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	05/06/2026

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to inform one (1) of 20 sampled residents (Resident 1), in writing, why Resident 1's bedside dialysis (hemodialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed) services will not be covered by Resident 1's insurance.This deficient practice had the potential to result in Resident 1 not receiving the appropriate care and services and impairing Resident 1's physical and psychosocial well-being.During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 1/15/2026 with diagnoses which included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD- irreversible kidney failure), and dependence on renal dialysis.During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/17/2026, the H&P indicated that the resident has capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 1/21/2026, the MDS indicated Resident 1 was dependent on showering/bathing self and lower body dressing. The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort to complete the activity) with toileting hygiene and upper body dressing.During a review of Resident 1's Order Summary Report (OSR), dated 4/28/2026, the OSR indicated Resident 1 had an active order for in-house (done in the facility) dialysis which started on 1/15/2026.During a review of Resident 1's Care Plan (CP), dated 1/16/2026, the CP indicated Resident 1 needed hemodialysis related to kidney failure and the intervention included to encourage Resident 1 to go for the scheduled dialysis appointments. The CP indicated Resident 1 received dialysis in-house on Monday, Wednesday, and Friday.During a review of Resident 1's Progress Notes (PN), dated 4/22/2026, the PN indicated Resident 1 was receiving in-house dialysis and was informed Resident 1's skilled coverage was ending, with anticipated transition to outpatient (done outside the facility) dialysis services.During a review of Resident 1's Progress Notes (PN), dated 4/27/2026, the PN indicated that Resident 1's insurance benefits were exhausted as of 4/24/2026.During a review of Resident 1's medical record, there was no written notice form for change of in-house dialysis to outpatient dialysis found in the medical record.During an interview on 4/28/2026 at 9:16 AM with Resident 1, Resident 1 stated that Resident 1 was told on 4/20/2026 that Resident 1 would no longer receive in-house bedside dialysis and needed to change to outpatient dialysis because Medicare will no longer cover Resident 1's in-house dialysis after 4/24/2026. Resident 1 stated Resident 1 did not receive any notice in writing.During an interview on 4/28/2026 at 10:12 AM with the Case Manager (CM), the CM stated the CM told Resident 1 on 4/20/2026 that the last in-house dialysis day would be 4/24/2026 and the in-house dialysis would change to outpatient dialysis after that. The CM stated the CM did not give a written notice to Resident 1 regarding the change of services from in-house dialysis to outpatient dialysis.During an interview on 4/28/2026 at 3:30 PM with the Director of Nursing (DON), the DON stated the facility did not give Resident 1 a written notice about changing bedside dialysis service to outpatient dialysis.During a review of the facility's policy and procedure (P&P) titled, Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised 9/2022, the P&P indicated, If the director of (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admissions or benefits coordinator believes (upon admission or during the resident's stay) that Medicare (Part A of the Fee for Service Medicare Program) will not pay for an otherwise covered skilled service(s), the resident (or representative) is notified in writing why the service(s) may not be covered and of the resident's potential liability for payment of the non-covered service(s). The P&P indicated, If the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to provide a comfortable, homelike environment by not fixing the window curtain from falling off the curtain rail for one (1) of 20 sampled residents (Resident 3).This deficient practice violated Resident 1's right to have a comfortable, homelike environment and had the potential to violate Resident 1's privacy and affect Resident 1's physical and psychosocial well-being.During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 3/25/2026 with diagnoses which included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney[s] have failed), and cellulitis (a skin infection that causes swelling and redness) of left lower limb.During a review of Resident 3's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/26/2026, the H&P indicated Resident 3 had capacity to make medical decisions.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 3 had intact cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort to complete the activity) with toileting hygiene, lower body dressing, and to shower/bathe self. The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and upper body dressing.During a concurrent observation and interview on 4/29/2026 at 9:09 AM with Resident 3 inside Resident 3's room next to Resident 3's bed, there were four black clips which held the two curtains together to cover the windows. Resident 3 stated Resident 3 had to buy the clips to clip the curtains together to prevent one curtain from dropping off the curtain rail and to prevent the sunshine from coming through and interrupting Resident 3's sleep. Resident 3 stated staff (in general) knew that the curtain was falling from the rail but had not fixed the curtain. Resident 3 stated that the facility should fix the curtain and provide a comfortable and homelike environment.During an interview on 4/29/2026 at 12:18 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated the curtain next to Resident 3's bed was broken and there were clips to clip the curtains together to prevent the curtain from falling off. CNA 1 stated the facility should fix the broken curtain to provide Resident 3 privacy. During an interview on 5/1/2026 at 11:48 AM with the Maintenance Supervisor (MS), the MS stated it was the maintenance service's responsibility to fix Resident 3's curtain, and it was important to fix the curtain to provide privacy and a comfortable, homelike environment.During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised 2/2021, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment. The P&P indicated, Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The P&P further indicated, The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.clean, sanitary, and orderly environment.comfortable (minimum glare) yet adequate (suitable to the task) lighting.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interview and record review, the facility failed to provide and document sufficient preparation and orientation to ensure a safe and orderly discharge for one (1) of 20 sampled residents (Resident 8) when:The facility failed to conduct a Discharge Planning Review prior to discharge.The facility failed to complete a Discharge Summary/Comprehensive Assessment (DSCA) and to provide Resident 8's caregiver upon discharge from the facility.The facility failed to provide caregiver training to Resident 8's caregiver.These failures had the potential for Resident 8 to experience an unsafe discharge and had the potential for Resident 8 to be hospitalized .(Cross reference F641, F658, and F686)During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on 1/16/2026 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic pain, and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). The AR indicated Resident 8's friend (RP 1) was Resident 8's Responsible Party (individual designated to manage a resident's funds, coordinate care, or sign admission documents). The AR indicated Resident 8 was discharged from the facility on 2/23/2026.During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 8 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort) from staff for lower body dressing and putting on/off footwear. The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort) assistance from staff for bathing, upper body dressing, and toileting and personal hygiene.During a telephone interview on 5/4/2026 at 9:26 AM with RP 1, RP 1 stated Resident 8 was discharged from the facility on 2/23/2026. RP 1 stated Resident 8 returned to Resident 8's apartment with hospice services. RP 1 stated RP 1 became Resident 8's caregiver when Resident 8 was discharged from the facility. RP 1 stated RP 1 was at Resident 8's apartment when Resident 8 arrived at Resident 8's apartment on a gurney (a mobile wheeled cot or stretcher). RP 1 stated the transportation team did not have any discharge paperwork to give to RP 1. RP 1 stated RP 1 did not know Resident 8 would arrive at the apartment on 3/23/26 because no one at the facility informed RP 1 that Resident 8 would be discharged on that day. RP 1 stated RP 1 had decided with the Case Manager (CM) for Resident 8 to be discharged home on hospice but that the CM had not informed RP 1 Resident 8 would be discharged on 3/23/2026. RP 1 stated that no one from the facility provided caregiver training to RP 1.During an interview on 5/4/2026 at 10:40 AM with the Case Manager (CM), the CM stated the discharge process for residents (in general) included discharge planning done by the Social Services department. The CM stated the discharge process also included caregiver training done by the rehab department. The CM stated the nursing department also provided discharge instructions. The CM stated if caregivers were not provided with training, then the discharge could not be considered a safe discharge.During a concurrent interview and record review on 5/5/2026 at 12:25 PM with Social Services Assistant (SSA 2), Resident 8's Discharge Planning Review (DPR), undated, was reviewed. The DPR was left blank with no entries indicating a discharge planning review was not conducted for Resident 8's discharge. SSA 2 stated the purpose of a discharge planning review was for the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of the resident) to go over any concerns or questions the residents (in general) might have about their discharge from the facility. SSA 2 stated the rehab department also needed to provide caregiver training prior to discharge. SSA 2 confirmed Resident 8 did not receive discharge planning by the IDT.During a concurrent interview and record review on 5/5/2026 at 12:40 PM with Registered Nurse (RN) 2, the facility's DSCA, undated, was reviewed. RN 2 stated the DSCA needed to be completed and provided to the residents' (in general) caregiver. RN 2 stated the DSCA communicated the level of care the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents (in general) would need after discharge. RN 2 stated there needed to be a DSCA in Resident 8's medical record.During a concurrent interview and record review on 5/5/2026 at 1:12 PM with the Director of Rehabilitation (DOR), Resident 8's medical record was reviewed, including documentation for Occupational and Physical Therapy. The DOR stated the facility did not provide caregiver training to any caregiver for Resident 8 prior to discharge.During an interview on 5/5/2026 at 2:38 PM with the Medical Records Director (MRD), the MRD stated Resident 8 did not have a DSCA in Resident 8's medical records.During a review of the facility's Policy and Procedure (P&P) titled, Transfer or Discharge, Preparing a Resident for, revised December 2016, the P&P indicated, .Nursing services is responsible for.Preparing the discharge summary and post-discharge plan.Providing the resident or representative (sponsor) with required documents (i.e., Discharge Summary and Plan) .During a review of the facility's P&P titled, Discharging the Resident, revised December 2016, the P&P indicated, If the resident is being discharged home, ensure that resident and/or responsible party receive teaching and discharge instructions.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS, a standardized assessment and care-screening tool) was accurate for one (1) of 20 sampled residents (Resident 8) when Resident 8's MDS, dated [DATE], incorrectly indicated Resident 8 did not have any pressure ulcer/injuries (localized injury to the skin and/or underlying tissue) upon discharge from the facility on 2/23/2026.This failure had the potential to result in Resident 8 not receiving appropriate treatment and/or services.(Cross reference F627, F658, and F686)During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on 1/16/2026 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic pain, and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should). The AR indicated Resident 8's friend (RP 1) was Resident 8's Responsible Party (individual designated to manage a resident's funds, coordinate care, or sign admission documents). The AR indicated Resident 8 was discharged from the facility on 2/23/2026.During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 1/22/2026, the MDS indicated Resident 8 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 8 required substantial/maximal assistance (helper does more than half the effort) from staff for walking 10 feet, walking 50 feet, walking 150 feet, lower body dressing, and putting on/off footwear. The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort) assistance from staff for rolling left and right, bathing, upper body dressing, and toileting and personal hygiene.During a concurrent interview and record review on 4/30/2026 at 2:01 PM with TN 2, Resident 8's elNTERACT Change in Condition Evaluation (CIC) form, dated 2/6/2026, was reviewed. The CIC indicated at 2:21 PM on 2/6/2026 Resident 8 had discoloration to the left heel. The CIC indicated upon assessment by TN 2, Resident 8 was assessed to have a diabetic ulcer to the left heel. TN 2 stated a wound developed on Resident 8's left heel on 2/6/2026. TN 2 stated the wound was diagnosed to be a diabetic ulcer. TN 2 stated TN 2 received the diagnosis of diabetic ulcer to resident left heel from the Nurse Practitioner (NP) over the telephone. TN 2 confirmed the NP did not assess Resident 8 before giving the diagnosis of diabetic ulcer. TN 2 stated the facility arranged for Resident 8 to be seen by the Wound Care Specialist (WCS, a medical professional trained to evaluate and treat complex wounds), who came to the facility every Thursday.During a telephone interview on 5/4/2026 at 9:26 AM with RP 1, RP 1 stated Resident 8 was discharged from the facility on 2/23/2026. RP 1 stated Resident 8 had a pressure sore on Resident 8's left heel when Resident 8 was discharged from the facility.During a concurrent telephone interview and record review on 5/4/2026 at 2:18 PM with the WCS, Resident 8's Progress Notes (PN), dated 2/12/2026, was reviewed. The PN indicated the WCS provided consultation for managing wounds for Resident 8 on 2/12/2026. The PN indicated Resident 8 had a diabetic ulcer left foot. The WCS stated if a diabetic resident (in general) had a wound on the foot, the WCS would always diagnose the wound to be a diabetic ulcer. The WCS stated that even if the cause of the wound to the diabetic resident's (in general) foot was caused by pressure, the WCS would diagnose the wound to be a diabetic ulcer. The WCS stated the WCS would continue the interview the next day after reviewing WCS's documentation for Resident 8.During a concurrent telephone interview and record review on 5/5/2026 at 11:39 AM with Resident 8's Physician (MD 1), Resident 8's PN, dated 2/12/2026 and 2/24/2026, were reviewed. MD 1 stated since the skin injury was on Resident 8's heel then pressure would be the primary contributor to the injury. MD 1 stated Resident 1's wound to the left heel was a pressure wound. MD 1 stated the wound on Resident 8's left heel should not have been diagnosed as a diabetic ulcer.During a concurrent interview and record review on 5/5/2026 at 1:40 PM with the MDS Coordinator (MDSC), Resident 8's MDS, dated [DATE], was reviewed. The MDS indicated Resident 8 did not have any pressure ulcer/injuries upon discharge from the facility on (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/23/2026. The MDSC stated the MDSC documented Resident 8 did not have any pressure ulcer/injuries based on the documentation in Resident 8's medical record from the WCS and TN 2. The MDSC stated if the WCS and TN 2 documentation was incorrect then the MDS would also be incorrect.During a follow-up telephone interview and record review on 5/5/2026 at 2:15 PM with the WCS, the manual titled, CMS's RAI Version 3.0 Manual, dated October 2025 was reviewed. The manual indicated the following definitions: Diabetic Foot Ulcers .Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful.Pressure Ulcer/Injury. A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.The surveyor read the definitions to the WCS. The WCS stated that based on the definitions in the manual, the WCS diagnosed Resident 8's left heel wound wrong. The WCS stated Resident 8's left heel wound was pressure injury.During a review of the manual titled, CMS's RAI Version 3.0 Manual, dated October 2025, (retrieved on 5/5/2026, from cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf-1) the manual indicated, .an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer. The manual described a diabetic foot ulcer as, Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful. The manual described a pressure ulcer/injury as, A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual indicated, It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. The manual indicated, Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Wound Care Specialist (WCS) inaccurately diagnosed on e (1) of 20 sampled resident's (Resident 8) pressure injury (localized injury to the skin and/or underlying tissue) as a diabetic foot ulcer (ulcers [an open sore] caused by the neuropathic [a condition, disease, or pain caused by damage or malfunction in the nervous system] and small blood vessel complications of diabetes [a chronic condition that affects the way the body processes blood sugar]).This failure had the potential for Resident 8 to receive inappropriate care and treatment for Resident 8's pressure injury.(Cross reference F627, F641, and F686)During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic pain, and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should).During a review of Resident 8's Minimum Data Set (MDS, a resident assessment 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 substantial/maximal assistance (helper does more than half the effort) from staff for walking 10 feet, walking 50 feet, walking 150 feet, lower body dressing, and putting on/off footwear. The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort) assistance from staff for rolling left and right, bathing, upper body dressing, and toileting and personal hygiene.During a review of Resident 8's Order Summary Report (OSR), dated [DATE], the OSR indicated Resident 8 had a physician order, dated [DATE], for a wound evaluation and treatment by the WCS.During a review of Resident 8's Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 8 had a diabetic ulcer of the left heel, The CPR included an intervention to determine and treat cause of Resident 8's diabetic ulcer of the left heel.During a concurrent interview and record review on [DATE] at 1:55 PM with Treatment Nurse (TN) 1, Resident 8's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation (BS), dated [DATE] was reviewed. The BS indicated Resident 8 was at high risk of developing a pressure ulcer.During a concurrent interview and record review on [DATE] at 2:01 PM with TN 2, Resident 8's elNTERACT Change in Condition Evaluation (CIC) form, dated [DATE], was reviewed. The CIC indicated at 2:21 PM on [DATE] Resident 8 had discoloration to the left heel. TN 2 stated the facility arranged for Resident 8 to be seen by the Wound Care Specialist (a medical professional trained to evaluate and treat complex wounds), who came to the facility every Thursday.During a concurrent telephone interview and record review on [DATE] at 2:18 PM with the WCS, Resident 8's Progress Notes (PN), dated [DATE], was reviewed. The PN indicated the WCS provided consultation for managing wounds for Resident 8 on [DATE]. The PN indicated Resident 8 had a diabetic ulcer left foot. The WCS stated if a diabetic resident (in general) had a wound on the foot, the WCS would always diagnose the wound to be a diabetic ulcer. The WCS stated that even if the cause of the wound to the diabetic resident's (in general) foot was caused by pressure, the WCS would diagnose the wound to be a diabetic ulcer. The WCS stated the WCS would continue the interview the next day after reviewing WCS's documentation for Resident 8.During a concurrent telephone interview and record review on [DATE] at 11:39 AM with Resident 8's Physician (MD 1), Resident 8's PN, dated [DATE] and [DATE], were reviewed. MD 1 stated MD 1 had seen Resident 8 on three (3) different occasions while Resident 8 was at the facility. MD 1 stated MD 1 was presently able to view Resident 8's PN dated [DATE] and [DATE] which were documented by WCS. MD 1 stated MD 1 could see a picture of the wound on the PN dated [DATE]. MD 1 stated since the skin injury was on Resident 8's heel then pressure would be the primary contributor to the injury. MD 1 stated Resident 1's wound to the left heel was a pressure wound. MD 1 stated the wound on Resident 8's left heel should not have been diagnoses as a diabetic ulcer.During a follow-up telephone interview and record review on [DATE] at 2:15 PM with the WCS, the manual titled, CMS's RAI Version 3.0 Manual, dated [DATE], was reviewed. The manual indicated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following definitions: Diabetic Foot Ulcers .Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful.Pressure Ulcer/Injury. A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.The surveyor read the definitions to the WCS. The WCS stated that based on the definitions in the manual, the WCS diagnosed Resident 8's left heel wound wrong. The WCS stated Resident 8's left heel wound was a pressure injury. The WCS stated the WCS would read up on pressure injuries versus diabetic foot ulcers to prevent the WCS from misdiagnosing similar wounds in the future.During a review of the manual titled, CMS's RAI Version 3.0 Manual, dated [DATE], (retrieved on [DATE], from cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf-1) the manual indicated, .an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer. The manual described a diabetic foot ulcer as, Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful. The manual described a pressure ulcer/injury as, A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual indicated, It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. The manual indicated, Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.

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	056431	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to create a care plan to ensure one (1) of 20 sampled residents (Resident 8), who was at high risk to develop pressure injury/ulcer (localized injury to the skin and/or underlying tissue), received interventions to prevent Resident 8 from developing a pressure injury/ulcer. This failure resulted in Resident 8 developing pressure injury to Resident 8's left heel while at the facility.(Cross reference F627, F641, and F658)During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted Resident 8 on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), chronic pain, and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should).During a review of Resident 8's Minimum Data Set (MDS, a resident assessment 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 substantial/maximal assistance (helper does more than half the effort) from staff for walking 10 feet, walking 50 feet, walking 150 feet, lower body dressing, and putting on/off footwear. The MDS indicated Resident 8 required partial/moderate (helper does less than half the effort) assistance from staff for rolling left and right, bathing, upper body dressing, and toileting and personal hygiene.During a review of Resident 8's Body Assessment (BA), dated [DATE], the BA indicated Resident 8's skin was intact upon admission to the facility (did not have any skin injuries to Resident 8's heels).During a concurrent interview and record review on [DATE] at 1:53 PM with Treatment Nurse (TN) 2, Resident 8's Skin Check (SC), dated [DATE], was reviewed. The SC indicated Resident 8 had no skin issues. TN 2 stated TN 2 inspected Resident 8's skin on [DATE] and Resident 8 did not have any skin injuries to the heels or any other areas of the body upon admission to the facility.During a concurrent interview and record review on [DATE] at 1:55 PM with TN 1, Resident 8's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation (BS), dated [DATE], and Resident 8's Care Plan Report (CPR), undated, were reviewed. The BS indicated Resident 8 was at high risk of developing a pressure ulcer. The CPR indicated the facility failed to create a care plan to address Resident 8's high risk of developing a pressure ulcer. TN 2 stated the facility's practice was to complete a BS assessment weekly for 4 weeks after a resident (in general) was admitted to the facility. TN 2 stated TN 2 completed Resident 8's BS assessment on [DATE] and assessed Resident 8 to be at high risk of developing a pressure ulcer. TN 2 stated the facility did not create a care plan to address Resident 8's risk of developing a pressure ulcer. TN 2 stated if a care plan with interventions to prevent skin breakdown is not created to address a resident's (in general) high risk in developing a pressure ulcer, the resident (in general) may experience skin breakdown.During a concurrent interview and record review on [DATE] at 2:01 PM with TN 2, Resident 8's elNTERACT Change in Condition Evaluation (CIC) form, dated [DATE], was reviewed. The CIC indicated at 2:21 PM on [DATE] Resident 8 had discoloration to the left heel. TN 2 stated the wound developed on Resident 8's left heel on [DATE]. TN 2 stated the facility arranged for Resident 8 to be seen by the Wound Care Specialist (a medical professional trained to evaluate and treat complex wounds), who came to the facility every Thursday.During a telephone interview on [DATE] at 9:26 AM with RP 1, RP 1 stated Resident 8 was discharged from the facility on [DATE]. RP 1 stated Resident 8 had a pressure sore on Resident 8's left heel when Resident 8 was discharged from the facility.During a concurrent telephone interview and record review on [DATE] at 2:18 PM with the Wound Care Specialist (WCS), Resident 8's Progress Notes (PN), dated [DATE], was reviewed. The PN indicated the WCS provided consultation for managing wounds for Resident 8 on [DATE]. The PN indicated Resident 8 had a diabetic ulcer left foot. The WCS stated if a diabetic resident (in general) had a wound on the foot, the WCS would always diagnose the wound to be a diabetic ulcer. The WCS stated that even if the cause of the wound to the diabetic resident's (in general) foot was caused by pressure, the WCS would diagnose (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wound to be a diabetic ulcer. The WCS stated the WCS would continue the interview the next day after reviewing WCS's documentation for Resident 8.During a concurrent telephone interview and record review on [DATE] at 11:39 AM with Resident 8's Physician (MD 1), Resident 8's PN, dated [DATE] and [DATE], were reviewed. MD 1 stated MD 1 had seen Resident 8 on three different occasions while Resident 8 was at the facility. MD 1 stated since the skin injury was on Resident 8's heel then pressure would be the primary contributor to the injury. MD 1 stated Resident 1's wound to the left heel was pressure injury.During a follow-up telephone interview and record review on [DATE] at 2:15 PM with the WCS, the manual titled, CMS's RAI Version 3.0 Manual, dated [DATE] was reviewed. The manual indicated the following definitions: Diabetic Foot Ulcers .Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful.Pressure Ulcer/Injury. A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.The surveyor read the definitions to the WCS. The WCS stated that based on the definitions in the manual, the WCS diagnosed Resident 8's left heel wound wrong. The WCS stated Resident 8's left heel wound was pressure injury.During a review of the facility's Policy and Procedure (P&P) titled, Prevention of Pressure Injuries, revised [DATE], the P&P indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. The P&P indicated, Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition.During a review of the facility's P&P titled, Pressure Injury Risk Assessment, revised [DATE], the P&P indicated, Once the assessment is conducted and risk factors are identified and characterized, a resident-centered care plan can be created to address the modifiable risks for pressure injuries.Repeat the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the resident's condition.During a review of the manual titled, CMS's RAI Version 3.0 Manual, dated [DATE], (retrieved on [DATE], from cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf-1) the manual indicated, .an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer. The manual described a diabetic foot ulcer as, Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape, and the wound edges are even with a punched-out appearance. These wounds are typically not painful. The manual described a pressure ulcer/injury as, A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful. The manual indicated, It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound. The manual indicated, Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review, the facility failed to arrange transportation to ensure one (1) of 20 sampled residents (Resident 3) received dialysis (hemodialysis, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) on 4/13/2026 and on 4/20/2026 as scheduled.This deficient practice resulted in Resident 3 missing two (2) dialysis treatments, placing Resident 3 at risk for serious health complications.During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 3/25/2026 with diagnoses which included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis, and cellulitis (a skin infection that causes swelling and redness) of left lower limb.During a review of Resident 3's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/26/2026, the H&P indicated Resident 3 had the capacity to make medical decisions.During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 3 has intact cognitive skills (ability to make daily decisions). The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort to complete the activity) with toileting hygiene, lower body dressing, and to shower/bathe self. The MDS indicated Resident 3 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and upper body dressing.During a review of Resident 3's Order Summary Report (OSR), dated 4/30/2026, the OSR indicated a physician's order (PO), dated 3/26/2026, indicated Resident 3 had an active order for hemodialysis with dialysis chair time on Monday-Wednesday-Friday at 1:50 PM. The PO indicated dialysis transportation was arranged with an outside transportation service for 14 trips.During a review of Resident 3's Care Plan (CP), dated 4/10/2026, the CP indicated Resident 3 needed hemodialysis related to renal/kidney failure with interventions which included encouraging Resident 3 to go for scheduled dialysis appointments.During a review of Resident3's Change in Condition Evaluation (CICE) form, dated 4/13/2026 and 4/20/2026, the CICE form indicated Resident 3 missed dialysis due to transportation issue on 4/13/2026 and 4/20/2026.During a review of Resident 3's Social Service Progress Notes (SSPN), dated 4/14/2026, the SSPN indicated Resident 3's transportation to dialysis was only covered by Resident 3's insurance until 4/17/2026 and the social service assistant needed to submit a new request to Resident 3's insurance for standing order for dialysis transportation.During a review of Resident 3's SSPN, dated 4/21/2026, the SSPN indicated the social services assistant submitted a standing order for dialysis transportation to Resident 3's insurance on 4/21/2026, four (4) days after coverage ended.During a review of Resident 3's SSPN, dated 4/21/2026, the SSPN indicated Resident 3's physician was notified Resident 3 missed dialysis on 4/20/2026 due to transportation issues.During an interview on 4/29/2026 at 9:09 AM with Resident 3, Resident 3 stated that Resident 3 missed two dialysis treatments, on 4/13/2026 and on 4/20/2026, due to transportation problems. Resident 3 stated that the facility should arrange the transportation to ensure Resident 3 could go to dialysis as scheduled.During an interview on 4/29/2026 at 12:55 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 3 missed two dialysis because the transportation did not come to transfer the resident to dialysis center on 4/13/2026 and 4/20/2026. LVN 1 stated that the facility should arrange transportation for the residents to make sure the residents get dialysis as scheduled.During a concurrent interview and record review on 4/30/2026 at 10:47 AM with Social Services Assistant (SSA) 1, the SSPN, dated 4/14/2026 and 4/21/2026 were reviewed. SSA 1 stated that the transportation did not come to transfer Resident 3 to dialysis on 4/20/2026. SSA 1 stated that the facility should arrange transportation to make sure the residents go dialysis at the scheduled time.During a concurrent interview and record review on 5/1/2026 at 2:12 PM with the Director of Nursing (DON), Resident 3's CICE on 4/13/2026 and 4/20/2026 were reviewed. The DON stated that (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3 did not get dialysis as scheduled on 4/13/2026 and 4/20/2026 due to transportation issues. The DON stated it was important to make sure residents get dialysis as scheduled to maintain residents' health condition. During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with revised 9/2010, the P&P indicated, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. The P&P indicated, Staff caring for residents with ESRD, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. The P&P indicated, Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: a. How the care plan will be developed and implemented.