

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  06/13/2025
NAME OF PROVIDER OR SUPPLIER  Inland Valley Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to provide three (3) of three sampled residents (Residents 4, 5, and 6) or the Residents' Representative a copy of the residents' medical records upon request and within two working days from notice per the facility's policy and procedure titled, Release of Information.</p> <p>This failure resulted violated Residents 4, 5, 6's rights and resulted in Resident 5 and Resident 4's and Resident 6's Representatives not receiving the medical records in timely manner.</p> <p>Findings:</p> <p>1. During a review of Resident 5's admission Record (AR), the facility admitted Resident 5 on 2/7/2025 with diagnoses that included unspecified injury at C5 level of the cervical spinal cord (spinal cord injury), fracture of the body of sternum (breastbone), and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing).</p> <p>During a review of Resident 5's History and Physical (H&amp;P), dated 2/10/2025, the H&amp;P indicated Resident 5 did have the capacity to understand and make decisions. The H&amp;P indicated Resident 5 was alert, oriented, and competent to make complex medical decisions.</p> <p>During a review of Resident 5's Minimum Data Set (MDS, a resident assessment), dated 2/13/2025, Resident 5 was cognitively (ability to understand and process information) intact. The MDS indicated Resident 5 required moderate (helper does less than half the effort) to substantial (helper does more than half the effort) assistance when performing activities of daily living (ADLs, a term used in healthcare that refers to self-care activities) such as toileting, oral, and personal hygiene. The MDS indicated Resident 5 required moderate to substantial assistance when transferring from chair to bed or bed to chair.</p> <p>During a review of the AR, the facility discharged Resident 5 on 4/13/2025.</p> <p>During a review of the facility's copy of Resident 5's Authorization for Release of Resident Information document, dated 4/22/2025, the document indicated the request for Resident 5's medical records was addressed to the facility.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent record review and interview on 6/12/2025 at 2:35 PM with the Medical Records Assistant (MRA), the facility's Disclosure Log (the log the Medical Records Offices used to track medical records requests) was reviewed. The MRA stated, Resident 5 requested Resident 5's medical records on 4/29/2025, but the Medical Records Office did not receive the request until 5/2/2025. The MRA stated, Resident 5's medical records were released to Resident 5 on 5/22/2025 and again on 6/2/2025.</p> <p>2. During a review of Resident 6's AR, the facility admitted Resident 6 on 10/14/2025 with diagnoses that included respiratory failure (difficulty for the resident to breathe on their own), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and End Stage Renal Disease (ESRD, irreversible kidney failure).</p> <p>During a review of Resident 6's H&amp;P, dated 10/24/2024, the H&amp;P indicated Resident 6 did have the capacity to understand and made decisions.</p> <p>During a review of Resident 6's MDS, dated [DATE], Resident 6 was cognitively intact. The MDS indicated Resident 6 was dependent (helper does all the effort) for bathing and toileting hygiene and needed substantial assistance for personal hygiene and ADLs. The MDS indicated Resident 6 needed substantial assistance with turning left to right in bed and transferring from the bed to chair or the chair to bed.</p> <p>During a review of Resident 6's AR, the facility discharged Resident 6 on 2/10/2025.</p> <p>During a review of the facility's copy of Resident 6's Authorization for Release of Resident Information document, dated 4/16/2025, the document indicated the request for Resident 5's medical records was addressed to the facility.</p> <p>During a concurrent record review and interview on 6/12/2025 at 2:30 PM with the MRA, the facility's Disclosure Log was reviewed. The MRA stated, Resident 6's Representative request Resident 6's medical records on 5/7/2025, but the Medical Records Office did not receive the request until 5/16/2025. The MRA stated, Resident 6's medical records were released to Resident 6's Representative on 5/21/2025.</p> <p>3. During a review of Resident 4's AR, the facility admitted Resident 4 on 1/10/2025 with diagnoses that included lumbar region spinal stenosis (narrowing of the spinal canal which added pressure on the spinal cord and nerves) and hypertension (HTN, high blood pressure).</p> <p>During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4's cognitive skills were intact. The MDS indicated Resident 4 required substantial assistance performing when performing ADLs. The MDS indicated Resident 4 required substantial assistance turning from left to right in bed and transferring from the bed to chair or the chair to the bed.</p> <p>During a review of Resident 4's AR, the facility discharged Resident 4 on 3/21/2025.</p> <p>During a review of the facility's copy of Resident 4's Representative's Authorization for Release of Resident information document, dated 5/5/2025, the document indicated the request for Resident 4's copy of medical records was addressed to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 4's Representative Notes, dated 5/8/2025, Resident 4's Authorization for Release of Patient information document was mailed to the facility.</p> <p>During a review of Resident 4's Representative Notes, dated 5/12/2025, 5/19/2025, and 5/27/2025, Resident 4's Representative was unable to contact the facility regarding the status of Resident 4's medical records.</p> <p>During a review of Resident 4's Representative Notes, dated 6/5/2025, Resident 4's Representative sent a follow up electronic mail (e-mail) to the facility requesting for Resident 4's medical records that has been past due for a while, and we [Resident 4's Representative] need the records as soon as possible.</p> <p>During a concurrent record review and interview on 6/12/2025 at 2:40PM with the MRA, the facility's Disclosure Log was reviewed. The Disclosure Log indicated Resident 4's Representative requested Resident 4's medical records on 5/7/2025 and the request was reviewed on 5/19/2025. The MRA stated, Resident 4's medical records request was on 5/7/2025 but the MRA received Resident 4's medical records request from the Business Office</p> <p>Manager (BOM) on 5/19/2025. The MRA stated, the MRA accidentally documented Resident 4's medical records review date wrong. The MRA stated, the date of review should have been 5/19/2025 when the Medical Records Office received the request from the BOM.</p> <p>During a concurrent record review and interview on 6/12/2025 at 3:00PM with the MRA, the e-mail between the MRA and facility, dated 5/19/2025 was reviewed. The MRA stated, the MRA emailed the facility Resident 4's AR and Authorization for Release of Resident Information document. The MRA stated, after Resident 4's AR and Authorization for Release of Resident Information document were reviewed by the facility, the facility will email the MRA a link to upload Resident 4's medical records for the facility to review.</p> <p>During a concurrent record review and interview on 6/12/2025 at 3:05PM with the MRA, the e-mail thread between the MRA and facility, dated 5/22/2025 timed at 1:25PM, was review. The MRA stated, the original link from the facility was not working and requested for another link to upload Resident 4's medical records.</p> <p>During a concurrent record review and interview on 6/12/2025 at 3:08PM with the MRA, the email thread between the MRA and facility, dated 5/23/2025 timed at 9:08AM, was reviewed. The MRA stated, the facility was supposed to send a new link to upload Resident 4's medical records for review.</p> <p>During a concurrent record review and interview on 6/12/2025 at 3:10PM with the MRA, the email thread between the MRA and facility, dated 6/2/2025 timed at 3:26PM, was reviewed. The MRA stated, the MRA sent a follow-up email to the facility related to the new link mentioned in the 5/23/2025 email.</p> <p>During a concurrent record review and interview on 6/12/2025 at 3:12PM with the MRA, the email thread between the MRA and facility, dated 6/2/2025 timed at 3:52PM, was reviewed. The MRA stated, the MRA sent another follow-up email to the facility and will send the records after approval to release. The MRA stated, the MRA still has not received authorization from the facility to release Resident 4's medical records.</p> <p>(continued on next page)</p>		

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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/12/2025 at 3:35PM with the MRA, the MRA stated, the process of the release of medical records usually takes about one (1) week or five (5) business days, from when the Medical Records Office received the request to release of the medical records to the resident or resident representative.</p> <p>During an interview on 6/12/2025 at 4:30PM with the Medical Records Director (MRD), the MRD stated documents should be released with five (5) working days. The MRD stated, it was important to release the resident's medical records within a timely manner because residents and the requester have the right to review their medical records.</p> <p>During an interview on 6/13/2025 at 10:15AM with the BOM, the BOM stated the medical records request were either physically mailed or electronically faxed to the facility. The BOM stated, the BOM and the BOM's assistants were not actively looking for medical records request that were mailed or electronically faxed to the facility. The BOM stated, the BOM and BOM's assistants often encounter these medically records request while filtering through mail or received fax reports. The BOM stated, the medical records request should be given to the Medical Records Office as soon as possible.</p> <p>During a review of the facility's policies and procedures (P&amp;P) titled, Release of Information, dated 11/2009, the P&amp;P indicated, a resident may obtain photocopies of his or her record by providing the facility with at least a forty-eight (48) hour (excluding weekends and holidays) advance notice of such request. A fee may be charged for copying services.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 7) was provided with the necessary treatment and services to prevent formation of and promote healing of an existing pressure injury (PI, injury to skin and underlying tissue resulting from prolonged pressure on the skin) by:</p> <ol style="list-style-type: none"> <li>1. failing to ensure Resident 7 received physician-ordered wound care treatment for a stage 3 PI on Resident 7's right knee.</li> <li>2. failing to follow the physician's order that indicated cleansing with normal saline (NS-sterile salt solution) and application of zinc oxide (barrier ointment) for Resident 7's sacrococcyx (sacral [a triangular shaped bone at the bottom of the spine] coccyx [tailbone]) stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) PI.</li> </ol> <p>This failure resulted in an increased risk for an infection, pain, and further skin breakdown to Resident 7. Additionally, the failure had the potential to result in delayed wound healing to Resident 7.</p> <p>Findings:</p> <p>During a review of Resident 7's admission Record (AR), the AR indicated the facility originally admitted Resident 7 on 3/3/2022 and readmitted the resident on 5/24/2025 with diagnoses including epilepsy (a brain disorder that can cause people to suddenly become unconscious and have violent, uncontrolled movements of the body) and metabolic encephalopathy (a broad term for any brain disease that alters brain function).</p> <p>During a review of Resident 7's History and Physical (H&amp;P), dated 5/26/2025, the H&amp;P indicated, Resident 7 did not have the capacity to understand and make decisions.</p> <p>During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 6/3/2025, the MDS indicated Resident 7's cognitive (the ability to think and process information) skills for daily decisions making was severely impaired. The MDS indicated Resident 7 needed supervision to extensive assistance from the staff for activity of daily living (ADL, term used in healthcare that refers to self-care activities).</p> <p>During a review of Resident 7's care plan (CP), dated 5/6/2025, the CP indicated Resident 7 had a stage 3 [PI] (full thickness tissue loss) on [Resident 7's] right knee. The CP's interventions included were to do treatment as ordered.</p> <p>During a review of Resident 7's CP dated 5/6/2025, the CP indicated Resident 7 had a sacrococcyx stage 4 PI. The CP's interventions included to do treatment as ordered: collagen on the wound bed, zinc oxide on the periwound (the tissue surrounding the wound), and to cover [the wound] with dry dressing.</p> <p>During a review of Resident 7's Order Summary Report (OSR), dated active as of 6/13/2025, the OSR indicated the following physician orders:</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Right Knee Pressure injury; Cleanse with NSS (normal Saline Solution), pat dry, apply collagen powder, and cover with dry dressing daily x (for) 21 days then re-evaluate. Every day shift for Stage 3 [PI] for 21 days, dated 5/26/2025.</p> <p>2. Sacrococcyx pressure injury-cleanse with NSS, pat dry, apply Medihoney (medical grade honey intended for wound care) to wound bed follow with calcium alginate (primary wound dressing derived from seaweed and are highly absorbent) and zinc oxide to the periwound and cover with dry dressing daily x 21days then re-evaluate. Every day shift for stage 4 [PI], dated 5/31/2025.</p> <p>During a wound care observation on 6/12/2025 at 9:10 AM in Resident 7's room with Treatment Nurse1 (TN1). TN 1 cleansed Resident 7's sacrococcyx area wound with Hibiclens (wound cleanser, antiseptic), applied collagen, and covered the wound with a dressing.</p> <p>During an interview on 6/12/2025 at 9:10AM with TN1, TN1 stated TN 1 used Hibiclens instead of normal saline, TN1 stated TN 1 did not apply zinc oxide to the sacrococcyx [stage 4] PI. TN1 stated TN 1 did not provide wound care to the Stage 3 PI on Resident 7's right knee.</p> <p>During an interview on 6/12/2025 at 4:30PM with the Assistant Director of Nursing (ADON), the ADON stated it was essential for nurses to follow physician orders as they were based on the resident's clinical needs and represented basic nursing care standards. The ADON stated the use other products without a physician's order was not acceptable.</p> <p>During a review of the facility's policy and procedure (P&amp;P) titled, Wound Care, revised 10/2010, the P&amp;P indicated the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The P&amp;P indicated to verify there was a physician's order for the procedure.</p>		