

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  12/12/2025
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)
F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals.  (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to provide care and services to one of three sampled residents (Resident 3) by failing to ensure: 1. RNA 1 correctly applied Resident 3's right palm protector as indicated by rehabilitation staff. 2. RNA 1 and RNA 2 informed nursing staff when Resident 3's right palm and hand was known to get sweaty and develop moisture accumulation between the right thumb and index finger. These failures resulted in Resident 3 developing multiple open skin wounds on Resident 3's right thumb and index finger, and Resident 3 developed redness and an indentation on Resident 3's index finger knuckle. 3. Restorative Nursing Assistant (RNA) 1 and RNA 2 informed licensed nurses on 12/11/2025 at 11 am when RNA 1 removed Resident 3's right palm protector (a hand splint or supportive device, often foam and fabric, designed to prevent fingers from digging into the palm, which stops skin breakdown, ulcers, and pain, especially in conditions causing severe finger flexion contracture [a stiffening/shortening at any joint, that reduces the joint's range of motion]) and observed skin breakdown and wounds to Resident 3's right thumb and index fingers. This failure had the potential to delay treatment of Resident 3's wounds and had the potential to cause further skin breakdown and put Resident 3 at risk for increased pain and development of infection. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 11/19/2024 and was readmitted on [DATE] with diagnoses that included intracerebral hemorrhage (serious type of stroke [a medical emergency where blood flow to the brain is cut off, causing brain cells to die within minutes due to lack of oxygen] caused by bleeding inside the brain tissue from a ruptured blood vessel), muscle wasting and atrophy (thinning of muscle mass caused by disuse of the muscles or neurogenic conditions), and attention to tracheostomy (incision made in the windpipe to relieve an obstruction to breathing). During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 3 had severely impaired cognition (ability to think, remember, and function). The MDS indicated Resident 3 was dependent on others for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 3's Joint/Mobility Assessment- Rehab (JMAR) dated 11/19/2025, timed at 10:17 am, the JMAR indicated Resident 3 had moderate/severe (25 - 50 percent movement) contracture of Resident 3's right hand fingers. During a review of Resident 3's untitled care plan (CP) initiated 11/25/2025, the CP indicated Resident 3 was at risk for decline in range of motion (ROM, the full movement potential of a joint) of upper and lower extremity related to limited mobility. The CP goals indicated to maintain and prevent decline in the resident's ROM and to decrease the risk of skin breakdown. The CP interventions included putting on splints per physician order, monitoring for pain and discomfort, and to monitor for any skin breakdown. During a review of Resident 3's Order Summary Report (OSR) active as of 12/10/2025, the OSR indicated Resident 3 had a physician order, dated 6/27/2025, for RNA to apply right hand palm protector to be removed only for hygiene, up to six hours every day, 5 times per week as tolerated. The order indicated RNA to monitor Resident 3's skin integrity and to monitor for signs or behavior indicating pain/discomfort during/after splint application. The order indicated if skin breakdown or signs of pain were present, to notify the charge nurse and document, every day shift every Monday, Tuesday, Wednesday, Thursday, and Friday. During a concurrent observation and interview with Registered Nurse 1 (RN 1) on 12/10/2025 at 12:57 pm, inside Resident 3's room, Resident 3 was observed. RN 1 stated the skin between Resident 3's right hand thumb and index finger were sticking together because they were too moist and the skin was open. RN 1 stated Resident 3's right hand was very contracted, and RN 1 could not open Resident 3's right hand. RN 1 stated Resident 3's middle fingernail on the right hand was long and had the potential to dig into Resident 3's palm. During an interview with RNA 1 and RNA 2 on 12/10/2025 at 1:13 pm, RNA 1 stated RNA 1 and RNA 2 worked together and would start to apply splints, hand rolls, and other devices on residents at 7 am. RNA 1 stated splints and devices were usually ordered to be in place for 4 or 6 hours. RNA 1 stated when RNA 1 went in to see Resident 3 on 12/10/2025 at 11 am, Resident 3 already had wounds on Resident 3's right thumb and index finger. RNA 2 refused to answer any questions. During an interview with Licensed Vocational Nurse 3 (LVN 3) on 12/10/2025 at 1:39 pm, LVN 3 stated LVN 3 worked as the facility's wound/treatment nurse. LVN 3 stated LVN 3 was never informed of Resident 3's wounds on Resident 3's right hand. LVN 3 stated it was important for VN 3 to be informed of resident's wounds so the wounds could be treated and monitored. During an interview with Certified Nursing Assistant 3 (CNA 3) on 12/10/2025 at</p>		