

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 03/04/2026
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to accommodate the needs for two (2) of 22 sampled residents (Resident 1 and Resident 2) when: 1. The facility did not ensure the call light (a device used by a resident to signal his or her need for assistance from staff) system was audible (able to be heard) for staff (in general) to hear. 2. The facility did not ensure the call light was answered in a timely manner for Resident 1 and Resident 2. These deficient practices resulted in Resident 1's and Resident 2's calls for assistance to be unanswered and for the residents to feel ignored. These deficient practices also placed Resident 1 and Resident 2 at risk for a delayed emergency response, accidents, or prolonged incontinence (lack of voluntary control over urination or defecation/bowel movement). Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included myasthenia gravis (a condition causing abnormal weakness of certain muscles) and other sequelae of cerebral infarction (long-term aftereffect and complications resulting from a stroke [loss of blood flow to a part of the brain]). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 12/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/31/2025, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 1 was dependent on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including transfers in and out of bed. During an interview on 3/3/2026 at 12:05 pm with Resident 1, Resident 1 stated no one came to Resident 1's room or it took forever for staff (in general) to answer the call light, whenever Resident 1 used the call light to ask for assistance. Resident 1 stated Resident 1 felt ignored and felt as if nobody cared. During an observation on 3/4/2026 at 10:50 am outside of Resident 1's room, Resident 1's call light was on and went unanswered for 25 minutes. During a concurrent observation and interview on 3/4/2026 at 11:17 am with Resident 1, inside Resident 1's room, Resident 1's call light was on. Resident 1 stated Resident 1's call light had been on for over 30 minutes, and no one had answered it. Resident 1 stated Resident 1's mouth was dry and Resident 1 was thirsty so Resident 1 wanted to ask for water. 2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 was dependent on staff for most activities of daily living including transfers in and out of bed. During a review of Resident 2's H&P, dated 2/8/2026, the H&P indicated Resident 2 was alert and oriented. During an interview on 3/3/2026 at 12:30 pm with Resident 2, Resident 2 stated there was no point in using the call light because nursing staff (in general) did not answer the call light. Resident 2 stated whenever Resident 2 pushed the call light, no one ever came to his room to see what Resident 2 needed. Resident 2 stated Resident 2 felt as if the nursing staff (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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>did not care about Resident 2 and they forgot that Resident 2 was a resident in the facility. Resident 2 stated Resident 2 could have had an emergency, and the nursing staff (in general) would not have known. During a concurrent observation and interview on 3/4/2026 at 11:28 am with Certified Nursing Assistant (CNA) 1, CNA 1 stated CNA 1 answered Resident 1's call light because CNA 1 saw the call light on. CNA 1 stated CNA 1 did not hear the call light and only saw the blinking light (indicates call light was on) above Resident 1's room door. CNA 1 stated CNA 1 did not know how long the call light was on before CNA 1 answered it. During an interview on 3/4/2026 at 12:05 pm with Licensed Vocational Nurse (LVN) 1, LVN 1 stated call lights should be answered promptly and all staff (in general) were supposed to answer call lights. LVN 1 stated if the staff (in general) who answered the call light cannot assist the resident (in general) the staff must inform someone else who can assist the resident. LVN 1 stated it was important for residents' call lights to be answered because it was the residents' only means of communication with the outside world. LVN 1 stated if a call light does not get answered it could delay resident's care and potentially cause a life-threatening situation. During a concurrent observation and interview on 3/4/2026 at 12:41 pm with LVN 1 in unit 6's and unit 5's nurses' station, LVN 1 pushed the call light in random resident rooms, and the call light was not audible inside the nurses' station and in the hallway outside of residents' rooms. LVN 1 stated the call light sound box inside the nurses' station should make a beeping sound whenever a call light was on. LVN 1 stated it was important for all staff (in general) to be able to hear when a call light was on because staff (in general) might be somewhere where they were not able to see the blinking call light above the residents' door. During an interview on 3/4/2026 at 2:44 p.m. with the Director of Nursing (DON), the DON stated a call light was utilized by residents to get assistance from staff. The DON stated staff answered call lights to accommodate resident needs. The DON stated if call lights did not get answered promptly, it could delay residents' care and treatments and would lead to more serious problems. The DON stated call lights should be answered as soon as possible to assist residents with their needs. The DON stated staff knew a call light was on by the blinking light over a resident room door and by the beeping sound at the nurses' station call light sound box. The beeping sound from the call light sound box in the nurses' station alerted staff to what room needed assistance. The DON stated every unit nurses' station had their own call light sound box, and it should be beep when a call light was on. During a review of facility policy and procedure (P&P) titled, Answering the Call Light, dated 9/2022, the P&P indicated the purpose for the procedure was to ensure timely response to resident's request and needs. The P&P indicated staff must report all defective call lights to the nurse supervisor promptly. During a review of facility's P&P titled, Accommodation of Needs, dated 3/2021, the P&P indicated resident's individual needs and preferences would be accommodated to the extent possible. The P&P indicated staff would accommodate individual needs and preferences.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the light fixture above the resident's bed was operable (functional) for one (1) of 22 sampled residents (Resident 13). This deficient practice violated Resident 13's right to a safe, comfortable and homelike environment. Findings: During a review of Resident 13's admission Record (AR), the AR indicated the facility readmitted Resident 13 to the facility on 5/13/2024 with diagnoses that included cholecystitis (gallbladder inflammation), and dementia (a progressive state of decline in mental abilities). During a review of Resident 13's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 5/14/2025, the H&P indicated Resident 13 had the capacity to make medical decisions. During a review of Resident 13's Minimum Data Set (MDS, a resident assessment tool), dated 1/8/2026, the MDS indicated Resident 13's cognitive skills (reasoning, learning, and problem-solving) to make daily decisions was moderately impaired. The MDS indicated Resident 13 required substantial/maximal assistance (helper does more than half the effort to complete the activity) with upper body dressing and with toileting and personal hygiene and was dependent on staff (in general) with showering, lower body dressing, putting on/taking off footwear, and transfers in and out of bed. During a concurrent observation and interview on 2/27/2026, at 12:40 pm with Maintenance Staff (MAINT) 1, the light fixture above Resident 13's bed was observed to be inoperable (not able to be turned on) and missing its cover. MAINT 1 stated there was no other light in the room except for the light above Resident 13's roommate's bed. MAINT 1 stated there was a work order put in on 2/27/2026 but MAINT 1 found an entry on the log (maintenance log - used by all facility staff to communicate needed repairs to the Maintenance Department) regarding Resident 13's light needing repairs on 2/25/2026. During a concurrent observation and interview, on 2/27/2026, at 12:45 pm with the Maintenance Supervisor (MS), Resident 13's light fixture was observed. The MS stated the MS could not provide a work order for the light fixture repair. The MS stated that lighting was important so the CNAs can see (during provision of care to residents) and for safety. A review of the facility Policy and Procedure (P&P), titled, Homelike Environment, revised February 2021, indicated comfortable and adequate lighting is provided in all areas of the facility to promote a safe, comfortable and homelike environment. The lighting design emphasizes sufficient general lighting in resident-use areas.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide medically related social services (services provided by the facility's staff to assist residents in attaining or maintaining their mental and psychosocial health) to one (1) of 22 sampled residents (Resident 15) when the Case Manager (CM- healthcare professional who supports, guides, and coordinates care for residents, families and caregivers) did not meet with Resident 15 upon Resident 15's request. This deficient practice resulted in Resident 15 not being seen by the CM from 2/10/2026 to 2/23/2026 which caused Resident 15 to be unaware of Resident 15's discharge plan and caused Resident 15's mental stress. Findings: During a review of Resident 15's admission Record (AR) the AR indicated Resident 15 was admitted to the facility on [DATE] with diagnoses which included unspecified fracture of lower end of right tibia (a broken right shinbone just above the ankle), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypotension (low blood pressure). The AR indicated Resident 15's insurance was a health maintenance organization (HMO - a type of health insurance). During a review of Resident 15's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/15/2026, the H&P indicated Resident 15 had the capability to make decisions. During a review of Resident 1's Minimum Data Set (MDS - resident assessment tool), dated 2/16/2026, the MDS indicated Resident 15's cognitive skills (reasoning, learning, and problem-solving) for decision making was intact and Resident 15 required substantial/maximal assistance (helper does more than half the effort to complete the activity) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a phone interview on 3/3/2026 at 10 am with Resident 15, Resident 15 stated the CM did not come see Resident 15 after Resident 15 made many requests to nurses (in general) for CM to see Resident 15. The CM not meeting with Resident 15 stressed out Resident 15 because Resident 15 was informed the CM and not the facility social workers was responsible for coordinating the care and discharge for residents under HMO. During an interview on 3/4/2026 at 10:30 am with Registered Nurse (RN) 1, RN 1 stated RN 1 remembered Resident 15 requesting to see the CM and RN 1 informed the CM of Resident 15's request but did not follow up. During a concurrent interview and record review on 3/4/2026 at 11:12 am with the CM, Resident 15's electronic medical record (EMR) was reviewed. The CM stated there were no notes in Resident 15's EMR regarding the CM speaking or meeting with Resident 15 until 2/24/2026, 14 days after Resident 15's admission. The CM stated the CM should have seen Resident 15 on 2/11/2026 but the CM did not. During a concurrent interview and record review on 3/4/2025 at 2:50 pm, with the Director of Nursing (DON), the DON reviewed the CM's job description. The job description indicated the CM Monitors daily all HMO/managed care residents for care needs and physician orders relating to same. The DON stated the CM's job description indicated it was the CM's responsibility to discuss the discharge plan with residents (in general) to ensure the plan and the level of care will meet their needs and ability to participate in the care. The DON stated the CM did not follow the job description. During a review of the facility policy and procedure (P&P) titled, Social Services, dated September 2021, the P&P indicated, Our facility provides medically related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being. The P&P indicated, The social worker/social services staff are responsible for assisting with informing and educating residents, families and representatives about health care options and ramifications. and assisting to identify and address factors that have a potentially negative effect on psychosocial functioning of a resident for example: assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights and accommodation needs.</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure fluids were provided to two (2) of 22 sampled residents (Resident 1 and 2) to maintain hydration (having enough water or fluids in the body) when Resident 1 and Resident 2 did not have a water pitcher in their room. This deficient practice had the potential to cause dehydration (absence of enough water or fluids in the body) which could lead to severe health complications for Resident 1 and Resident 2. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included myasthenia gravis (a condition causing abnormal weakness of certain muscles) and other sequelae of cerebral infarction (long-term aftereffect and complications resulting from a stroke [loss of blood flow to a part of the brain]). During a review of Resident 1's History and Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 12/12/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/31/2025, the MDS indicated Resident 1's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was intact. The MDS indicated Resident 1 was dependent on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including transfers in and out of bed. 2. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making was intact. The MDS indicated Resident 2 was dependent on staff for most activities of daily living including transfers in and out of bed. During a review of Resident 2's H&P, dated 2/8/2026, the H&P indicated Resident 2 was alert and oriented. During a concurrent observation and interview on 3/3/2026 at 12:05 pm with Resident 1, in Resident 1's room, there was no water pitcher found in Resident 1's room. Resident 1 stated Resident 1 did not have a water pitcher. Resident 1 stated Resident 1 requested water and staff (in general) provided Resident 1 with a small cup of water. Resident 1 stated Resident 1's lips and throat were dry. Resident 1 stated Resident 1 did not know why staff (in general) limited Resident 1's fluid intake and it made Resident 1 upset. During a concurrent observation and interview on 3/3/2026 at 12:30 pm with Resident 2, in Resident 2's room, Resident 2 stated Resident 2 was not given a water pitcher. There were no cups and no water pitcher found in Resident 2's room. Resident 2 stated Resident 2 drank water and juices only during mealtimes. During a concurrent observation and interview on 3/4/2026 at 11:17 am with Resident 1, inside Resident 1's room, Resident 1's call light was on. Resident 1 stated Resident 1's call light had been on for over 30 minutes, and no one had answered it. Resident 1 stated Resident 1's mouth was dry and Resident 1 was thirsty so Resident 1 wanted to ask for water. During a concurrent observation and interview on 3/4/2026 at 11:28 am with Certified Nursing Assistant (CNA) 1, CNA 1 was observed walking into Resident 1's room with a water pitcher and a plastic cup. CNA 1 stated CNA 1 provided a water pitcher to Resident 1 because Resident 1 requested water and CNA 1 noticed Resident 1 did not have a water pitcher in Resident 1's room. CNA 1 stated CNA 1 was not assigned to care for Resident 1 and CNA 1 did not know why Resident 1 did not have a water pitcher because all residents should have a water pitcher at their bedside. CNA 1 stated it was important to provide a water pitcher to residents to prevent dehydration. During an interview on 3/4/2026 at 11:41 am with Licensed Vocational Nurse (LVN) 1, LVN 1 stated all residents must have a water pitcher available at their bedside table to be able drink water whenever the residents wanted. LVN 1 stated all staff were responsible for providing water for residents. LVN 1 stated not having a water pitcher (continued on next page)</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>available to a resident (in general) would place the resident (in general) at risk of dehydration. During an interview on 3/4/2026 at 1:21 pm with CNA 2, CNA 2 stated CNA 2 was assigned to care for Resident 1. CNA 2 stated when CNA 2 made rounds in the morning, CNA 2 thought Resident 1 did not need water because when CNA 2 asked Resident 1 if Resident 1 needed anything, Resident 1 answered no. CNA 2 stated CNA 2 would only provide water to a resident if the resident requested it. During a concurrent observation and interview on 3/4/2026 at 1:41 pm with CNA 2 and Resident 1, in Resident 1's room, Resident 1 stated today was the first time Resident 1 had a water pitcher in the last four (4) days. CNA 2 stated Resident 1 should always have a water pitcher at the bedside table. CNA 2 stated it was important to assist the residents with their needs and keep residents hydrated. During an interview on 3/4/2026 at 3:05 pm with the Director of Nursing (DON), the DON stated all residents who could swallow and were not on fluid restriction must have water pitchers at their bedside. The DON stated all water pitchers should be changed every day at the start of the day and as needed. The DON stated all residents receive a water pitcher to keep them hydrated and to prevent dehydration which could cause health issues. The DON stated it was the nursing staff's (in general) responsibility to assure that all residents have a water pitcher. During a review of facility's Policy and Procedure (P&P) titled, Accommodation of Needs dated 3/2021, the P&P indicated resident's individual needs and preferences would be accommodated to the extent possible. The P&P indicated staff would accommodate individual needs and preferences. During a review of facility's P&P titled Activities of Daily Living (ADL), Supporting), dated 3/2018, the P&P indicated residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. The P&P indicated residents who are unable to carry out ADLs will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.</p>