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	10/23/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect a residents' right to be free from physical abuse (willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) for one of three sampled residents (Resident 8) when Resident 9 pushed Resident 8 during an altercation on [DATE]. This failure resulted in Resident 8 falling to the floor, sustaining a laceration (a pattern of injury in which skin and underlying tissues are cut or torn) to the back of Resident 8's head and a fracture (broken bone) to Resident 8's right elbow. Findings: a. During a review of the facility's Midnight Census Report (MCR), dated [DATE], the MSR indicated Residents 8 and 9 were roommates of the same room while at the facility. During a review of Resident 8's admission Record (AR), the AR indicated, Resident 8 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), Alzheimer's disease (a progressive disease that destroys memory and other important mental functions) and anxiety disorder (mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 8's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 8 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort) assistance from staff for toileting and personal hygiene, and dressing. During a review of Resident 8's Change in Condition Evaluation (CIC), dated [DATE], the CIC indicated, Resident (Resident 8) with her roommate (Resident 9) argue in their room.when CNA (Certified Nursing Assistant 4) and charge nurse (unknown) heard the sound and came to check immediately. Resident (Resident 8) falling on floor due to roommate (Resident 9) pushing her (Resident 8). Pt (Resident 8) got a small cut back of head and with. minimal bleeding.Pt (Resident 8) also reported her Left elbow and left thigh hurting. The CIC indicated Resident 8's Physician ordered for Resident 8 to be transferred to a General Acute Care Hospital (GACH) 1. During a review of Resident 1's GACH 1 Emergency Department (ED) Note Physician (ED Note), dated [DATE], the ED Note indicated Resident 8 presented to GACH 1 ED on [DATE] with a laceration to the back of the head. The ED Note indicated Resident 8 was pushed by Resident 8's roommate, fell, and hit the back of Resident 8's head. The ED Note indicated Resident 8 complained of right elbow and right hip pain. The ED Note indicated Resident 8's laceration to the head was repaired with one staple (specialized staples that are used instead of sutures to mend skin wounds). The ED Note indicated Resident 8 was placed in a right long-arm splint (a medical device used to immobilize and support the arm after an injury) and was given a sling (a supportive device used to immobilize and protect an injured arm or shoulder). During a review of Resident 8's Diagnostic Radiology (DR), dated [DATE], the DR indicated Resident 8's right elbow was x-rayed (x-ray, type of medical imaging that uses a small amount of radiation to create pictures of the inside of the body) due to pain and status post assault with blunt trauma. The DR indicated Resident 8 had a fracture at the back of the right elbow. b. During a review of Resident 9's AR, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including dementia (a group of thinking and social symptoms that interfere with daily functioning), encephalopathy (brain disease that alters brain function or structure), and anxiety disorder. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 was severely impaired in cognitive skills. The MDS indicated Resident 9 required partial/moderate assistance from staff for toileting and personal hygiene, lower body dressing, and bathing. During a review of Resident 9's Care Plan Report (CPR), undated, the CPR indicated the facility initiated a care plan on [DATE] with the focus being, The resident is/has potential to be physically aggressive r/t (related to) throwing items on the floor, and The resident is/has potential to be verbally aggressive r/t screaming/yelling at staff. The care plan indicated an intervention was to closely observe Resident 9. During a review of Resident 9's CIC, dated [DATE], the CIC indicated, on [DATE] Resident (Resident 9) with her roommate (Resident 8) argue in their room.CNA (4) and charge nurse (LVN 1) came to check immediately, resident (Resident 9) pushes her roommate (Resident 8) out of the room on the ground. During an interview on [DATE], at 10:30 AM with Resident 9, Resident 9 stated Resident 8 would always open Resident 8's privacy curtain. Resident 9 stated Resident 8 was taking Resident 9's clothes out of the closet. Resident 9 stated Resident 8 was trying to take Resident 9's blanket from Resident 9 so Resident 9 pushed Resident 8. Resident 9 stated Resident 8 fell. During an interview on [DATE], at 3:30 PM with CNA 4, CNA 4 stated that

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to arrange for a safe and orderly discharge for one of two sampled residents (Resident 7) when the facility failed to communicate Resident 7's medical conditions and needs to Intermediate Care Facility (ICF, provides long-term care for individuals who need more assistance than residential care but less than a skilled nursing facility) 1 prior to Resident 7's transfer to ICF 1. This failure had the potential for Resident 7 to experience an unsafe discharge due to receiving inappropriate and or inadequate care.Findings: During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted Resident 7 on 8/8/2025 with diagnoses including acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood), malignant melanoma of skin (skin cancer), and dysphagia (difficulty swallowing foods or liquids). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 8/14/2025, the MDS indicated Resident 7 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 7 was dependent (helper does all the effort) on staff for bathing and required substantial/maximal assistance (helper does more than half the effort) from staff for dressing, toileting, and personal hygiene. During a telephone interview on 10/22/2025 at 1:12 PM with the Administrator (ADM) from ICF 1, ADM stated the ADM was expecting Resident 1 to come to ICF 1 and was in contact with Resident 7's sister several weeks prior to Resident 7's discharge from the facility. The ADM stated when Resident 7 arrived to ICF 1 on 10/6/2025, ICF 1 staff assessed Resident 7 and realized ICF 1 could not accept Resident 7 to ICF 1 because Resident 7 had bed sores and a tumor on the neck that looked infected. The ADM stated Resident 7 was sent to a General Acute Care Hospital (GACH) 1 for the infected tumor on the neck. The ADM stated it was not appropriate for Resident 7 to be at ICF 1 because ICF 1 was an ICF/DD-H (Intermediate Care Facility for the Developmentally Disabled-Habilitative). The ADM stated Resident 7 needed to be at an ICF/DD-N (Intermediate Care Facility for the Developmentally Disabled-Nursing) facility due to Resident 7's medical needs. The ADM stated the ADM had not received any transfer paperwork from the facility prior to Resident 1 being discharged to ICF 1 and that the ADM did not realize ICF 1 was not an appropriate facility for Resident 7. The ADM stated the facility did not communicate Resident 7's needs to ICF 1 prior to discharging Resident 1 to ICF 1 on 10/6/2025. During an interview on 10/23/2025 at 9:15 AM with the Case Manager (CM), the CM stated the CM was responsible for arranging the discharge of Resident 7. The CM stated a fax confirmation would be the evidence the CM communicated Resident 7's medical condition and needs to ICF 1. The CM stated the CM did not have a fax confirmation that the facility communicated Resident 7's needs prior to Resident 7's discharge to ICF 1. The CM confirmed the CM did not call ICF 1 to communicate Resident 7's medical needs prior to Resident 7's discharge to ICF 1. During a review of the facility's Policy and Procedure (P&P) titled, Transfer and Discharge, Resident -Initiated, dated October 2025, the P&P indicated: 1. If the resident is being transferred. and return is expected, the following information is conveyed to the receiving provider:a. Contact information of the practitioner who was responsible for the care of the resident;b. Resident representative information, including contact information;c. Advance directive information;d. All special instructions and/or precautions for ongoing care, as appropriate such as:(1) treatments and devices (oxygen, implants, IVs, tubes/catheters);(2) transmission-based precautions such as contact, droplet. or airborne; and(3) special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions:e. The resident's comprehensive care plan goals:f. All other information necessary to meet the resident's needs, which includes. but may not be limited to:(1) resident status, including baseline and current mental, behavioral, and functional status;(2) reason for transfer, recent vital signs;(3) diagnoses and allergies;(4) medications (including when last received); and(5) most recent relevant labs, other diagnostic tests, and recent immunizations; andg. additional information. if any, outlined in the transfer agreement with the acute care provider (per S483.70U)).2. The above information is conveyed as close as possible to the actual time of transfer.3. Information may be conveyed using a universal transfer fom1 or an electronic health record summary, as long as the method contains the required elements, the resident's privacy is protected and the receiving facility has the capacity to receive and use the information.4. For residents being discharged (return not expected). all of the information listed above is conveyed to the receiving provider, along with a copy of the required information found at S483 .21 (c)(2) Discharge Summary (F661), as applicable.5. Communication of this required information will occur as close as possible to the time of discharge