered Nurse Supervisor (RNS) or charge nurses would be responsible for posting the nursing hours on the weekends. LVN 1/DSD stated the nursing hours would be posted before 10:00 AM and after the stand-up meeting everyday. The LVN1/DSD stated that the posting would show how many direct care staff were provided for residents care that day.On 5/17/2026 at 11:06 AM, LVN 1/DSD stated that LVN1/DSD did not know why the nursing hours were not posted on 5/16/2026. LVN 1/DSD stated that the nursing hours could have been posted on the other side but the area near the entrance would be the best place to post the nursing hours because it was more accessible.During a review of the facility's policy and procedure (P&P), titled Nurse Staffing Posting Information, revised on 3/10/2025, the P&P indicated it is the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. The P&P indicated the facility will post the Nurse Staffing Sheet at the beginning of each shift. The P&P indicated the information posted will be.in a prominent place readily accessible to staff, residents and visitors.

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	05/18/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure their medication error rate was not 5 percent or greater. Three medication errors were identified out of 29 opportunities and resulted in a medication error rate of 10.34 percent. The facility failed to ensure medications were administered in accordance with physician orders for two of six sampled residents (Resident 3 and Resident 5) by failing to:A. Ensure Resident 3's Omeprazole (medication used to reduce stomach acid and treat stomach irritation or reflux [backward flow of stomach acid into the esophagus [tube that connects the mouth to the stomach]) and Divalproex (medication used to treat seizures [episodes of abnormal brain activity] and mood disorders) medications were administered to swallow whole.B. Ensure Resident 5's Metformin (medication used to control blood sugar levels in diabetes [a persistent or long-lasting disease characterized by high blood sugar levels due to insufficient insulin [a hormone which regulates the amount of sugar in the blood] production]) was administered with food.These failures had the potential to result in ineffective therapeutic response and adverse medication reactions (injuries resulting from medication use including physical and mental harm, or loss of function), fluctuations in blood glucose levels, worsening of underlying medical conditions, and the potential for physical declines to Resident 3 and Resident 5. Findings: A. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 3/26/2025, and re-admitted the resident on 12/13/2025, with diagnoses including epilepsy (neurological disorder marked by sudden recurrent episodes of sensory disturbance, loss of consciousness, or convulsions [body muscles contract and relax rapidly and repeatedly, causing uncontrollable shaking and limb movements], associated with abnormal electrical activity in the brain), and encounter for attention to gastrostomy (G-tube, soft flexible tube surgically inserted directly into the stomach through a small opening in the abdomen, used to deliver liquid nutrition, hydration, and medications for people who cannot eat or swallow safely). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 3/31/2026, the MDS indicated Resident 3's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 3 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and with mobility. During a review of Resident 3's Medication Administration Record (MAR), dated 5/2026, the MAR indicated various medications were to be administered at 4:30 and 5 PM including: 1.Divalproex 125 milligrams (mg-a unit of medication measurement), give two capsules by mouth two times a day for seizure disorder, and to swallow whole do not crush or chew. 2.Omeprazole 40 mg, give one capsule by mouth two times a day for gastroesophageal reflux disease (GERD-acid reflux), and duodenal ulcer (sore in the small intestine), give before meals, swallow whole, and to not crush or chew. During a review of Resident 3's Order Summary Report (OSR), dated active as of 5/17/2026, the OSR included the following physician orders: Divalproex 125 mg, dated 4/1/2026, give 2 capsules by mouth two times a day for seizure disorder, the order indicated to swallow whole to not crush. The OSR (continued on next page)

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	05/18/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Omeprazole 40 mg, dated 4/1/2026, give one capsule by mouth two times a day for GERD/duodenal ulcer. The order indicated to swallow the capsule whole, and to not crush. During a medication pass (preparation and administration) observation on 5/17/2026 at 4:30 PM, Licensed Vocational Nurse (LVN) 2 prepared the following medications for Resident 3: Divalproex, Omeprazole, Lactulose (medication used to treat constipation or reduce ammonia [waste substance in blood] level), Namenda (medication used to treat memory loss and confusion), NovoLog (rapid-acting insulin [medication used to lower blood sugar]), Rifaximin (antibiotic used to reduce harmful bacteria in the intestines [bowels]), and Brimonidine Tartrate (eye medication used to lower eye pressure). LVN 2 removed the Omeprazole capsule from the bubble packaging (pre-packaged medications sealed in plastic bubbles), opened the capsule, and poured the contents into a medication cup. LVN 2 removed two Divalproex capsules from the bubble packaging and poured the contents into a separate medication cup. LVN 2 then prepared the remaining medications and administered each medication via G-tube. During an interview and concurrent record review on 5/17/2026 at 6:27 PM, Resident 3's OSR, dated 5/17/2026, was reviewed with LVN 2, LVN 2 stated the physician's orders for Resident 3's Divalproex and Omeprazole indicated the medications were to be swallowed whole and not to be crushed or chewed. LVN 2 stated she opened both capsules prior to the administration of the medications [and administered the contents of the capsule] via g-tube. LVN 2 stated that delayed release (medication coated to dissolve slowly instead of immediately) medications should not be opened unless specifically indicated by the physician or pharmacy as reflected in the physician's orders. LVN 2 stated altering the capsule may have affected how the medication was released and absorbed by the body, potentially reducing medication effectiveness or increasing the risk of adverse effects (AE, undesired harmful effect resulting from a medication). During an interview on 5/17/2026 at 6:46 PM, with the Director of Nursing (DON), the DON stated physician's orders are to be followed as written and should be properly followed when the order indicated medications are to be swallowed whole, not crushed or chewed. The DON stated delayed release or extended-release medications should not be altered unless specifically clarified and authorized by the prescribing physician or consulting pharmacist. The DON stated opening the capsules may alter the medication's intended release mechanism, potentially affecting absorption, decreasing therapeutic effectiveness, or increasing the risk for AEs. The DON stated nursing staff were expected to verify medication administration instructions prior to altering medications for G-tube administration. The DON stated these practices were essential to ensure resident safety and ensure medications were administered accurately according to the physician's orders. During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration via Enteral Tube, revised 12/19/2022, the P&P indicated it is the policy of the facility to ensure the safe and effective administration of medications via enteral feeding tubes [G-tube] by utilizing best practice guidelines. The P&P indicated sublingual, enteric coated, or modified release medications will not be administered through the enteral tube [G-tube]. The P&P indicated pharmacy will be notified for more appropriate dosage form[s]. B. During a review of Resident 5's AR, the AR indicated the facility admitted Resident 5 on 12/16/2025, with diagnoses that included type 2 diabetes mellitus (DM, a disease that affects how the body uses glucose), and protein-calorie malnutrition. During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5 had intact (continued on next page)

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	05/18/2026

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition and required supervision or touching assistance (helper provides verbal cues, steadying and/or contact guard assistance as resident completes the activity) with oral hygiene, and upper body dressing. During a review of Resident 5's Medication Review Report (MRR), dated 5/1/2026 to 5/31/2026, the MRR indicated a physician's order for Metformin Hydrochloride 500 mg, give one tablet by mouth three times a day for DM. The order indicated to administer Metformin with food. During an observation on 5/17/2026 4:32 PM, LVN 4 administered 500 mg of Metformin Hydrochloride to Resident 5 and did not provide or give food prior to the administration to Resident 5. During an interview on 5/17/2026 at 4:40 PM, LVN 4 stated Resident 5 usually had snacks at Resident 5's bedside. LVN 4 stated LVN did not remind or inform Resident 5 to take the medication [Metformin Hydrochloride] with food. LVN 4 stated taking Metformin with food as ordered [by the physician] prevented an upset stomach and a drop in blood sugar. During a review of the facility's P&P titled Medication Administration revised 12/19/2022, the P&P indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.