

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2025
NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</b></p> <p>Based on interview and record review, the facility failed to ensure four of four sampled residents (Resident 1, 4, 5, and 6) call lights (call bell- a device used by a resident to signal his or her need for assistance from staff) were answered promptly.</p> <p>This failure had the potential for Resident 1, 4, 5, and 6 needs not being met.</p> <p>Cross Reference: F689</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/3/2025 with diagnoses including acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and history of falling.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2025, the MDS indicated Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for bathing and toileting hygiene. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for dressing.</p> <p>During a review of Resident 1 ' s untitled care plan, initiated on 3/11/2025, the care plan indicated Resident 1 was at risk for falls. The care plan indicated interventions included, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>During a review of Resident 1 ' s Progress Notes (PN), dated 4/1/2025, the PN indicated Resident 1 fell on [DATE] while residing at the facility.</p> <p>During a review of Resident 4's AR, the AR indicated the facility admitted Resident 4 on 11/21/2020 and readmitted Resident 4 on 5/13/2024 with diagnoses including hypertension (high blood pressure), muscle weakness, and history of falling.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was moderately impaired in cognitive skills. The MDS indicated Resident 4 required substantial/maximal assistance from staff for lower body dressing and toileting hygiene. The MDS indicated Resident 4 required partial/moderate (helper does less than half the effort) assistance from staff for bathing and personal hygiene.</p> <p>During a review of Resident 5's AR, the AR indicated the facility admitted Resident 5 on 1/27/2025 with diagnoses including congestive heart failure (condition in which the heart cannot pump enough blood to all parts of the body), chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems), and insomnia (persistent problems falling and staying asleep).</p> <p>During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 was moderately impaired in cognitive skills. The MDS indicated Resident 5 required partial/moderate assistance from staff for dressing and personal and toileting hygiene.</p> <p>During a review of Resident 6's AR, the AR indicated the facility admitted Resident 6 on 3/27/2025 with diagnoses including dementia (a group of thinking and social symptoms that interferes with daily functioning), hemiplegia (Muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) and hemiparesis (muscle weakness or partial paralysis on one side of the body), following cerebral infarction (also called ischemic stroke, occurs as a result of disrupted blood flow to the brain).</p> <p>During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 was severely impaired in cognitive. The MDS indicated Resident 6 was dependent on staff for bathing, dressing, and toileting and personal hygiene.</p> <p>During a review of the facility ' s Daily Census Report (Census), dated 4/14/2025, the Census indicated Resident 1 and Resident 6 resided in the same room at the facility.</p> <p>During an interview on 4/15/2025 at 11:10 a.m. with Resident 1, Resident 1 stated Resident 1 fell about a week ago while at the facility. Resident 1 stated Resident 1 had pressed Resident 1's call light button and had waited for an hour without staff coming to assist Resident 1. Resident 1 stated Resident 1 was calling to get help for Resident 1's roommate (Resident 6) who was crying. Resident 1 stated Resident 1's roommate (Resident 6) was confused and needed assistance. Resident 1 stated Resident 1 yelled down the hall to try to get someone's attention. Resident 1 stated when no one came to answer Resident 1 ' s call light, Resident 1 attempted to get into Resident 1's wheelchair so that Resident 1 could wheel Resident 1 down to the nurses ' station to get help for Resident 1's confused roommate (Resident 6). Resident 1 stated Resident 1 fell to the ground while transferring Resident 1's self to the wheelchair.</p> <p>During an interview on 4/15/2025 at 12:20 p.m. with Resident 4, Resident 4 stated the night shift was the worst time to get help from staff. Resident 4 stated after midnight, it would take 15-30 minutes for a staff person to respond to Resident 4's call light for assistance.</p> <p>(continued on next page)</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/15/2025 at 12:32 p.m. with Resident 5, Resident 5 stated sometimes Resident 5 had to wait an hour to get assistance from staff when Resident 5 pressed Resident 5's call light. Resident 5 stated sometimes Resident 5 experienced panic attacks (sudden episode of intense fear or anxiety and physical symptoms) and would need a nurse due to Resident 5 having a hard time breathing. Resident 5 stated staff took forever to respond to Resident 5's call light and that made Resident 5 ' s anxiety worse.</p> <p>During a review of the facility ' s Resident Council Minutes, dated 4/9/2025, the Resident Council Minutes indicated residents (in general) were complaining The call takes a long time to be answered (11 pm to 7 am shift) mainly.</p> <p>During a review of the facility ' s policy and procedure (P&amp;P) titled, Communication- Call System revised on 1/1/2012, indicated to provide a mechanism for residents to promptly communicate with nursing staff. The P&amp;P indicated nursing staff will answer call bells promptly, in a courteous manner. The P&amp;P indicated the facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. The P&amp;P indicated, in answering to request, nursing staff will return to resident with the item or reply promptly.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38108</p> <p>Based on observation, interview, and record review, the facility failed to ensure Resident 9 did not physically assault (occurs when a person uses physical violence and causes injury to another person's body) two of six sampled residents (Resident 7 and Resident 8). On 3/31/2025, Resident 9 hit Resident 7 multiple times on Resident 7's face with Resident 9's closed fist and pulled Resident 8's necklace and held Resident 8's neck.</p> <p>As a result, on 3/31/2025 Resident 7 sustained a facial (face) contusion (bruising or skin discoloration), a closed head injury (head injury that does not break through the skull and occurs when the head gets hit hard), swelling and discoloration to Resident 7's left cheek, discoloration to the left and right eyelids, and bleeding from inside Resident 7's mouth. Resident 7 experienced sudden facial pain rated six out of 10 pain (moderately strong pain that interferes with normal daily activities) on a pain scale from 0 to 10 (0 means no pain, and 10 means the worst possible pain felt). The facility transferred Resident 7 to General Acute Care Hospital (GACH) 1 for further evaluation due to facial and a head injury. Additionally, Resident 8 sustained redness on the left side of the Resident 8's neck.</p> <p>Cross Reference: F689</p> <p>Findings:</p> <p>a. During a review of Resident 7's Admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities), Schizophrenia (a serious mental health condition that affects how people think, feel, and behave) and psychosis (abnormal condition of the mind that involves a loss of contact with reality).</p> <p>During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 3/11/2025, the MDS indicated Resident 7's cognition (ability to think and process information) was severely impaired. The MDS indicated Resident 7 used a wheelchair for mobility.</p> <p>During a review of Resident 7's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 3/31/2025, timed at 8:40 AM, the COC indicated (on 3/31/2025) at 6:30 AM, Resident 7 was sitting in the hallway on Resident 7's wheelchair saying, P--a (offensive language in Spanish) repeatedly and was swinging Resident 7's doll. The COC indicated the doll touched another resident (Resident 9). The COC indicated Resident 9 reacted and made physical contact with Resident 7's face by using a closed fist. The COC indicated Resident 7 had swelling and discoloration on Resident 7's left cheek, left and right eyelids, and Resident 7 was bleeding inside Resident 7's mouth. The COC indicated Resident 7 complained of sudden pain rated six out of 10.</p> <p>During a review of Resident 7's Physician's Order (PO), dated 3/31/2025, the PO indicated to apply an ice pack to Resident 7's face prn (as needed).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 7's Transfer Form (TF) dated 3/31/2025, timed at 1:34 PM, the TF indicated the facility transferred Resident 7 to GACH 1 for further evaluation for facial injury and a CT (computed tomography scan, a medical imaging technique used to obtain detailed internal images of the body) scan of Resident 7's face. The TF indicated Resident 7 was administered Acetaminophen (pain medication) 325 milligrams (mg, unit of measurement) for facial pain on 3/31/2025 at 10:30 AM.</p> <p>During a review of Resident 7's GACH 1 record, titled, Emergency Department Note Physician (ENP), dated 3/31/2025, the ENP indicated Resident 7's chief complaint was bruising and mouth pain (unrated) to Resident 7's face and head after Resident 9 assaulted Resident 7 at the facility. The ENP indicated Resident 7 reported mouth pain (unrated) due to Resident 7 being punched in the face several times (by Resident 9). The ENP indicated Resident 7 had bilateral (left and right side) facial contusions, and a closed head injury.</p> <p>During an observation of Resident 7's face and concurrent interview with Resident 7, on 4/16/2025 at 8:15 AM, Resident 7 had light gray discoloration around both eyes. Resident 7 stated a guy (Resident 9) with two hands, hit me on the face, Boom, Boom, in my eyes. Resident 7 raised Resident 7's left and right fists and punched the air. Resident 7 stated, I was bleeding in the mouth. Resident 7 stated, It hurt.</p> <p>b. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 11/5/2021, with diagnoses that included dementia and bipolar disorder (a mental disorder with periods of depression [serious illness that negatively affects how one feels, thinks and acts] and periods of elevated mood).</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition was severely impaired.</p> <p>During a review of Resident 8's COC, dated 3/31/2025, timed at 7:37 AM, the COC indicated, (on 3/31/2025) at 6:33 AM, Resident 8 was standing in the hallway close to the nurse's station. The COC indicated another resident [Resident 9] came from behind and pulled Resident 8's shirt and necklace, causing Resident 8's necklace to break, and held Resident 8 around Resident 8's neck. The COC indicated Resident 8 had redness on Resident 8's left side of the neck and first aid was applied (no specific treatment indicated).</p> <p>c. During a review of Resident 9's AR, the AR indicated the facility admitted Resident 9 on 2/4/2025, with diagnoses that included dementia and bipolar disorder.</p> <p>During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9's cognition was severely impaired. The MDS indicated Resident 9 used a walker and had no impairment to both lower and upper extremities.</p> <p>During a review of Resident 9's COC, dated 3/31/2025, timed at 6:30 AM, the COC indicated Resident 9 had a resident-to-resident altercation (fight between two residents) and Resident 9 made physical contact, using closed fists, with another resident's [Resident 7] face.</p> <p>During a review of Resident 9's Progress Notes (PN), dated 4/1/2025, timed at 9:57 AM, the PNs indicated on 3/31/2025 at 6:30 AM, Resident 9 had an altercation with two residents (Resident 7 and Resident 8).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 9's PO, dated 3/31/2025, the PO indicated to transfer Resident 9 to GACH 1 for evaluation of aggressive behavior (act aimed at harming a person or animal or damaging physical property) manifested by hitting other residents.</p> <p>During a review of Resident 9's TF dated 3/31/2025, timed at 7:58 AM, the TF indicated Resident 9 was transferred to GACH 1 for behavioral symptoms that included agitation (unpleasant state of extreme arousal) and psychosis.</p> <p>During a review of Resident 9's GACH 1's ENP, dated 3/31/2025, the ENP indicated Resident 9 was at risk for danger to others. The ENP indicated Resident 9 reported, she [Resident 7] was asking for it and I [Resident 9] was trying to kill her [Resident 7].</p> <p>During an interview on 4/15/2025 at 5:17 PM, the Director of Nursing (DON) stated abuse was defined as intentional harm to another person (physically, verbally, or mentally). The DON stated, It was not ok for Resident 9 to pull Resident 8's necklace or hold Resident 8 around the neck. The DON stated, Resident 9 used a closed fist and harmed Resident 7 more than once. The DON stated Resident 9's actions were willful, and This was abuse.</p> <p>During an interview on 4/16/2025 at 9:20 AM, Licensed Vocational Nurse (LVN) 6 stated on 3/31/2025, Resident 9 was walking by Resident 7 when Resident 7 was swinging Resident 7's doll. LVN 6 stated, Resident 7's doll hit Resident 9 and Resident 9 reacted by hitting Resident 7 with a closed fist three to four times on Resident 7's face. LVN 6 stated Resident 7's mouth was bleeding, and Resident 7 had swelling around the eyebrows, cheeks, and lips. LVN 6 stated within a minute after Resident 9 hit Resident 7, Resident 9 wheeled himself close to Resident 8, pulled Resident 8's shirt from behind and held Resident 8's neck.</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Safety of Residents, dated 1/1/2012, the P&amp;P indicated the purpose of the policy was to provide a safe environment for residents and facility staff.</p> <p>During a review of the facility's P&amp;P titled Abuse - Prevention, Screening &amp; Training Program, dated July 2018, the P&amp;P indicated, Abuse was defined as willful, deliberate infliction of injury .with resulting physical harm, pain or mental anguish.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38108</p> <p>Based on interview and record review, the facility failed to develop and implement an individualized person-centered care plan (CP), for one of six sampled residents (Resident 7), that addressed a possible head injury to Resident 7 due to being struck in the head multiple times by Resident 9 during a resident-to-resident altercation (fight between two residents).</p> <p>This failure had the potential to result in unmet individualized needs for Resident 7 and the potential to affect the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>During a review of Resident 7's Admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities), Schizophrenia (a serious mental health condition that affects how people think, feel, and behave) and psychosis (abnormal condition of the mind that involves a loss of contact with reality).</p> <p>During a review of Resident 7's History and Physical (H&amp;P), dated 3/20/2024, indicated Resident 7 could make needs known but cannot make medical decisions.</p> <p>During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 3/11/2025, the MDS indicated Resident 7's cognition (ability to think and process information) was severely impaired. The MDS indicated Resident 7 used a wheelchair for mobility.</p> <p>During a review of Resident 7's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 3/31/2025, timed at 8:40 AM, the COC indicated (on 3/31/2025) at 6:30 AM, Resident 7 was sitting in the hallway on Resident 7's wheelchair saying, P--a (offensive language in Spanish) repeatedly and was swinging Resident 7's doll. The COC indicated the doll touched another resident (Resident 9). The COC indicated Resident 9 reacted and made physical contact with Resident 7's face by using a closed fist.</p> <p>During a review of Resident 7's Physician's Order (PO), dated 3/31/2025, the PO indicated to apply an ice pack to Resident 7's face prn (as needed).</p> <p>During a review of Resident 7's Transfer Form (TF) dated 3/31/2025, timed at 1:34 PM, the TF indicated the facility transferred Resident 7 to GACH 1 for further evaluation for facial injury and a CT (computed tomography scan, a medical imaging technique used to obtain detailed internal images of the body) scan of Resident 7's face.</p> <p>During a review of Resident 7's GACH 1 record, titled, Emergency Department Note Physician (ENP), dated 3/31/2025, the ENP indicated Resident 7 had bilateral (left and right side) facial contusions (bruising or skin discoloration) and a closed head injury.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and concurrent record review of Resident 7's paper and electronic medical record (chart), with the Medical Records Supervisor (MRS), on 4/15/2025 at 4:39 PM, the MRS stated Resident 7's chart did not have a CP regarding Resident 7's being struck in the face multiple times.</p> <p>During an interview and concurrent record review of Resident 7's paper and electronic chart, with the Director of Nursing (DON), on 4/15/2025 at 4:45 PM, the DON stated Resident 7 did not have a CP that addressed a possible head injury due to being struck in the head multiple times by Resident 9. The DON stated CPs were important to provide proper care and effective interventions for the individualized and overall care of Resident 7.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Comprehensive Person-Centered Care Planning, revised 11/2018, the P&amp;P indicated it was the policy of the facility to provide person-centered, comprehensive, and interdisciplinary care that reflects the best practice standards for meeting health, safety, psychosocial, behavioral and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well-being. The P&amp;P indicated additional changes or updates to the resident's comprehensive CP will be made based on the assessed needs of the resident .the comprehensive CP will also be reviewed and revised at the following times, onset of new problems, change of condition, and during other times as appropriate or necessary.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027</b></p> <p>Based on interview and record review, the facility failed to ensure three of four sampled residents (Resident 1, Resident 7, and Resident 8) received adequate supervision by failing to,</p> <p>a. Ensure Resident 1 ' s call light (a device used by a resident to signal his or her need for assistance from staff) was answered promptly by facility staff.</p> <p>b. Ensure Resident 9 did not physically assault (occurs when a person uses physical violence and causes injury to another person's body) Resident 8 right after Resident 9 physically assaulted Resident 7.</p> <p>These failures resulted in Resident 1 falling to the floor on 4/1/2025, and had the potential for Resident 1 to sustain injuries. Additionally, the failures resulted in Resident 9 holding Resident 7 in chokehold [position] around Resident 8's neck and resulted in redness to Resident 8's neck.</p> <p>Findings:</p> <p>a. During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on 3/3/2025 with diagnoses including acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and history of falling.</p> <p>During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2025, the MDS indicated Resident 1 had no impairments in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for bathing and toileting hygiene. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) from staff for dressing.</p> <p>During a review of Resident 1's untitled care plan, initiated on 3/11/2025, the care plan indicated Resident 1 was at risk for falls. The care plan indicated interventions included, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.</p> <p>During a review of Resident 1's Progress Notes (PN), dated 4/1/2025, the PN indicated Resident 1 fell on [DATE] while residing at the facility.</p> <p>During a review of the facility's Daily Census Report (Census), dated 4/14/2025, the Census indicated Resident 1 and Resident 6 resided in the same room at the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/15/2025 at 11:10 a.m. with Resident 1, Resident 1 stated Resident 1 fell about a week ago while at the facility. Resident 1 stated Resident 1 had pressed Resident 1's call light button and had waited for an hour without staff coming to assist Resident 1. Resident 1 stated Resident 1 was calling to get help for Resident 1's roommate (Resident 6) who was crying. Resident 1 stated Resident 1's roommate (Resident 6) was confused and needed assistance. Resident 1 stated Resident 1 yelled down the hall to try to get someone's attention. Resident 1 stated when no one came to answer Resident 1's call light, Resident 1 attempted to get into Resident 1's wheelchair so that Resident 1 could wheel Resident 1 down to the nurses' station to get help for Resident 1's confused roommate (Resident 6). Resident 1 stated Resident 1 fell to the ground while transferring Resident 1's self to the wheelchair.</p> <p>During a review of the facility's Resident Council Minutes, dated 4/9/2025, the Resident Council Minutes indicated residents (in general) were complaining The call takes a long time to be answered (11 pm to 7 am shift) mainly.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Fall Management Program, revised 3/13/2021, the P&amp;P indicated the purpose of the facility's Fall Management Program was to provide residents a safe environment that minimizes complications associated with falls. The P&amp;P indicated, as part of the Admission Assessment, the licensed nurse will complete a fall risk evaluation.</p> <p>b1. During a review of Resident 7's AR, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included dementia (a group of symptoms affecting memory, thinking, and social abilities), Schizophrenia (a serious mental health condition that affects how people think, feel, and behave) and psychosis (abnormal condition of the mind that involves a loss of contact with reality).</p> <p>During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognition was severely impaired. The MDS indicated Resident 7 used a wheelchair for mobility.</p> <p>During a review of Resident 7's Change in Condition Evaluation (COC, a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains), dated 3/31/2025, timed at 8:40 AM, the COC indicated (on 3/31/2025) at 6:30 AM, Resident 7 was sitting in the hallway and Resident 7's The COC doll touched Resident 9. The COC indicated Resident 9 reacted and made physical contact with Resident 7's face by using a closed fist.</p> <p>b2. During a review of Resident 8's AR, the AR indicated the facility admitted Resident 8 on 11/5/2021, with diagnoses that included dementia and bipolar disorder (a mental disorder with periods of depression [serious illness that negatively affects how one feels, thinks and acts] and periods of elevated mood).</p> <p>During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition was severely impaired.</p> <p>During a review of Resident 8's COC, dated 3/31/2025, timed at 7:37 AM, the COC indicated, (on 3/31/2025) at 6:33 AM, Resident 8 was standing in the hallway close to the nurse's station. The COC indicated Resident 9 came from behind and pulled Resident 8's shirt and necklace, causing Resident 8's necklace to break, and held Resident 8 around Resident 8's neck. The COC indicated Resident 8 had redness on Resident 8's left side of the neck and first aid was applied.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555852	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/16/2025
NAME OF PROVIDER OR SUPPLIER  Park Avenue Healthcare & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1550 North Park Avenue 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b3. During a review of Resident 9's AR, the AR indicated the facility admitted Resident 9 on 2/4/2025, with diagnoses that included dementia and bipolar disorder.</p> <p>During a review of Resident 9's MDS dated [DATE], the MDS indicated Resident 9's cognition was severely impaired. The MDS indicated Resident 9 used a walker and had no impairment to both lower and upper extremities.</p> <p>During a review of Resident 9's PN, dated 4/1/2025, timed at 9:57 AM, the PNs indicated on 3/31/2025 at 6:30 AM, Resident 9 had an altercation with two residents (Resident 7 and Resident 8).</p> <p>During an interview on 4/15/2025 at 5:17 PM, the Director of Nursing (DON) stated Resident 7 walked by Resident 9 and Resident 9 got behind Resident 7, pulled Resident 7's necklace, and held Resident 7 by the neck. The DON stated it was not ok for Resident 9 to pull Resident 7's necklace and Resident 9's action of holding Resident 7 around the neck</p> <p>During an interview on 4/16/2025 at 9:20 AM, with Licensed Vocational Nurse (LVN) 6, LVN 6 stated on 3/31/2025, Resident 9 was walking by when Resident 7 was swinging Resident 7's doll. LVN 6 stated, Resident 7's doll hit Resident 9 and Resident 9 reacted by hitting Resident 7. LVN 6 stated Resident 8 was standing in the hallway when Resident 9 wheeled himself close to Resident 8, pulled Resident 8's shirt from behind and held Resident 8's neck. LVN 6 stated the incident between Resident 8 and Resident 9 occurred a minute after the incident between Resident 7 and Resident 9.</p> <p>During an interview on 4/16/2025 at 9:35 AM, with Certified Nursing Assistant (CNA) 5 stated after the incident between Resident 7 and Resident 9, LVN 6 and LVN 7 stayed with Resident 7. Resident 9 stayed behind while the CNA's tried to control the situation. CNA 5 stated CNA 5 was leaning next to the utility room while watching Resident 9 who was in the hallway, when Resident 8 came up to CNA 5 and Resident 9 held Resident 8 in a chokehold [position] around Resident 8's neck. CNA 5 stated during altercations between residents, the residents needed to be separated to avoid further physical contact and staff needed to stay with the residents [by the resident's side] involved in the altercation.</p> <p>During a telephone interview on 4/16/2025 at 9:47 AM, CNA 7 stated per the facility's training on resident-to-resident altercations, staff members needed to stay with the residents involved in the altercation to avoid another altercation.</p> <p>During a telephone interview on 4/16/2025 at 10:18 AM, with LVN 7 stated it was important to supervise the residents involved in an altercation because the aggressive behavior could escalate and could result in another altercation</p> <p>During a review of the facility's Policy and Procedure (P&amp;P) titled, Safety of Residents, dated 1/1/2012, the P&amp;P indicated the purpose of the policy was to provide a safe environment for residents and facility staff. The P&amp;P indicated Residents who displayed combative behaviors received prompt and appropriate interventions. The P&amp;P indicated if a resident's behavior became abusive, hostile, or unmanageable in a way that compromised his or her safety or the safety of others, the charge nurse will maintain one on one supervision of the resident until the behavior subsided.</p>		