

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 03/31/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice by failing to perform reassessment, repeat blood pressure measurement or physician notification by the licensed nurse following the elevated blood pressure reading of Resident 1 on 2/27/2026. This deficient practice placed Resident 1 at risk of harm. Findings: During a review of Resident 1's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 1 on 2/23/2026 with diagnoses including hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated), and heart failure (a condition in which the heart can't pump enough blood to meet the body's needs). During a review of Resident 1's History and Physical (H&P) dated 2/25/2026, 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 federally mandated resident assessment tool) dated 2/28/2026, the MDS indicated Resident 1 had intact cognitive (the ability to think and process information) skills for daily decisions. The MDS indicated Resident 1 was dependent to staff for toileting, shower/bathing, lower body dressing and putting on footwear. During a review of Resident 1's Vital Signs Record (VSR) dated 3/31/2026, the VSR indicated a blood pressure reading of 168/77-millimeter mercury (mmHg) on 2/27/2026 with a prior reading of 128/75 mmHg. During the same review, there was no documentation of reassessment, repeat blood pressure measurement, nor physician notification by the licensed nurse following Resident 1's elevated blood pressure reading. During a review of Resident 1's Progress Notes (PN) dated 3/31/2026, the PN did not indicate a change in condition (COC) documentation initiated following Resident 1's elevated blood pressure reading on 2/27/2026. During a telephone interview on 3/31/2026 at 10:00AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated LVN 1 took and documented Resident 1's blood pressure reading of 168/77 mmHg on 2/27/2026. LVN 1 stated the physician was not notified of the elevated blood pressure reading. LVN 1 stated that no reassessment, repeat blood pressure measurement, or change in condition documentation was completed following the elevated reading. During a concurrent interview and record review on 3/31/2026 at 12:00PM with the Assistant Director of Nursing (ADON), Resident 1's VSR and PN were reviewed. The ADON stated the records indicated Resident 1 had a blood pressure reading of 168/77 mmHg on 2/27/2026 with no documented reassessment, change of condition documentation, and physician notification. The ADON stated staff were expected to assess residents, monitor vital signs, and notify the physician for changes in condition. The ADON stated that a change in blood pressure reading from 128/75 mmHg to 168/77 mmHg required assessment and documentation, even if the resident denied any symptoms. The ADON stated a thorough assessment should have been completed on Resident 1 following an elevated blood pressure reading on 2/27/2026. During a review of the facility's Policy and Procedure (P&P) titled, Blood Pressure, Measuring, revised September 2010, the P&P indicated hypertensive readings should be reported to the physician and staff should document and evaluate findings.</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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