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	09/15/2025

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on interview and record review, the facility failed to provide one of three sampled residents (Resident 14) or the Resident's Representative a copy of the Resident 14's medical record upon request and within two working days from notice per the facility's Policy and Procedure (P&P) titled, Residents Access to Records. This failure resulted in violation of Resident 14's rights and in Resident 14's Representatives not receiving the medical records in a timely manner. Findings: During a review of Resident 14's admission Record (AR), the AR indicated the facility admitted Resident 14 on 1/10/2025 with diagnoses that included lumbar region stenosis (narrowing of the spinal cannel which added pressure on the spinal cord and nerves) and hypertension (HTN, high blood pressure). During a review of Resident 14's Minimum Data Set (MDS, a resident assessment), dated 1/16/2025, the MDS indicated Resident 14's cognitive skills were intact. The MDS indicated Resident 14 required substantial assistance performing Activities of Daily Living (ADLs). The MDS indicated Resident 14 required substantial assistance turning from left to right in bed and transferring from the bed to chair or the chair to the bed. During a review of the Declaration of Custodian of Records (DCR), dated 6/13/2025, the DCR indicated record request date of 6/13/2025, addressed to medical records assistant in facility. During a review of Health Insurance Portability and Accountability Act (HIPPA, United States federal law enacted in 1996 that sets national standards for protecting sensitive patient health information, or Protected Health Information (PHI). It establishes rules for the secure and confidential handling, storage, and transmission of PHI to prevent unauthorized disclosure, and also addresses continuity of health insurance coverage and fraud reduction) Compliant Authorization for The Release of Patient Information dated 5/1/2025, the form indicated Resident 14 signed the authorization. During an interview on 9/11/2025 at 3:30 pm with Legal Assistant (LA), the LA stated, I have continued to request records from Point Click Care (PCC, a cloud based electronic health record platform designed for the skilled nursing facilities) format, but the facility continues to send uncomplete printed and scanned records. During a concurrent record review and interview on 9/15/2025 at 11:00 am with Director of Medical Records (DMR), the facility's policy and procedure (P&P) titled, Resident Access to Records, dated 12/14/2020 was reviewed. The P&P indicated Electronic Access-In an electronic form or format when such records are maintained electronically upon request Respond within twenty-four (24) hours for access, within forty-eight (48) hours for copies or provision in electronic format excluding weekends and holidays. The DMR stated the medical records department should have followed the P&P but they didn't.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect one of three sampled resident (Resident 8) from medication administration error in accordance with prescriber orders as indicated in the facility's policy and procedure (P&P) titled, Administering Medications. This failure resulted in Resident 8 administered melatonin (a hormone supplement that signals the body that it's time to sleep) pills without a physician order. Findings: During a review of Resident 8's admission Record (AR), the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (the final stage of chronic kidney disease (CKD) where the kidneys have permanently failed and can no longer function at a level needed to sustain life), and dependence on renal dialysis (a patient's lifelong reliance on the dialysis machine to filter waste from their blood, as their kidneys can no longer perform this function.) During a review of Resident 8's History and Physical Examination (H&P), dated 8/25/2025, the H&P indicated Resident 8's has the capacity to understand and make decisions. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was intact, and independent in eating, oral hygiene, with partial to moderate assistance with toileting hygiene, lower body dressing, and putting on/taking off footwear. During a review of Resident 8's Change in Condition Evaluation (CIC), dated 8/28/2025 at 11:48 pm, the CIC indicated Resident 8 was given four (4) tablets of Melatonin on 8/27/2025, physician notified, without order, continue to monitor, call MD for any change of condition. During a review of Resident 8's Care Plan Report (CP), dated 8/28/2025, the CP indicated risk for possible adverse reaction from melatonin, goal will be free from adverse reaction, and interventions monitor for adverse reaction such as drowsiness, headache, vivid dreams – nightmare, dizziness or nausea, mood changes, stomach cramps, and notify MD promptly. During a review of Resident 8's Resident Grievance/Complaint Procedures (RGCP), dated 8/28/2025, RGCP indicated date the incident occurred: 8/27/2025, Patient was given four pills of melatonin = 12 milligrams (a unit of weight or mass) without physician order by Licensed Vocational Nurse (LVN, a healthcare profession who provides basic nursing care to patients under the supervision of registered nurses (RNs) or physicians) 2. LVN 2 validated the administration of four tablets of melatonin to Resident 8 upon request and failed to check the order prior to administration. During a review of Resident 8's Progress Notes (PN), dated 8/29/2025 at 11:22 am, the PN indicated Assessment done today due to four tablets of melatonin supplement taken. During an interview on 9/15/2025 at 8:30 am with Resident 8, Resident 8 stated the night of 8/27/2025 LVN 2 gave me four melatonin tablets without a physician order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/15/2025 at 10:00 am with Director of Nursing (DON, a licensed, experienced registered nurse who holds a senior leadership position within a healthcare facility, overseeing all aspects of nursing services and patient care), the facility's P&P titled Administering Medications, dated April 2019 was reviewed. The P&P indicated, Policy Statement, Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. DON stated we did not follow our facility P&P.