Approved on 05/29/2025
48267

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055126	A. BUILDING _____ B. WING _____	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHINO VALLEY HEALTH CARE CENTE	2351 S TOWNE AVENUE POMONA, CA 91766

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The findings are in accordance with 42 Code Federal Regulations (CFR) 483.73, Requirement for Long Term Care (LTC) Facilities. The facility is in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care (LTC) Facilities. Census: 95	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M Gang | TITLE: Administrator | (X6) DATE: 5-28-25

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.

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	055126	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/05/2025

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 1969 K7 SURVEY UNDER: 2012 EXISTING STRUCTURE TYPE: ONE STORY, FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health during an annual Life Safety Code recertification survey. The findings are in accordance with 42 Code of Federal Regulations (CFR) 483.90(a)(b)(c)(j), National Fire Protection Association (NFPA) 101 - Life Safety Code, 2012 Edition, and NFPA 99 - Health Care Facilities Code, 2012 Edition. The facility is not in substantial compliance with 42 CFR 483.90 for Long Term Care (LTC) Facilities. Resident Certified Beds: 102 Census: 95	K 000	The signing of this plan of correction is not an admission or agreement by this facility of the truth of the facts alleged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as our written credible allegation of compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the fire alarm	K 345		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 5-27-25

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.

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K 345	Continued From page 1 system (building system designed to detect fires and alert occupants) equipment in accordance with NFPA 101, 2012 Edition, Section 9.6.1.3, NFPA 70, National Electrical Code, 2011 Edition, Section 760.121(B), and NFPA 72, National Fire Alarm Code, 2010 Edition, Section 10.3, affecting eight of eight smoke compartments (a space within a building enclosed by smoke barriers on all sides, having an appropriate resistance to the spread of smoke). This failure has the potential to delay the identification of the dedicated fire alarm system electrical disconnect to prevent the disconnecting of the fire alarm system and increase the probability of a fire related injury, affecting the safety of 95 of 95 residents, staff, and visitors at the facility. Findings: During a concurrent observation and interview on 5/5/25 at 10:43 AM with the Maintenance Supervisor (MS) at the fire alarm electrical panel, the MS was unable to identify the fire alarm circuit disconnect. The fire alarm panel disconnect was not easily identifiable nor properly indicated. The MS stated they should know where the fire alarm disconnect is and should be clearly indicated on the electrical panel. During a review of the facility's policy and procedure (P&P) titled, "Maintenance Service," last revised 12/09, the P&P indicated, "Functions of maintenance personnel include...maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines...maintaining the building in good repair and free from hazards...maintaining the fire alarm system and emergency generator system in good working order."	K 345	Immediate Corrective Action: On 5/20/25 the Maintenance Supervisor consulted with the Corp. Electrician, and he was able to identify and label all the fire alarm panel disconnect. Identify Other Residents: Corporate Electrician made rounds with the MS and checked all fire alarm electrical panels to ensure that all the fire alarm panel disconnect are identified. No other fire panel had this deficient practice. Measures into place: On 5/22/25 the Administrator in serviced the MS and Maintenance assistant ensuring that all fire alarm panels are labeled indicating the fire alarm circuit disconnect is easily identifiable. Monitoring: Administrator and DSD will randomly check the fire panels on a monthly basis x 3 months to ensure that the fire alarm panel disconnect is identifiable. Findings will be presented to QAPI meeting quarterly for further review and or actions if necessary.	

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K 345	Continued From page 2 During a review of the facility's P&P titled, "Fire Alarm System," last revised 1/19, the P&P indicated, "Our facility maintains an operable fire alarm system at all times...An emergency electrical power system supplies power to maintain the fire alarm system in the event that there is a loss of power."	K 345	Completed date: 5/22/25 Corrective Acton: On 5/5/25 the Maintenance Supervisor immediately dated and initialed the monthly PFE tag. Identify Other Residents: No other portable fire extinguisher had this deficient practice. Measures into place: On 5/6/25 the Administrator in serviced the MS and Maintenace Assistant ensuring that all PFE tags are monthly inspected with a date and initials of person doing the inspection. Monitoring: Administrator and Director of Staff Development will monitor monthly PFE tags to ensure that all are being inspected with dates and initials of the person doing inspection x 3 months. Findings will be presented to QAPI meeting quarterly for further review and/ or actions if necessary. Completed date: 5/22/25	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the portable fire extinguisher (PFE) in the main electrical panel room was inspected and maintained monthly in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Sections 7.2.1.2, 7.2.4.3, 7.2.4.4, 7.2.4.5, affecting one of eight smoke compartments. This failure has the potential for the PFE to fail or delay the extinguishment of a fire, affecting the safety of residents, staff, and visitors during an actual fire emergency. Findings: During a concurrent observation and interview on 5/5/25 at 10:39 AM with the MS at the main electrical panel room, the PFE tag was missing monthly inspection dates and the initials of the	K 355		

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K 355	Continued From page 3 person performing the inspection between 2/25 to 4/25. There was no indication the PFE was inspected from 2/25 to 4/25. The MS stated PFEs should be inspected monthly, and inspection should be documented monthly. During a review of the facility's P&P titled, "Maintenance Service," last revised 12/09, the P&P indicated, "Functions of maintenance personnel include...maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines...maintaining the building in good repair and free from hazards."	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363	Immediate Correction Action: On 5/6/25 the MS switched out the bed that was impeding the doorway closure pathway with a smaller frame bed. It no longer impedes the doorway closure pathway. On 5/5/25 the MS immediately removed the door stopper in order for the corridor door to remain closed. Identifying Other Residents: No other rooms had this deficient practice. Measures into place: On 5/20/25 the Administrator in serviced MS and Medical Records Director on not to impede the doorway closure pathway with a door stopper or any furniture.	

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K 363	Continued From page 4 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to utilize an approved automatic door release device and prevent the impediment to the closing of a corridor door in one of eight smoke compartments, in accordance with NFPA 101, 2012 Edition, Section 19.3.6.3.10. This failure has the potential for fire and/or smoke to spread to adjacent rooms or spaces in the event of a fire and/or smoke emergency, affecting the safety of residents, staff, and visitors. Findings: During a concurrent observation and interview on 5/5/25 at 9:44 AM with the MS inside Resident Room 139, the corridor door was unable to close due to a resident bed impeding the door closure pathway. The MS had to move the bed aside for the resident room door to properly close and positively latch. The MS stated he had to move the bed for the door to close and the door closure pathway should be kept clear.	K 363	Monitoring: During daily rounds the MS and MS assistant will visually monitor that all resident room doors will be able to and positively latch x 3 months. Also monitoring daily x 3 months that no office door be propped open with a kick down stopper. Findings will be presented to QAPI meeting quarterly for further review and/ or actions if necessary. Completion date: 5/20/25	

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K 363	Continued From page 5 During a concurrent observation and interview on 5/5/25 at 10:03 AM with the MS inside the Medical Records Office, the corridor door was being held in the open position by a kick down stopper. The MS stated the use of the kick down stopper propping the door open should not be used and should use an approved release device. During a review of the facility's P&P titled, "Hazardous Areas, Devices and Equipment," last revised 7/17, the P&P indicated, "All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible." The P&P also indicated, "As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the safety committee." During a review of the facility's P&P titled, "Maintenance Service", last revised 12/09, the P&P indicated, "Functions of maintenance personnel include...maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines...maintaining the building in good repair and free from hazards."	K 363		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		

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K 923	Continued From page 6 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain full pressurized oxygen cylinders (cannisters filled with oxygen for patient use) separated from empty oxygen cylinders in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.5.2, affecting one of eight smoke	K 923	Immediate Corrective Action: The MS immediately removed the full oxygen cylinder that was stored in the "EMPTY" indicator side, to the " FULL" indicator side. The two empty oxygen cylinders that were stored in the "FULL" indicator side were moved to the "EMPTY" indicator side. Identifying of Others: All full and empty oxygen cylinders were all stored in their appropriate indicated sign. No other oxygen cylinders had this deficient practice. Measures in place: On 5/22/25 the DSD in serviced the Licensed Staff on the storing of oxygen. The "FULL" indicator of oxygen needs to be stored on the right side as it indicates and the " EMPTY" needs to be stored on the left side as indicated. Monitoring: The MS and the MS assistant when doing their daily rounds x 3 months they will ensure the oxygen storage room is being maintained with the full and empty oxygen cylinders separated and as indicated.	

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K 923	Continued From page 7 compartments. This failure has the potential for staff to experience confusion and delay if a full cylinder is needed in a rapid manner, placing residents at risk in an event of an emergency. Findings: During a concurrent observation and interview on 5/5/25 at 10 AM with the MS at the Oxygen Storage Room, there was one full oxygen cylinder stored with empty oxygen cylinders under the "EMPTY" indicator sign. There were two empty oxygen cylinders stored with full oxygen cylinders under the "FULL" indicator sign. The MS stated the full and empty oxygen cylinders should be stored separately. During a review of the facility's P&P titled, "Hazardous Areas, Devices and Equipment," last revised 7/17, the P&P indicated, "All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. The P&P also indicated, "As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the safety committee." During a review of the facility's P&P titled, "Maintenance Service," last revised 12/09, the P&P indicated, "Functions of maintenance personnel include...maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines...maintaining the building in good repair and free from hazards."	K 923	Findings will be presented to QAPI meeting quarterly for further review and/ or actions if necessary. Completion date: 5/22/25	