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	03/13/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on observation, interview, and record review, the facility failed to ensure the ordered tab alarm (device used to notify staff when residents attempted to transfer unassisted by staff) was attached to one of three sampled residents (Resident 8) who was at risk of falls. This failure resulted in Resident 8 falling to the floor on 3/12/2025 while in the care of the facility. The failure had the potential for Resident 8 to be injured due to the fall. Findings: During a review of Resident 8's Admission Record (AR), the AR indicated the facility admitted Resident 8 on 3/11/2025 with diagnoses including 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), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and chronic obstructive pulmonary disease (COPD, a group of diseases that cause airflow blockage and breathing-related problems). During a review of Resident 8's Fall Risk Evaluation, dated 3/12/2025, the Fall Risk Evaluation indicated score 10 or higher was a high risk of falls. The Fall Risk Evaluation, indicated to initiate fall risk precautions. During a review of Resident 8 ' s Post Fall Evaluation, dated 3/12/2025, the Post Fall Evaluation indicated Resident 8's pre-fall risk score was 15. The Post Fall Evaluation indicated Resident 8 fell on [DATE]. The Post Fall Evaluation indicated Resident 8 ' s personal alarm did not sound while Resident 8 was found on the floor. During a review of Resident 8's History and Physical (H&P), dated 3/13/2025, the H&P indicated Resident 8 did not have the capacity to understand and make decisions. During a review of Resident 8 ' s Order Summary Report, dated 3/13/2025, the Order Summary Report indicated Resident 8 had a physician order dated 3/11/2025, .tab alarm while in bed to alert the staff of unassisted transfer. (continued on next page)

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/13/2025 at 1:00 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 was assigned to care for Resident 8 on 3/12/2025. CNA 1 stated Resident 8 fell from his bed on 3/12/2025. CNA 1 stated CNA 1 was aware Resident 8 was at risk for falls. CNA 1 stated Resident 8 had a tab alarm the facility staff applied to Resident 8 while Resident 8 was lying in bed. CNA 1 stated CNA 2 notified CNA 1 that Resident 8 had fallen. CNA 1 stated when CNA 1 arrived at Resident 8 ' s room, Resident 8 ' s tab alarm was not sounding. During a telephone interview on 3/13/2025 at 1:24 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 was assigned to care for Resident 8 on 3/12/2025. LVN 1 stated Resident 8 moved a lot, and that Resident 8 did not want to lay in bed. LVN 1 stated Resident 8 needed a tab alarm to notify staff when Resident 8 tried to get out of bed. LVN 1 stated Resident 8 ' s tab alarm sounded two times during the shift and when LVN 1 responded to the alarm, Resident 8 was trying to get out of bed without assistance from staff. During an interview on 3/13/2025 at 1:40 p.m. with CNA 2, CNA 2 stated CNA 2 found resident 8 on the floor next to Resident 8 ' s bed on 3/12/2025 at around 12:30 p.m. CNA 2 stated Resident 8 was lying face down on the floor. During a concurrent observation and interview on 3/13/2025 at 1:50 p.m. with CNA 2 in Resident 8 ' s room, Resident 8 ' s tab alarm was observed. The tab alarm consisted of a rectangular box with a cord connected to the box by a magnet. When the magnet was pulled off the box, an alarm sounded. At the other end of the cord was a metal clip that was clipped to Resident 8 ' s hospital gown. CNA 2 stated Resident 8 ' s tab alarm was not sounding. CNA 2 stated Resident 8 ' s tab alarm was not clipped to Resident 8. During a concurrent observation and interview on 3/13/2025 at 2:38 p.m. with the Maintenance Assistance (MA), a tab alarm was observed. The MA stated the tab alarm was a device used to alert staff when residents (in general) were attempting to get out of bed unassisted. The MA stated the box was to be clipped to the resident ' s (in general) bed and the cord was to be clipped to the resident ' s (in general) clothing. The MA stated the tab alarm would sound when the cord was pulled from the box. The MA stated when staff heard the alarm, the staff should think a resident (in general) was trying to get out of bed. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised March 2018, the P&P indicated, Position-change alarms will not be used as the primary or sole intervention to prevent falls, but rather will be used to assist the staff in identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. During a review of the facility ' s manufacturers manual, titled Basic Series Magnet Alarm Monitor, undated, the manual indicated, .Place the alarm box on the desired monitoring surface (bed or chair or floor) and make sure that the magnet is sturdily and place. Attach the alligator clip to the patient's shirt being careful not to catch the patient's skin .Warning: the effectiveness of monitors and sensor pad systems depends on proper equipment installation and operation. Always test the system prior to use .