STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 37198 Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, for one of thirteen sampled residents (Resident 12) by failing to: 1. Ensure Housekeeper (HK) 1 timely reported an abuse allegation involving Certified Nursing Assistant (CNA) 3 and Resident 12 to the Housekeeping Supervisor (HS) and/or to the Administrator (ADM). 2. Ensure the facility reported an abuse allegation to the California Department of Public Health (CDPH) immediately but no later than two hours of knowing about the abuse allegation. These deficient practices had the potential to compromise the safety of Resident 12 and exposed Resident 12 to further potential abuse. Findings: During a review of Resident 12's Admission Record (AR), the AR indicated the facility originally admitted Resident 12 on 2/15/2023, and readmitted Resident 12 on 4/21/2023, with diagnoses that included hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease (kidney damage caused by high blood pressure), respiratory failure (a serious condition that occurs when the lungs are unable to get enough oxygen into the blood or remove enough carbon dioxide), and muscle weakness. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 11/7/2024, the MDS indicated Resident 12 was usually understood by others and had the ability to usually understand others. The MDS indicated Resident 12 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, showering/bathing self, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. During an interview on 2/5/2025 at 11:37 am with HK 1, HK 1 stated five months ago, HK 1 saw CNA 3 sitting on top of Resident 12's bed pulling Resident 12 up towards CNA 3. HK 1 stated HK 1 did not report what HK 1 saw at that time because HK 1 was nervous and did not want anything to happen to CNA 3. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 12:38 pm with the ADM, the ADM stated on 12/26/2024, HK 1 reported to the HS that two months prior to 12/26/2024 at 11:30 am, HK 1 allegedly saw CNA 3 kissed Resident 12. The ADM stated the protocol for any abuse allegation was to file a SOC 341 (a confidential report of suspected dependent adult/elder abuse) within two hours (to CDPH) and for the facility to continue the investigation for five days. The ADM stated the abuse allegation was not reported to CDPH because Resident 12 denied the allegation during the facility's investigation. The ADM stated the facility's abuse policy was for staff to report the incident (alleged abuse) right away so the facility could start the investigation and to prevent any harm to the resident. The ADM stated facility staff were aware they had to immediately report all alleged abuse to the ADM so the resident could be protected from harm. During a follow-up interview on 2/5/2025 at 3:27 pm with HK 1, HK 1 stated five months ago, HK 1 stated HK 1 saw CNA 3 sitting on top of Resident 12's bed, either pulling Resident 12 up towards CNA 3 or hugging Resident 12. HK 1 stated HK 1 should have reported the incident to the HS and/or the ADM right away. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, the P&P indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. The P&P indicated, If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The P&P indicated, The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman; c. The resident's representative; d. Adult protective services (where state law provides jurisdiction in long-term care); e. Law enforcement officials; f. The resident's attending physician; and g. The facility medical director. The P&P indicated, .Immediately is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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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** 37198 Based on observation, interview, and record review, the facility failed to provide the necessary care and services for three of thirteen sampled residents (Residents 1, 2, and 13) as indicated in the facility's policies and procedures (P&P) titled, Neurological Assessment, Charting and Documentation, and Change in a Resident's Condition or Status by failing to: a. Ensure assigned licensed nurses completed neurological (relating to the functioning of the brain, spine, and nerves) assessments for the 72-hour monitoring period after Resident 1 was involved in a resident-to-resident altercation. b. Ensure assigned licensed nurses completed neurological assessments for the 72-hour monitoring period after Resident 2 was involved in a resident-to-resident altercation. c. Ensure assigned licensed nurses monitored and documented Resident 13's condition when Resident 13 tested positive for Covid-19 (a respiratory illness caused by a virus that is easily spread from person to person) and was transferred to the facility's red zone (area designated for residents who tested positive for Covid-19). These failures had the potential to result in incomplete and improper assessments of potential changes in Resident 1's and Resident 2's neurological status and Resident 13's condition while in the facility's Covid-19 red zone. Findings: a. During a review of Resident 1's Admission Record (AR), the AR indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought) and dementia (a progressive state of decline in mental abilities). During a review of Resident 1's History & Physical (H&P), dated 7/2/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/3/2024, Resident 1 had severely impaired cognition (ability to understand) and needed supervision or touching assistance (helper provides verbal cue and/or touching/steadying and/or contact guard assistance as the resident completes the activity with assistance provided throughout the activity or intermittently) with personal hygiene (included combing hair, having, washing/drying face and hands) and walking 10 feet in a room, corridor, or similar space. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Situation-Background-Assessment-Recommendation Communication Form and Progress Note (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents), dated 2/1/2025, the SBAR indicated Resident 1 and Resident 2 had an altercation on 2/1/2025 at 10:30 am. The SBAR indicated Resident 1 went out the wrong door and was struck by Resident 2, sustaining lower lip discoloration. The SBAR indicated neurological checks (neuro checks -assessment that checks the resident's level of consciousness, pupil response, motor functions [hand grasp strength and movement of extremities], pain response, and vital signs with a monitoring frequency (unless specified by the doctor) of every 15 minutes for 1 hour, every 30 min for 4 hours, every 1 hour for 2 hours and then every shift for 72 hours) were being done every shift. During a review of Resident 1's Care Plan (CP), dated 2/2/2025, the CP indicated Resident 1 had a physical altercation with another resident. The CP goal indicated to avoid complications due to the altercation. The CP interventions included for staff to monitor the resident closely. During a review of Resident 1's IDT Conference record (IDT - interdisciplinary team, a group of healthcare providers involved in the resident's care), dated 2/3/2025, the IDT indicated the IDT was being conducted due to the resident-to-resident altercation that occurred on 2/1/2025. The IDT indicated Resident 1's body assessment noted left lower lip discoloration and interventions included 72 hours of monitoring. During a review of Resident 1's Psychiatric Follow-up Note (PFN), dated 2/3/2025, the PFN indicated Resident 1 was seen due to the resident-to-resident altercation. The PFN indicated the plan included for Resident 1 to be observed for deterioration in function. During an observation on 2/4/2025 at 2:45 pm in the dining room, Resident 1 was sitting up in a chair and had small amount of purplish-gray discoloration on the bottom lip. During a concurrent interview and record review on 2/4/2025 at 4:32 pm with the Quality Assurance Nurse (QA), Resident 1's Neurological Assessment Flowsheet (NAF- form used to document neurological assessment checks/neuro checks on a resident) started on 2/1/2025 at 10:30 am was reviewed. The NAF indicated documentation was documented through 2/3/2025, during the 3 pm to 11 pm shift, with some lines of documentation missing pain responses and motor function assessment. The QA stated after a resident-to-resident altercation, the 72-hour monitoring included 72 hours of neurological checks, which were charted on the flowsheets, and monitoring for any emotional distress. The QA stated 72 hours from 2/1/2025 at 10:30 am was 2/4/2025 at 10:30 am and the documentation should have been completed through that morning (2/4/2025). The QA stated it was important to do neuro checks to verify the resident was okay and to monitor the resident for any neurological changes. b. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes mellitus (DM2- elevated blood sugar level) with diabetic chronic kidney disease (damage to the kidneys so they cannot filter blood properly) and major depressive disorder or depression (a persistent sadness and loss of interest in activities that interferes with daily life). During a review of Resident 2's H&P, dated 10/7/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's MDS, dated [DATE], Resident 2 had severely impaired cognition (ability to understand) and was independent walking 10 feet in a room, corridor, or similar space. During a review of Resident 2's SBAR, dated 2/1/2025, the SBAR indicated Resident 1 and Resident 2 had an altercation on 2/1/2025 at 10:30 am. The SBAR indicated Resident 1 went out the wrong door and was struck by Resident 2. The SBAR indicated Resident 2 sustained left under eye discoloration. The SBAR indicated residents were separated, behavioral monitoring was in place, and neurological checks were being done every shift. During a review of Resident 2's CP, dated 2/2/2025, the CP indicated Resident 1 had a physical altercation with another resident. The CP goal indicated to avoid complications due to the altercation. The CP interventions included to monitor the resident closely. During a review of Resident 2's IDT, dated 2/3/2025, the IDT indicated the IDT was conducted due to the resident-to-resident altercation that occurred on 2/1/2025. The IDT indicated Resident 1's body assessment noted left side eye discoloration and interventions included 72 hours of monitoring. During a review of Resident 2's PFN, dated 2/3/2025, the PFN indicated Resident 2 was seen due to the resident-to-resident altercation. The PFN indicated the plan included to observe Resident 2 for deterioration in function. During a concurrent observation and interview on 2/4/2025 at 2:59 pm with Resident 2, in Resident 2's room, Resident 2 had dark purple bruising under Resident 2's left eye. Resident 2 stated Resident 1 hit him (Resident 2) with his (Resident 1's) fist. Resident 2 stated the nurses were not doing neuro checks on him. During a concurrent interview and record review on 2/4/2025 at 4:32 pm with the QA, Resident 2's NAF started on 2/1/2025 at 10:30 am was reviewed. The NAF indicated the NAF was completed through 2/3/2025 during the 3 pm to 11 pm shift. The QA stated after a resident-to-resident altercation the 72-hour monitoring included 72 hours of neurological checks, which were charted on the flowsheets, and monitoring for any emotional distress. The QA stated72 hours from 2/1/2025 at 10:30 am was 2/4/2025 at 10:30 am and the documentation should have been completed through that morning (2/4/2025). The QA further stated it was important to verify the resident was okay and to monitor the resident for any neurological changes. During an interview on 2/5/2025 at 4:33 pm with the Director of Nursing (DON), the DON stated after a resident-to-resident altercation with physical abuse, including a hit to the head, the facility's process included a charge nurse initiating neuro checks and usually continuing then neuro checks for 48 to 72 hours to make sure the resident was stable. The DON stated neurological assessments were important to identify abnormalities that arise during the observation time. The DON stated documentation should be complete and when neurological assessments were undocumented, staff would lack resident data to evaluate and would not recognize when something was wrong with the resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 1:21 pm with the DON, the DON stated the importance of monitoring and documenting a resident's condition after a change in condition was for staff to be able to have a picture of what the resident had, the resident's care and condition, and to recognize signs and symptoms (of a possible health concern). The DON stated if staff identified a change of condition with the resident, staff needed to monitor and document their assessments so the change of condition could be addressed. During a review of the facility's P&P titled, Neurological Assessment, revised October 2010, the P&P indicated, The purpose of this procedure is to provide guidelines for a neurological assessment . when indicated by the resident's condition. The P&P indicated, The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised May 2017, the P&P indicated The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. During a review of the facility's P&P titled, Charting and Documentation, revised July 2017, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical physical, functional or psychological condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.