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	04/24/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained or enhanced a resident's dignity and respect in full recognition of her individuality for four of 67 sampled residents (Residents 2, 5, 11 and 14) as indicated in the facility's policies and procedures (P&P) by failing to: a. Ensure Resident 2 was not awakened inappropriately early in the morning by a loud noise from the licensed nurse and the light was turned on in Resident 2's room. b. Ensure Resident 5's urinal receptacle (a container used to hold bodily waste) was kept clean and labeled with Resident 5's name. c1. Ensure staff (general) were not rude whenever they answered Resident 11's call light and disrespectful whenever they spoke to Resident 11. c2. Ensure staff (general) did not joked around loudly outside Resident 11's room while Resident 11 was taking a nap. d. Ensure Resident 14 was not sitting in the hallway in a wheeled recliner chair with only a short-sleeved shirt and an incontinence brief. These failures resulted in Resident 2 verbalizing feeling scared in her environment, Resident 5 verbalizing feelings of disgust, Resident 11 verbalizing feeling horrible and unimportant, and the potential to result in Resident 14's bodily privacy being violated. Findings: a. During a review of Resident 2's Admission Record, dated 4/23/2025, the Admission Record indicated Resident 2 was readmitted on [DATE] with diagnoses that included ESRD (End Stage Renal Disease -irreversible kidney failure), dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and anxiety disorder (persistent feeling of dread or panic that can interfere with daily life). During a review of Resident 2's History and Physical (H&P), dated 1/25/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. (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: 056431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) assessment, dated 8/16/2024, the MDS indicated Resident 2 had intact cognition and lower extremity (hip, knee, ankle, foot) impairment on both sides. During a review of Resident 2's Physician Order, dated 4/8/2025 at 4:03 pm, the physician order indicated Resident 2 had an order to monitor for emotional distress every shift for 72 hours. During a review of Resident 2's SBAR (situation, background, assessment, recommendation- a communication tool used by healthcare workers when there is a change of condition among the residents) dated 4/9/2025 at 8:00 am, the SBAR indicated during morning medications Resident 2 complained that LVN 8 woke her without turning on the light and she was startled. The SBAR indicated, Resident 2 stated LVN 8 was screaming at her and she was scared thinking LVN 8 was a ghost. The SBAR further indicated, behavioral changes of increased anxiety. During an interview on 4/22/2025 at 4:00 pm with Resident 2, Resident 2 stated that on 4/9/2025 at 4 am she was awakened (not in the usual manner) by a loud noise from Licensed Vocational Nurse 8 (LVN 8). Resident 2 stated, the room was dark, she was unable to communicate as her speaking valve was not connected to her tracheostomy (incision made in the windpipe to relieve an obstruction to breathing), and she was scared by the sound. Resident 2 stated, she believed a hand was in front of her face and by her neck but couldn not see who was at her bedside. Resident 2 stated, she tried to push and bang on her bed rail with her right hand to get help for herself because she thought she was having a nightmare. Resident 2 stated, because of this she felt unsafe in her environment. During an interview on 4/22/2025 at 4:29 pm with Resident 2's roommate, Resident 7, Resident 7 stated the incident occurred when she was asleep in bed and heard LVN 8 make a loud rooster crow. Resident 7 stated she was unsure what was happening but could see Resident 2 moving both arms and could tell she was afraid and trying to get away from something. Resident 7 stated, she asked LVN 8 what was happening and requested her light be turned on. Resident 7 stated, she asked LVN 8 why he did that after he turned on the light but received no response. Resident 7 stated, Resident 2 was crying and was in shock after the incident. During an interview on 4/23/2025 at 12:35 pm with Licensed Vocational Nurse 11 (LVN 11), LVN 11 stated nurses should knock before entering and when waking a resident, the nurse should do it as gently as possible, to prevent startling them, then announce yourself and your purpose. During an interview on 4/23/2025 at 3:51 pm with the Quality Assurance Nurse (QAN), QAN stated if the resident was sleeping the nurse could tap them and if the resident was still asleep, they could leave the resident and come back after ensuring the resident was okay. QAN stated it was important to wake them gently so they are not shocked when awakened and as a courtesy to the resident because this was the residents' home. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2001, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, residents are treated with dignity and respect at all times. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was admitted to the facility on [DATE] with diagnosis of respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and Rheumatoid Arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 5's MDS, dated [DATE], indicated Resident 5 had intact cognition (ability to think and reason) for daily decision making. The MDS indicated Resident 5 required maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting, showering, personal hygiene, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 5 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) to perform oral hygiene and upper body dressing, and to roll left and right. The MDS indicated Resident 5 required supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for eating, and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for lower body dressing, putting on/off footwear, and chair to bed transfer. During a concurrent observation and interview on 4/21/2025 at 10:34 AM with Resident 5 in Resident 5's room, Resident 5 was laying down in his bed, head of bed was elevated, and two (2) urinal receptacles with a small amount of urine residual and foamy substance inside the receptacle were hanging from the left side of the bed rails, unlabeled. Resident 5 stated the staff does not clean out his urinal receptacles and although they put the lid on them, he can still smell his own urine throughout the day and it makes him feel disgusted by it. Resident 5 stated he has communicated with the staff on how to properly dispose of the urine but they do not listen to him. During an interview on 4/21/2025 at 10:51 AM with Certified Nursing Assistant 1 (CNA1), the CNA1 stated the facility's policy for handling and cleaning the urinals is to label it with some kind of resident identifier such as the room number, empty the urine, rinse it with water, dump the water, dry it and hang it back on the bed rail. The CNA1 stated no label to identify the urinal belonged to Resident 5. CNA 1 also stated there was urine residual left on the containers and needed to be cleaned. CNA 1 stated she emptied out the urinal earlier. During an interview on 4/21/2025 at 11:19 AM, with the Director of Staff Development (DSD), the DSD stated residents' urinals should be emptied when its half full, changed if it looks dirty, and it should have a resident name written on it because sometimes there is room changes which could cause an identification error. The DSD stated it was unacceptable to leave behind urine residual because it can affect how residents feel about seeing their own bodily waste affecting their psychosocial well-being. During a review of the facility's policy and procedure (P&P) titled Bedpan/Urinal, offering/removing, dated February 2018, indicated staff assistance with a urinal should remove the urinal from the bedside, clean the urinal and be sure that it is clean and dry. During a review of the facility's P&P titled, Cleaning and Disinfection of Resident-Care items and Equipment, dated October 2018, indicated single resident-use items such as urinals and bedpans are cleaned/disinfected between uses and disposed of afterwards. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Dignity dated February 2021, indicated staff are expected to promote dignity and assist residents by helping the resident to keep urinary items covered. c1. During a review of Resident 11's Face Sheet (FS), the FS indicated Resident 11 was admitted to the facility on [DATE] for post care of the right and left thighbone fracture (a partial or complete break in the bone) and for post care of fracture of multiple ribs on the left side. The FS indicated Resident 11 was self-responsible (accountable for their own actions and decisions). During a review of Resident 11's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 12/20/2024, the H&P indicated Resident 11 had the capacity to understand and make decisions. During a review of Resident 11's MDS, dated [DATE], the MDS indicated Resident 11 required setup or clean-up assistance (helper sets up or cleans up and resident completes activity) in eating, required supervision or touching assistance (helper provides verbal cues and/or touching /steadying and/or contact guard assistance as resident completes activity) with upper body dressing, and required partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, with personal hygiene, and to shower/bathe self, c2. During an interview on 4/22/2025 at 3:41 pm with Resident 11 inside Resident 11's room, Resident 11 stated staff (general) treat Resident 11 and other residents (unknown) like a nuisance and an irritant. Resident 11 stated 90 percent of facility staff, including kitchen staff, had a bad attitude and did not talk to residents with respect. Resident 11 stated whenever Resident 11 put on the call light, staff would answer the call light and say what happened instead of asking nicely if Resident 11 needed anything. Resident 11 stated Staff joked around loudly outside of Resident 11's door while Resident 11 was taking a nap, and did not care if they woke up Resident 11. Resident 11 stated the staff attitude and how staff treat Resident 11 made Resident 11 feel horrible and made Resident 11 feel like Resident 11 was not important. d. During a review of Resident 14's FS, the FS indicated Resident 14 was admitted to the facility on [DATE] with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should) and parkinsonism (brain conditions that cause slowed movements, rigidity [stiffness] and tremors). During a review of Resident 14's H&P, dated 12/7/2024, the H&P indicated Resident 14 did not have the capacity to understand and make decisions. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 was dependent (helper does all the effort) on others for eating, oral hygiene, toileting hygiene, personal hygiene, upper and lower body dressing, and to shower/bathe. During an observation on 4/22/2025 at 4:32 pm, Resident 14 was observed in the hallway sitting in a wheeled recliner chair with only a short-sleeved shirt and an incontinence brief on. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/22/2025 at 4:35 pm with Licensed Vocational Nurse (LVN) 2, LVN 2 approached Resident 14 and covered Resident 14 with a sheet. LVN 2 stated it was important for residents to have pants on when Resident 14 was out of Resident 14's room for privacy amd dignity. During an interview on 4/22/2025 at 4:38 pm with Certified Nursing Assistant (CNA) 1, CNA 1 stated it was not acceptable for residents to not have pants when they were out of bed for their dignity and privacy. During an interview on 4/24/2025 at 10:38 am with the Director of Staff Development (DSD), the DSD stated staff must approach and talk to residents with respect and with a respectful tone and modulation of voice. Staff must not sound mad when answering a resident's call light and ask the resident nicely if they needed help. The DSD stated residents must have pants on and/or clothing that covers them up to their knees when out of bed and still have a blanket or sheet to cover them. During an interview on 4/24/2025 at 2:20 pm with CNA 6, CNA 6 stated CNA 6 got Resident 14 up out of bed on 4/22/2025. CNA 6 stated CNA 6 put pants on Resident 14, but Resident 14 removed them. CNA 6 stated CNA 6 tried to put pants on Resident 14 again, but Resident 14 removed them again, so CNA 6 covered Resident 14 with a blanket. CNA 6 stated residents should not be exposed and show any part of their body for privacy. CNA 6 stated residents must have a gown on and/or a blouse and pants on whenever they were outside their room. CNA 6 stated staff must talk to residents with respect and in a nice way. During an interview on 4/24/2025 at 3:26 pm with the Director of Nursing (DON), the DON stated staff must be compassionate and respond to residents with a good approach for residents' dignity. The DON stated residents had to be fully dressed and fully covered when out of bed for their dignity and privacy. During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2001, the P&P indicated, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, residents are treated with dignity and respect at all times.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 34273 Based on interview and record review, the facility failed to ensure that 59 of 67 sampled residents (Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67) who required assistance with activities of daily living (ADLs-tasks of everyday life such as bathing dressing, and toileting) were provided care and received assistance with showering/bathing in accordance with the residents' care plan and the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting. These failures resulted in 59 residents not receiving assistance with ADLs as needed and had the potential to affect the residents' well-being. Findings: During a review of the Face Sheet (FS - front page of the chart that contains a summary of basic information about the resident) of Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67, the FS indicated the residents were admitted to the facility with diagnoses which included respiratory failure (when the lungs cannot get enough oxygen into the blood or remove carbon dioxide [waste gas made in the body's cells] from the blood) and had a tracheostomy tube. During a review of the Minimum Data Set (MDS - a resident assessment tool) for Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67, the MDS indicated the residents were either dependent (helper does all the effort) on staff or required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, to shower/bathe, and to get in and out of a tub/shower and/or to transfer to and from a bed to a chair or wheelchair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the care plan for Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67, the care plan which focused on the residents' deficit to perform ADL care on their own indicated to provide the residents with assistance with ADLs as needed. During an interview on 4/23/2025 at 10:43 am with Licensed Vocational Nurse (LVN) 3, LVN 3 stated in the subacute, LVNs on each shift would get 2 residents to provide total care for in addition to passing medications, doing daily charting, and doing any change of condition assessment. LVN 3 stated The Registered Nurses (RNs) assisted with calling the doctor and family and receiving and carrying out physician orders. LVN 3 stated there was always a shower nurse who did all the showers every time LVN 3 worked. LVN 3 stated Certified Nursing Assistants (CNAs) on the day shift usually have 10 residents each, but it depends on how many CNAs were working. LVN 3 stated LVN 3 have heard some CNAs say that they could not get their residents up for a shower because they were busy. LVN 3 stated the least number of CNAs that LVN 3 had seen on the day shift was four (4) and most was six (6). During an interview on 4/23/2025 at 11:29 am with CNA 2, CNA 2 stated CNA 2 had 12 residents on the day shift and there was no shower nurse that day. CNA 2 stated whenever CNAs had 12 residents on the day shift, the CNAs get overwhelmed with trying to change the residents and showers would not be provided. CNA 2 stated if there was a shower nurse, then showers would be provided. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 11:56 am with CNA 3, CNA 3 stated CNA 3 just started working as a shower nurse but also worked as a CNA on the night shift. CNA 3 stated there was supposed to be a shower nurse assigned on the day shift and the evening shift. CNA 3 stated the shower nurse did all the showers scheduled on the shift they were working. CNA 3 stated most of the time the CNA scheduled to work as a shower nurse would get pulled to work on the floor and take an assignment because we are really short (staffed). CNA 3 stated usually there were four CNAs on the floor. CNA 3 stated if there were five CNAs scheduled, then there would be a shower nurse. CNA 3 stated that when there are four CNAs working, the showers would not be done because scheduling the showers would get tricky. CNA 3 stated there was only one shower room for residents who did not have a history of Candida auris (C. auris, a fungal infection which can cause severe illness and spread easily) and that one shower room was used by both station 1 and station 2 (subacute). CNA 3 stated there was another shower room dedicated only for residents with the history of C. auris. CNA 3 stated it also would get tricky to give showers to residents in the subacute because the Respiratory Therapist (RT) had to assist with showers and CNAs had to wait for RTs and the shower room to become available. CNA 3 stated if all the CNAs were going to give showers, then it would make it difficult to schedule the showers. If there was only one person giving showers, then it would be easier to schedule a shower. CNA 3 stated having more shower rooms would also help. CNA 3 stated short staffing was usually caused by staff call offs. CNA 3 stated the only place to document that a shower was provided to a resident was on the Shower Sheet. CNA 3 sated a Shower Sheet would be completed after each shower and put in the binder in the nurses' station. The Shower Sheets were collected by the Director of Staff Development (DSD) every day. CNA 3 stated CNA 3 had worked with only 2 CNAs on the night shift previously. CNA 3 stated that with only 2 CNAs working, CNAs wouldn't be able to reposition residents every 2 hours and if the resident had a urinary catheter, the resident would only be changed once in the shift. CNA 3 stated, even with 4 CNAs in the subacute, it would be hard to provide a shower to the residents because it subacute residents have tracheostomies, G-tubes, needed total care, and were mostly residents were nonverbal. During an interview on 4/23/2025 at 1:16 pm with CNA 4, CNA 4 stated CNA 4 usually providing care for10 - 14 residents on the day shift in the subacute unit. CNA 4 stated with 10-14 residents, CNA 4 would not be able to provide showers to the residents unless there was a shower nurse. During an interview on 4/23/2025 at 1:54 pm with CNA 5, CNA 5 stated CNA 5 occasionally providing care for 12 -14 residents on the day shift when short staffed, but normally CNA 5 would providing care for 9-10 residents on the day shift. CNA 5 stated staff calling-offs cause a shortage of staff and when CNAs providing care for 12 -14 residents then care would be affected. CNA 5 stated that when there is not enough CNAs, the shower nurse would get pulled to work on the floor with an assignment and CNA 5 would not have enough time to give showers to the residents. CNA 5 stated CNA 5 would try to provide a bed bath instead of a shower but could not always provide a bed bath. CNA 5 stated in the subacute unit, CNAs were supposed to provide oral care to residents twice a shift but whenever CNA 5 had 12 -14 residents CNA 5 could only provide oral care once a shift. During an interview on 4/23/2025 at 2:39 pm with Resident 8 stated Resident 8's shower days are on Sundays and Thursdays. Resident 8 stated for the past two weeks, Resident 8 had not had a shower or a bed bath on Thursdays. Resident 9 stated showers were not provided because CNAs would say they were short staffed. Resident 8 stated call lights sometimes not answered for 5 hours on the night shift. Resident 8 stated sometimes CNAs on the night shift would not come around until 4 am because they were short staffed. Resident 8 stated Resident 8 usually turned on the call light to be changed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 3:32 pm with Resident 7, Resident 7 stated when they were short staffed, Resident 7 would only recieved shower once a week. Resident 7 stated that when they were short staffed on the night shift, it would sometimes take an hour to answer the call light, and staff would only come once during the night. Resident 7 stated it had been a while since Resident 7 had two showers in a week because they were short staffed. During a concurrent interview and record review on 4/24/2025 at 10:38 am with the Director of Staff Development (DSD), the nurse staffing and assignment for the day shift (7 am to 3 pm), the evening shift (3 pm to 11 pm), and the night shift (11 pm to 7 am) from 4/7/2025 to 4/21/2025 in the subacute unit were reviewed. The DSD stated the facility staffing was not short. The DSD stated they schedule enough staff on each shift for the day and go from there. The DSD stated they had to make sure they are meeting the State staffing hours and staff to resident ratio per day and that there are enough staff to provide care to the residents. The DSD stated they also schedule a shower nurse on the day shift and on the evening shift in the subacute to ensure showers are being provided to the residents. The DSD stated when there is a call off, they sometimes pull the shower nurse to cover the assignment of the person who called off. The main goal is for all the needs of the residents to be met and provided. The DSD stated LVNs in the subacute unit were also assigned to two residents, each shift to provide patient care to which lessen the number of residents assigned to the CNAs. The DSD stated the staffing goal in the subacute was to have 6 LVNs each shift, 5 CNAs on the day shift, 4-5 CNAs on the evening shift, and 3-4 CNAs on the night shift. The DSD also stated the shower sheets for the subacute were collected by the subacute staffer (person who makes the nurse staffing schedule for the subacute) every day. The DSD stated if there was no shower sheet completed then there was no way to prove that the resident received a shower because that was how showers and bed baths were documented by the CNAs, and the licensed nurses had to sign the shower sheet. The DSD reviewed the nurse staffing and assignment for the day shift (7 am to 3 pm), the evening shift (3 pm to11 pm), and the night shift (11 pm to 7 am) from 4/7/2025 to 4/21/2025 in the subacute. The review of the nurse staffing and assignment indicated that the LVNs on each shift were not always assigned to two residents to provide patient care. The review of the nurse staffing and assignment indicated the following: a. 4/7/2025 - Day shift - Census of 58. 5 Certified Nursing Assistants (CNAs) were scheduled to work, but 1 CNA called off. 4 CNAs worked with 11 residents each and there was no shower nurse (a CNA assigned to provide all resident showers scheduled for the shift) assigned. No shower was provided. The residents who were not provided with showers according to the Shower Schedule and the facility census for 4/7/2025 were Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, and Resident 26. b. 4/7/25 - Evening shift - Census of 57. 4 CNAs worked; 3 CNAs had 11 residents, and 1 CNA had 10 residents. Ther was no shower nurse. The residents who were not provided with showers were Resident 5, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, and Resident 34. c. 4/9/25 - Evening shift - Census of 59. 4 CNAs worked with 11 to 12 residents each. There was no shower nurse. No shower was provided. The residents who were not provided with showers were Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, and Resident 42. (continued on next page)

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	056431	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. 4/10/25 - Day shift - Census of 59. No CNA called off. 4 CNAs worked with 1 orientee and no shower nurse. 4 CNAs had 12 residents each. No shower was provided. The residents who were not provided with showers were Resident 17, Resident 18, Resident 29, Resident 30, Resident 38, Resident 8, and Resident 26. e. 4/10/25 - Night shift - Census of 59. 2 CNAs called off and 2 CNAs worked. 1 CNA had 21 residents, and 1 CNA had 20 residents. f. 4/11/25 - Day shift - Census of 60. 4 CNAs worked with no shower nurse. 2 CNAs had 12 residents, and 2 CNAs had 11 residents each. No call off and no shower nurse. No shower was provided. The residents who were not provided with showers were Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, and Resident 6. g. 4/11/25 Evening shift - Census of 60. 4 CNAs worked. 2 CNAs had 12 residents, 1 CNA had 10 residents, and 1 CNA with 11 residents. No shower nurse. No shower was provided. The residents who were not provided with showers were Resident 52, Resident 31, Resident 53, Resident 54, Resident 15, Resident 16, Resident 55, Resident 56, Resident 57, and Resident 58. h. 4/12/25 Night shift - Census of 61. 3 CNAs worked with 17 residents each. i. 4/13/25 - Day shift - Census of 61. 4 CNAs worked. 3 CNAs had 12 residents, and 1 CNA had 13 residents. The shower nurse called off and was not replaced. No shower was provided. The residents who were not provided with showers were Resident 2, Resident 7, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 38, Resident 8, and Resident 66. j. 4/15/25 - Day shift - Census of 58. 4 CNAs with no shower nurse. CNAS had 12 residents each. No shower was provided. The residents who were not provided with showers were Resident 44, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, and Resident 6. k. 4/17/25 - Evening shift - Census of 57. 3 CNAs worked and had 14 residents each. No shower nurse. No shower was provided. The residents who were not provided with showers were Resident 27, Resident 21, Resident 4, Resident 9, Resident 67, Resident 32, Resident 33, Resident 5, and Resident 34. l. 4/18/25 - Day shift - Census of 57. 4 CNAs worked. 3 CNAs had 11 residents and 1 had 12 residents. No shower nurse. No shower was provided. The residents who were not provided with showers were Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, and Resident 6. m. 4/18/25 - Evening - Census of 57. 5 CNAs worked with no shower nurse. 3 CNAs had 8 residents and 2 CNAs had 9 residents. No shower was provided. The residents who were not provided with showers were Resident 52, Resident 31, Resident 53, Resident 54, Resident 15, Resident 16, Resident 55, Resident 56, Resident 57, and Resident 58. n. 4/20/25 - Day shift - Census of 57. 3 CNAs worked with no shower nurse. 3 CNAs had 16 residents each. 2 CNAs called off and 1 CNA was a no call no show. No showers provided. The residents who were not provided with showers were Resident 2, Resident 7, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 38, Resident 8, and Resident 66. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. 4/21/25 - Day shift - Census of 57. 4 CNAS worked. 1 CNA was a no call no show. No shower nurse was on duty because the shower nurse called off. 3 CNAs had 14 residents, and 1 CNA had 15 residents. There was no shower provided to the residents. The residents who were not provided with showers were Resident 17, Resident 18, Resident 19, Resident 20, Resident 29, Resident 30, Resident 22, Resident 23, Resident 24, Resident 25, and Resident 26. During an interview on 4/24/2025 at 3:26 pm with the Director of Nursing (DON), the DON stated no matter what, the facility must provide care and showers for the residents as part of accommodating the residents' needs. The DON stated not getting a shower could affect the overall well-being of the residents and not enough staffing should not be an excuse for not providing showers or care for residents. During a review of the facility P&P titled Activities of Daily Living (ADLs) Supporting, dated March 2018, the P&P indicated, appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the plan of care .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 34273 Based on interview and record review, the facility failed to provide sufficient nurse staffing for 16 of 45 shifts staffing reviewed in the subacute unit (specific unit in the facility where residents with a tracheostomy tube [a tube inserted in a surgically created hole in the windpipe to provide an alternative airway for breathing] and residents on a ventilator [a medical device to help support or replace breathing] stayed) to provide care and assistance to 59 of 67 sampled residents in accordance with the facility's policy and procedure (P&P) titled, Staffing, and Facility Assessment, and the facility's Facility Assessment, (FA- a guide used by the facility to evaluate what resources are necessary to care for the facility's residents) and staffing goal for the subacute unit when: 1. Showers were not provided for 59 residents (Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67). 2. The call light (a device used by a resident to signal their need for assistance from staff) for Resident 7 and Resident 8 was not answered promptly on the night shift (11 pm to 7 am). These failures had the potential to result in a decline in the residents' physical and psychosocial well-being due to poor quality of care. Findings: During a review of the Face Sheet (FS - front page of the chart that contains a summary of basic information about the resident) of Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67, the FS indicated the residents were admitted to the facility with diagnoses which included respiratory failure (when the lungs cannot get enough oxygen into the blood or remove carbon dioxide [waste gas made in the body's cells] from the blood) and had a tracheostomy tube. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Minimum Data Set (MDS - a resident assessment tool) for Resident 2, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, Resident 34, Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, Resident 42, Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, Resident 52, Resident 53, Resident 54, Resident 55, Resident 56, Resident 57, Resident 58, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 66, and Resident 67, the MDS indicated the residents were either dependent (helper does all the effort) on staff or required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, showering/bathing, getting in and out of a tub/shower, and/or transferring to and from a bed to a chair or wheelchair. During an interview on 4/23/2025 at 10:43 am with Licensed Vocational Nurse (LVN) 3, LVN 3 stated in the subacute, LVNs on each shift would get 2 residents to provide total care for, in addition to passing medications, doing daily charting, and doing any change of condition assessment. LVN 3 stated the Registered Nurses (RNs) assisted with calling the doctor and family and receiving and carrying out physician orders. LVN 3 stated there was always a shower nurse who did all the showers every time LVN 3 worked. LVN 3 stated Certified Nursing Assistants (CNAs) on the day shift usually had 10 residents each, but it depended on how many CNAs were working. LVN 3 stated LVN 3 heard some CNAs (unidentified) verbalized that they could not get their residents up for a shower because they (CNAs) were busy. LVN 3 stated the least number of CNAs that LVN 3 had seen on the day shift was four (4) and most was six (6). During an interview on 4/23/2025 at 11:29 am with CNA 2, CNA 2 stated CNA 2 had 12 residents on the day shift and there was no shower nurse that day. CNA 2 stated whenever CNAs had 12 residents on the day shift, the CNAs would get overwhelmed with trying to change the residents and showers would not be provided. CNA 2 stated if there was a shower nurse, then showers would be provided. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 11:56 am with CNA 3, CNA 3 stated CNA 3 just started working as a shower nurse but also worked as a CNA on the night shift. CNA 3 stated there was supposed to be a shower nurse assigned on the day shift and the evening shift. CNA 3 stated the shower nurse did all the showers scheduled on the shift they were working. CNA 3 stated most of the time the CNA scheduled to work as a shower nurse would get pulled to work on the floor and take an assignment because, we are really short (staffed). CNA 3 stated usually there were 4 CNAs on the floor. CNA 3 stated if there were five (5) CNAs scheduled, then there would be a shower nurse. CNA 3 stated when there were four CNAs working, the showers would not be done because scheduling the showers would get tricky. CNA 3 stated there was only one shower room for residents who did not have a history of Candida auris (C. auris, a fungal infection which can cause severe illness and spread easily) and that one shower room was used by both station 1 and station 2 (subacute). CNA 3 stated there was another shower room dedicated only to residents with a history of C. auris. CNA 3 stated it also would get tricky to give showers to residents in the subacute because the Respiratory Therapist (RT) had to assist with showers and CNAs had to wait for the RT and the shower room to become available. CNA 3 stated if all the CNAs were going to give showers, then it would make it difficult to schedule the showers. If there was only one person giving showers, then it would be easier to schedule a shower. CNA 3 stated having more shower rooms would also help. CNA 3 stated short staffing was usually caused by staff call offs. CNA 3 stated the only place to document that a shower was provided to a resident was on the Shower Sheet. CNA 3 stated a Shower Sheet would be completed after each shower and filed in the binder in the nurses' station. The Shower Sheets were collected by the Director of Staff Development every day. CNA 3 stated CNA 3 had worked with only 2 CNAs on the night shift previously. CNA 3 stated with only 2 CNAs working, CNAs would not be able to reposition residents every 2 hours, and if the resident had a urinary catheter, the resident would only be changed once in the shift. CNA 3 stated even with 4 CNAs in the subacute, it would be hard to provide showers to the residents because subacute residents had tracheostomies and G-tubes, needed total care, and were mostly nonverbal. During an interview on 4/23/2025 at 1:16 pm with CNA 4, CNA 4 stated CNA 4 usually had 10 to 14 residents on the day shift in the subacute unit. CNA 4 stated with 10 to 14 residents, CNA 4 would not be able to provide showers to the residents unless there was a shower nurse. During an interview on 4/23/2025 at 1:54 pm with CNA 5, CNA 5 stated CNA 5 occasionally had 12 to 14 residents on the day shift when short staffed, but normally CNA 5 would have 9 to 10 residents on the day shift. CNA 4 state call-offs caused a shortage of staff and when CNAs have 12 to14 residents then care would be affected. CNA 5 stated that when there were not enough CNAs, the shower nurse would get pulled to take an assignment and CNA 5 would not have enough time to give showers. CNA 5 stated CNA 5 would try to provide a bed bath instead of a shower but could not always provide a bed bath. CNA 5 stated in the subacute unit, CNAs were supposed to provide oral care to residents twice a shift but whenever CNA 5 had 12 to 14 residents, CNA 5 could only provide oral care once a shift. During an interview on 4/23/2025 at 2:39 pm with Resident 8, Resident 8 stated Resident 8's shower days were on Sundays and Thursdays. Resident 8 stated for the past two weeks, Resident 8 had not had a shower or a bed bath on Thursdays. Resident 8 stated showers were not provided because CNAs would say the facility was short staffed. Resident 8 stated call lights sometimes were not answered for five hours on the night shift. Resident 8 stated sometimes CNAs on the night shift would not come around until 4 am because the facility was short staffed. Resident 8 stated Resident 8 usually turned on the call light to be changed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/23/2025 at 3:32 pm with Resident 7, Resident 7 stated when the facility was short staffed, Resident 7 would only shower once a week. Resident 7 stated that when the facility was short staffed on the night shift, it would sometimes take the staff an hour to answer the call light, and staff would only come once during the night. Resident 7 stated it had been a while since Resident 7 had two showers in a week because the facility was short staffed. During an interview on 4/24/2025 at 10:38 am with the Director of Staff Development (DSD), the DSD stated facility staffing was not short. The DSD stated the facility scheduled enough staff on each shift for the day and go from there. The DSD stated the facility had to make sure it was meeting the State staffing hours and staff to resident ratio per day and that there were enough staff to provide care for the residents. The DSD stated the facility also scheduled a shower nurse on the day shift and on the evening shift in the subacute unit to ensure showers were being provided for the residents. The DSD stated when there was a staff call off, the facility would sometimes pull the shower nurse to cover the assignment of the person who called off. The DSD stated the main goal was for all the needs of the residents to be met and provided. The DSD stated Licensed Vocational Nurses (LVNs) in the subacute unit were also assigned two residents each shift to provide patient care to lessen the number of residents assigned to the CNAs. The DSD stated the staffing goal in the subacute was to have six (6) LVNs each shift, 5 CNAs on the day shift, 4 to 5 CNAs on the evening shift, and 3 to 4 CNAs on the night shift. The DSD stated the shower sheets for the subacute were collected by the subacute staffer (person who makes the nurse staffing schedule for the subacute) every day. The DSD stated if there was no shower sheet completed then there was no way to prove that the resident received a shower because that was how showers and bed baths were documented by the CNAs, and the licensed nurses had to sign the shower sheet. During the same concurrent interview and record review on 4/24/2025 at 10:38 am with the DSD, the nurse staffing and assignment for the day shift (7 am to 3 pm), the evening shift (3 pm to 11 pm), and the night shift (11 pm to 7 am) from 4/7/2025 to 4/21/2025 in the subacute unit were reviewed. The review of the nurse staffing and assignment indicated that LVNs on each shift were not always assigned to two residents to provide patient care. The review of the nurse staffing and assignment indicated the following: a. 4/7/2025 - Day shift - Census of 58. 5 CNAs were scheduled to work, but one (1) CNA called off. 4 CNAs worked with 11 residents each and there was no shower nurse (a CNA assigned to provide all resident showers scheduled for the shift) assigned. No shower was provided. The residents who were not provided with showers according to the Shower Schedule and the facility census for 4/7/2025 were Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, and Resident 26. b. 4/7/25 - Evening shift - Census of 57. 4 CNAs worked; 3 CNAs had 11 residents, and 1 CNA had 10 residents. There was no shower nurse. The residents who were not provided with showers were Resident 5, Resident 27, Resident 28, Resident 29, Resident 30, Resident 31, Resident 32, Resident 33, and Resident 34. c. 4/9/25 - Evening shift - Census of 59. 4 CNAs worked with 11 to 12 residents each. There was no shower nurse. No shower was provided. The residents who were not provided with showers were Resident 35, Resident 36, Resident 37, Resident 38, Resident 39, Resident 40, Resident 41, and Resident 42. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. 4/10/25 - Day shift - Census of 59. No CNA called off. 4 CNAs worked with 1 orientee and no shower nurse. 4 CNAs had 12 residents each. N shower was provided. The residents who were not provided with showers were Resident 17, Resident 18, Resident 29, Resident 30, Resident 38, Resident 8, and Resident 26. e. 4/10/25 - Night shift - Census of 59. Two (2) CNAs called off and 2 CNAs worked. 1 CNA had 21 residents, and 1 CNA had 20 residents. f. 4/11/25 - Day shift - Census of 60. 4 CNAs worked with no shower nurse. 2 CNAs had 12 residents, and 2 CNAs had 11 residents each. No call offs and no shower nurse. No shower was provided. The residents who were not provided with showers were Resident 43, Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, and Resident 6. g. 4/11/25 Evening shift - Census of 60. 4 CNAs worked. 2 CNAs had 12 residents, 1 CNA had 10 residents, and 1 CNA with 11 residents. No shower nurse. No shower was provided. The residents who were not provided with showers were Resident 52, Resident 31, Resident 53, Resident 54, Resident 15, Resident 16, Resident 55, Resident 56, Resident 57, and Resident 58. h. 4/12/25 Night shift - Census of 61. Three (3) CNAs worked with 17 residents each. i. 4/13/25 - Day shift - Census of 61. 4 CNAs worked. 3 CNAs had 12 residents, and 1 CNA had 13 residents. The shower nurse called off and was not replaced. No shower was provided. The residents who were not provided with showers were Resident 2, Resident 7, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 38, Resident 8, and Resident 66. j. 4/15/25 - Day shift - Census of 58. 4 CNAs with no shower nurse. CNAS had 12 residents each. No shower was provided. The residents who were not provided with showers were Resident 44, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, and Resident 6. k. 4/17/25 - Evening shift - Census of 57. 3 CNAs worked and had 14 residents each. No shower nurse. No shower was provided. The residents who were not provided with showers were Resident 27, Resident 21, Resident 4, Resident 9, Resident 67, Resident 32, Resident 33, Resident 5, and Resident 34. l. 4/18/25 - Day shift - Census of 57. 4 CNAs worked. 3 CNAs had 11 residents and 1 had 12 residents. No shower nurse. No shower was provided. The residents who were not provided with showers were Resident 44, Resident 45, Resident 46, Resident 47, Resident 48, Resident 49, Resident 50, Resident 51, and Resident 6. m. 4/18/25 - Evening - Census of 57. Five (5) CNAs worked with no shower nurse. 3 CNAs had 8 residents, and 2 CNAs had 9 residents. No shower was provided. The residents who were not provided with showers were Resident 52, Resident 31, Resident 53, Resident 54, Resident 15, Resident 16, Resident 55, Resident 56, Resident 57, and Resident 58. n. 4/20/25 - Day shift - Census of 57. 3 CNAs worked with no shower nurse. 3 CNAs had 16 residents each. 2 CNAs called off and 1 CNA was a no call no show. No showers provided. The residents who were not provided with showers were Resident 2, Resident 7, Resident 59, Resident 60, Resident 61, Resident 62, Resident 63, Resident 64, Resident 38, Resident 8, and Resident 66. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o. 4/21/25 - Day shift - Census of 57. 4 CNAS worked. 1 CNA was a no call no show. No shower nurse was on duty because the shower nurse called off. 3 CNAs had 14 residents, and 1 CNA had 15 residents. No shower provided. The residents who were not provided with showers were Resident 17, Resident 18, Resident 19, Resident 20, Resident 29, Resident 30, Resident 22, Resident 23, Resident 24, Resident 25, and Resident 26. During an interview with on 4/24/2025 at 3:26 pm with the Director of Nursing (DON), the DON stated no matter what, the facility needed to provide care and showers for the residents as part of accommodating the residents' needs. The DON stated not getting a shower could affect the overall well-being of the residents and not enough staffing should not be an excuse for not providing showers or care for the residents. During a review of the facility's P&P titled, Staffing, dated 10/2017, the P&P indicated the facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and facility assessment . During a review of the facility's P&P titled, Facility Assessment, dated 10/2018, the P&P indicated, a facility assessment is conducted annually to determine and update our capacity to meet the needs of and competently care for our residents during day-to-day operations .Once a year, and as needed, a designated team conducts a facility-wide assessment to ensure that the resources available to meet the specific needs of our residents . During a review of the facility's FA, dated 12/10/2024, the FA indicated the staffing plan for CNAs was to provide one CNA per 8 to 9 residents on the day shift, one CNA for 10 to 13 residents on the evening shift, and one CNA for 14 to 16 residents on the night shift. The FA did not address how staff call offs would be addressed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678 Based on observation, interview, and record review, the facility failed to ensure proper medication administration for six of six sampled residents (Resident 5, Resident 6, Resident 26, Resident 55, Resident 56, and Resident 68) by failing to: 1. Ensure the facility followed best practices for medication preparation and administration for Resident 6 when multiple medications were crushed and mixed in one medication cup and administered via gastrostomy tube (G-tube, a feeding tube inserted directly into the stomach through the abdominal wall). 2. Ensure medications were administered at their respective scheduled times as prescribed by the ordering physicians for Resident 6, 26, 55, 56, and 68 on 4/21/2025. 3. Ensure Resident 5's medication was omitted due to lack of supply for Resident 5, without timely notification to the pharmacy or physician, potentially compromising Resident 5's treatment plan. These deficient practices had the potential to affect Resident 6, 26, 55, 56, and 68's health, safety, and well-being by placing the residents at risk for decreased therapeutic effectiveness of the medications and potential adverse effects (unwanted effects that are related to a drug), causing increased rigidity in Resident 5's body, and potentially causing medication interactions, and G-tube occlusions (blockage) for Resident 6. Findings: A. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses of respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions), and rheumatoid arthritis (RA- a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5 had intact cognition (ability to think and reason) for daily decision making. The MDS indicated Resident 5 required substantial/maximal assistance (helper does more than half the effort to lift or hold trunk or limbs and provides more than half the effort) for toileting, showering, personal hygiene, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 5 required partial assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs, but provides less than half the effort) to perform oral hygiene and upper body dressing, and to roll left and right. The MDS indicated Resident 5 required supervision (helper provides verbal cues and or touching as resident competes activity. Assistance may be provided throughout the activity or intermittently) for eating and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for lower body dressing, putting on/off footwear, and chair to bed transfer. During a review of Resident 5's Order Summary, dated 1/2/2025, the Order Summary indicated to inject one dose of Adalimumab Pen-injector (medication to treat RA) once a day every two weeks on Thursday for RA. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Progress Notes, dated 3/13/2025, the Progress Note indicated Adalimumab Pen-injector was not available, pending delivery, sent re-fill request will be delivered tonight (3/13/2025) latest tomorrow morning (3/14/2025), and therefore not administered to Resident 5 on 3/13/2025. During a review of Resident 5's Medication Administration Record (MAR), the MAR indicated Resident 5 received a scheduled dose of Adalimumab on 2/27/2025, and his next dose was to be administered on 3/13/2025. The MAR indicated a dose of Adalimumab was omitted (leave out or exluded) on 3/13/2025, and administered next on 3/28/2025, four weeks after his last dose on 2/27/2025. B. During a review of Resident 6's Admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of G-tube, type 2 diabetes mellitus (DM2- A condition that happens because of a problem in the way the body regulates and uses sugar as fuel), hypertensive chronic kidney disease (damage to the kidney due to chronic high blood pressure [HTN-hypertension]), and atrial fibrillation (Afib- an irregular and often very rapid heart rhythm, potentially leading to blood clots in the heart). During a review of Resident 6's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/20/2025, the MDS indicated Resident 6 had severely impaired cognition (ability to think and reason) for daily decision making. The MDS indicated Resident 6 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for oral hygiene, toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and tub/shower transfer. During a review of Resident 6's Order Summary, the Order Summary indicated to administer Pantoprazole (medication to treat conditions which there is too much acid in the stomach), Alogliptin (medication to treat DM2), Amiodarone (medication to treat Afib), and Amlodipine (medication to treat hypertension) via G-tube at 9AM. The Order Summary indicated Flush tube with 20-30 milliliters (ml- unit of measurement) of water before and after medication administration. C. During a review of Resident 26's AR, the AR indicated Resident 26 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of gastro-esophageal reflux disease (GERD , hypertension (HTN-high blood pressure), dermatitis (inflammation of the skin, characterized by redness, itching, and a rash), and seizures (a temporary burst of uncontrolled electrical activity in the brain that can cause changes in physical and mental function). During a review of Resident 26's MDS, dated [DATE], the MDS indicated Resident 26 had severely impaired cognition (ability to think and reason) for daily decision making. The MDS indicated Resident 26 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for oral hygiene, toileting, showering, upper and lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and tub/shower transfer. During a review of Resident 26's Order Summary, the Order Summary indicated to administer Amlodipine (medication to treat HTN), Metoprolol (medication to treat HTN), prednisone (medication to treat dermatitis), Omeprazole (medication to treat GERD), and Keppra (medication to treat seizures), daily at 9 AM via G-tube. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. During a review of Resident 55's AR, the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnosis of epilepsy (a neurological condition characterized by recurring seizures, which are sudden, abnormal electrical discharges in the brain). During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55 had severely impaired cognition (ability to think and reason) for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for oral hygiene, toileting, showering, upper and lower body dressing, putting on taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and tub/shower transfer. During a review of Resident 55's Order Summary, the Order Summary indicated to administer Levetiracetam (medication to treat seizures/epilepsy), every 12 hours via G-tube for seizure diagnosis. E. During a review of Resident 56's AR, the AR indicated Resident 56 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnosis of HTN. During a review of Resident 56's MDS dated [DATE], the MDS indicated Resident 56 had severely impaired cognition (ability to think and reason) for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for eating, oral hygiene, toileting, showering, upper and lower body dressing, putting on taking off footwear, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed and tub/shower transfer. During a review of Resident 56's Order Summary, the Order Summary indicated to administer Metoprolol (medication to treat hypertension), daily at 9 AM via G-tube. F. During a review of Resident 68's AR, the AR indicated Resident 68 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of HTN, epilepsy, GERD, and anxiety (persistent feeling of dread or panic that can interfere with daily life). During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68 had severely impaired cognition (ability to think and reason) for daily decision making and was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for oral hygiene, toileting, showering, upper and lower body dressing, putting on taking off footwear, personal hygiene, roll left and right and tub/shower transfer. During a review of Resident 68's Order Summary, the Order Summary indicated to administer Lacosamide (medication to treat epilepsy), Levetiracetam, Hydroxyzine (medication to treat anxiety), Amlodipine (medication to treat HTN), and Omeprazole (medication to treat GERD), daily at 9 AM via G-tube. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/21/2025 at 10:27 AM with Licensed Vocational Nurse 7 (LVN 7), LVN 7 was observed passing medications to Resident 6 in Resident 6's room. LVN 7 stated LVN 7 was late in administering Resident 6's medications because three licensed nurses called off, therefore increasing her patient workload to pass medications, and was also going to be late giving medications to Resident 26, 55, 56, and 68. LVN 7 stated facility protocol to administer medications was one hour before and one hour after the prescribed time which was 9 AM. LVN 7 was observed placing the following medications into one cup and mixing them together with water: Alogliptin, Amiodarone, amlodipine, and Pantoprazole, then administer them to Resident 6 via G-tube which was not infusing the medication via gravity. LVN 7 stated LVN 7 had not checked for G-tube placement prior to administration of medications, and LVN 7 was aware that best practice was to administer each medication separately, flushing with water after each medication to prevent occlusion of the g-tube. LVN 7 stated LVN 7 had not utilized the best nursing practice because LVN 7 felt pressed for time since LVN 7 had to administer medications to four more residents (Residents 26, 55, 56 and 68) and LVN 7 was just trying to move as fast as possible. During an interview on 4/21/2025 at 10:34 AM with Resident 5, Resident 5 stated Resident 5 was concerned with Resident 5's health status because Resident 5 was supposed to get Resident 5's injection to manage Resident 5's arthritis every two weeks, but sometimes the nurses told him the medication was not available in the facility. Resident 5 stated Resident 5 had been taking this medication for nearly two years, and Resident 5 is constantly reminding the staff about his injection so that they can order it ahead of time. Resident 5 stated he felt the nurses would get mad when Resident 5 persisted in reminding the licensed nurses. Resident 5 stated Resident 5 reminded staff because when Resident 5 did not get Resident 5's medication on time every two weeks, Resident 5 felt nervous, and Resident 5's shoulders, knees, hips, and bilateral arms would hurt. Resident 5 stated Resident 5 received medications to treat the pain, but the injection helped mostly with controlling the rigidity in Resident 5's body. Resident 5 stated when a dose was omitted and received the next dose at the next scheduled time, the medication was not as effective in controlling the rigidity in Resident 5's body. During an interview on 4/21/2025 at 11:19 AM with the Director of Staff Development (DSD), the DSD stated the facility was responsible for having enough staff to give medication on time. The DSD stated that not giving medications to residents on time was unacceptable. The DSD stated licensed nurses must check for g-tube placement, if residual was more than 100 ml, the nurse had to stop the feeding. The DSD stated medications had be administered in different cups and flushed with 15-30 ml of water before and after each medication administration. The DSD stated it was unacceptable to give all the medications together because some medications increase the risk of drug to drug interactions, tube blockage, and alter medication absorption. During an interview on 4/21/2025 at 1:22 PM with Registered Nurse Supervisor (RNS) 2, RNS 2 stated to ensure medications such as Adalimumab Pen-injector are available in the facility, the nursing staff must order the medication that was in the short supply room as soon as the nurses administered the medication. RNS 2 stated RNS 2 was aware the medication was order only once every two weeks because the medication was very expensive. RNS 2 stated that if a nurse gave the last injection, the nurse should notify the pharmacy the same day so that it was ready to be administered again in two weeks or whenever the next dose was due. RNS 2 stated nurses must endorse this information to the next shift so that everyone was aware and responsible for ensuring medications for residents were available in the facility to prevent omitting a dose of medication because it can have adverse effects for residents' well-being. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/21/2025 at 1:32 PM with the Director of Nursing (DON), the DON stated the charge nurse, or any licensed nurse should order medications ahead of time, consistently, so the residents have their medications available in the facility. The DON stated failure to ensure medications are available can result in unmanageable pain, and in this case manifest flare ups for Resident 5 who had RA. The DON stated if there was only 2 or 3 injections left of the injection, nurses should order immediately to ensure proper and timely delivery of the medication. The DON stated it was important for licensed nurses to administer medications on time, one hour before or one hour after medication was due to ensure therapeutic effectiveness, particularly for time-sensitive medications such as seizure medications, pain medications, antibiotics (medications to treat infection), and hypertension medications. The DON stated checking for G-tube placement prior to administering medication was important to ensure the tube had not become dislodged, which could result in aspiration (accidental breathing in of food or fluid into the lungs, potentially causing pneumonia or other lung problems) or ineffective delivery of medications. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, indicated staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed time, unless otherwise specified. During a review of the facility's P&P titled, Pharmaceutical Services, dated November 2020, indicated Medications shall be ordered from Alliance Pharmacy. Refills of medications should be called to the pharmacy 3 to 4 days in advance of need to assure an adequate supply is on hand. During a review of the facility's P&P titled, Administering Medications Through an Enteral Tube [soft, flexible plastic tubes through which liquid nutrition travels], dated November 2018, indicated verify placement of feeding tube, administer each medication separately and flush between medications.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on observation, interview, and record review, the facility failed to keep the facility clean for four of four rooms (Rooms 421, 416, 222 and 223). 1. There were dried reddish-brown stains on the privacy curtain next to the bed by the window in room [ROOM NUMBER]. The privacy curtain separated the two beds in room [ROOM NUMBER]. 2. The baseboards in room [ROOM NUMBER] were dirty. 3. There were unpainted white patches on the walls in room [ROOM NUMBER]. 4. There was a brownish gray stain on the ceiling and on the top of the wall by the air vent in room [ROOM NUMBER]. 5. There were holes in the wall with chipped paint behind the headboard of the bed by the window in room [ROOM NUMBER]. 6. The baseboards in room [ROOM NUMBER] were dirty. 7. The linoleum flooring in the restroom in room [ROOM NUMBER] was cracked and peeling off the wall. 8. The sink in the restroom in room [ROOM NUMBER] was chipped and the faucet was corroded. 9. The window tint on the sliding door in room [ROOM NUMBER] was peeling off. 10. There were brown stains on the ceiling above both beds in room [ROOM NUMBER]. 11. There were brown stains on the ceiling in the hallway in front of room [ROOM NUMBER] and in front of the storage room by room [ROOM NUMBER]. 12. The Maintenance Department's Checklist did not indicate which resident rooms were checked on each day of the month and what items were checked in each room. These failures resulted in unclean environment for Residents 11, 12, other residents, staff and visitors. Findings: (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/22/2025 at 3:41 pm inside room [ROOM NUMBER], Resident 11 stated the housekeeper deep cleaned room [ROOM NUMBER] on 4/21/25, but the baseboards in room [ROOM NUMBER] were still dirty. Resident 11 stated there was dried blood on the privacy curtain by Resident 11's bed which had been there since Resident 11 moved into room [ROOM NUMBER] about two months ago. Resident 11 told a staff member (unable to identify) to change the privacy curtain when Resident 11 moved into room [ROOM NUMBER], but the curtain still had not been changed. The privacy curtain which separated the two beds in room [ROOM NUMBER] was observed to have dried reddish-brown stains on the side next to Resident 11's bed. Resident 11 stated there were multiple white patches on the walls of room [ROOM NUMBER] and a grayish discoloration on the ceiling by the air vent in room [ROOM NUMBER]. The baseboards in room [ROOM NUMBER] were observed to be dirty and there were multiple unpainted white patches on the wall in room [ROOM NUMBER]. There was also a brownish gray stain on the ceiling and on the top of the wall by the air vent in room [ROOM NUMBER]. During a concurrent observation and interview on 4/22/2025 at 4:01 pm inside room [ROOM NUMBER], Resident 12 showed the surveyor the wall behind the headboard of Resident 12's bed. There were holes in the wall with chipped paint behind the headboard of Resident 12's bed. Resident 12 stated the holes in the wall with chipped paint had been there since Resident 12 moved into room [ROOM NUMBER]. Resident 12 also pointed to the sliding door in room [ROOM NUMBER] and the window tint on the sliding door was observed to be peeling off. The baseboards in room [ROOM NUMBER] were also dirty. Resident 12 stated the tile flooring was cracked, and the sink is corroded in the restroom in room [ROOM NUMBER]. The linoleum flooring in the restroom in room [ROOM NUMBER] was observed to be cracked and peeling off the wall, and the sink in the restroom was chipped and the faucet was corroded. During a concurrent observation and interview on 4/23/2025 at 1:16 pm with Certified Nursing Assistant (CNA) 4, CNA 4 showed the surveyor the brown stains on the ceiling above both beds in room [ROOM NUMBER]. CNA 4 did not know how long the brown stains had been on the ceiling in room [ROOM NUMBER]. There were brown stains observed on the ceiling in the hallway in front of room [ROOM NUMBER] and in front of the storage room by room [ROOM NUMBER]. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/23/2025 at 3:56 pm with Maintenance Assistant (MA) 1, MA 1 stated the facility had some water stains on the ceiling from the leaks on the roof which were now fixed. MA 1 did not remember when the roof was fixed. MA 1 stated the Maintenance Department did not make a note of which rooms had water stains on the ceiling because staff (general) usually told the Maintenance Department which rooms had water stains. MA 1 stated the major leak was in room [ROOM NUMBER] and the ceiling in room [ROOM NUMBER] was fixed. The Maintenance Department staff did not fix the ceilings in all the other rooms even though they knew about it because the roof had been leaking on and off. MA 1 stated, Now that the roof is fixed then we (Maintenance Department) will change them (ceiling) out. MA1 made a note of the brown stains on the ceiling in the hallway in front of room [ROOM NUMBER] and in front of the storage by room [ROOM NUMBER]. MA 1 checked room [ROOM NUMBER] and stated the brown stains on the ceiling above the bed next to the window was a water stain, but the stain on the ceiling above the bed close to the door was probably from a feeding formula splashing onto the ceiling. MA 1 stated chipped paint in resident rooms had to be written down by staff (general) in the Maintenance Log (ML) kept in each nurses' station. MA 1 stated when things were broken or needed work in the resident rooms, the Maintenance Department would not know about them unless they were written in the ML and/or unless the Maintenance Department sees them. MA 1 stated the Maintenance Department checks every call light in each resident rooms in the facility every month. MA 1 went inside room [ROOM NUMBER], saw the white patches on the walls, and stated, We patched up the walls and forgot to come back to paint. MA 1 went inside room [ROOM NUMBER] and saw the holes in the wall with chipped paint behind the headboard of Resident 12's bed. MA 1 stated, I did not see that (holes and chipped paint on the wall in room [ROOM NUMBER]) when I checked the call light, it is new. Resident 12, who was present in room [ROOM NUMBER], stated the holes in the wall along with the chipped paint were already there when Resident 12 moved into the room and were not new. MA 1 stated, There's only three of us, but did not explain further. MA 1 went inside the restroom in room [ROOM NUMBER] and made a note of the cracked and peeling linoleum tile, the chipped sink, and the corroded faucet. MA 1 looked at the peeling window tint on the sliding door in room [ROOM NUMBER] and stated the window tint was put on by an outside company so MA 1 would have to contact them. During an interview on 4/23/2025 at 4:17 pm with the Director of Housekeeping, Laundry, and Food Services (DHLF), the DHLF stated privacy curtains in resident rooms were changed as needed and during deep cleaning day of the room. The DHLF stated room [ROOM NUMBER] was deep cleaned on 4/21/2025, but the privacy curtain was not changed because there was no male staff who could take down the privacy curtain on that day. The DHLF stated if there was blood or a stain on the privacy curtain, it was important that the curtain be changed right away because of infection control issues and to make it look good for the residents. The DHLF stated the privacy curtain for room [ROOM NUMBER] was changed today, 4/23/2025. During an interview on 4/24/2025 at 10:38 am with the Director of Staff Development (DSD), the DSD stated any staff who noticed any repair needed should place it in the Maintenance Log in the nurses' station right away so the Maintenance Department would become aware of things which needed to be repaired. Any dried blood or stain on the privacy curtain should be reported by nursing to housekeeping and/or laundry right away so they can remove the privacy curtain and clean it. During an interview on 4/24/2025 at 3:26 pm with the Director of Nursing (DON), the DON stated privacy curtains which were soiled and stained with blood must be replaced once identified. The DON stated feces and/or blood could be contaminated and affect the health of residents and staff. The DON stated every resident has a right to live in a homelike environment, and cleanliness and sanitation for the health of the residents. (continued on next page)

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	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/24/2025 at 4:14 pm with the Administrator (ADM), the ADM stated the facility roof leaked during the rainy season and was repaired in January or February of 2025. The ADM was informed of all the environmental issues discussed with MA 1, the dirty baseboards in the resident rooms, and the dried reddish-brown stain on the privacy curtain in a resident's room. The ADM stated the ADM expected the Maintenance Department to make routine rounds in resident rooms on a weekly basis and to follow a log. Expectation was for the Maintenance Department to go back and fix anything they find which needed fixing during their routine rounds in resident rooms. The ADM stated nurses should write down anything they notice which needed repair in the Maintenance Book or Log (ML) and the first thing the Maintenance Department should do in the morning was to go over the ML and prioritize the items written in the ML. The April 2025 Maintenance Department's Checklist was reviewed with the ADM. The Checklist did not indicate which resident rooms were checked on each day of the month and what items were checked in each room. The ADM stated, They (Maintenance Department) probably need to do a more thorough inspection when doing facility rounds and might have missed it (environmental issues discussed). During a review of the Deep Clean Check off List, dated 4/21/2025, the Deep Clean Check off List (DCL) indicated a housekeeping staff completed the deep cleaning of room [ROOM NUMBER] on 4/21/2025. The DCL indicated the roof, the walls, the vents, and the trim (baseboards) inside room [ROOM NUMBER] was cleaned. During a review of the facility policy and procedure (P&P) titled, Quality of Life - Homelike Environment, dated 5/2017, the P&P indicated the facility would provide residents with a safe, clean, sanitary, comfortable, and orderly environment.