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	05/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain the residents' dignity for three of four sampled residents (Residents 1, 3 and Resident 4) by failing to:1. Provide peri care (washing/cleaning the genitals/anal area) to Resident 1.2. Answer Residents 1 and 3's call light promptly.3. To assist Resident 3 with activities of daily living (ADLs).4. To assist Resident 4 with ADLs upon returning from dialysis (procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances). These deficient practices did not maintain the residents' dignity and the residents' highest practicable physical, mental, and psychosocial well-being.Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was admitted to the facility 2/25/2025 with diagnoses including urinary tract infection (a bacterial infection in the urinary system), chronic obstructive pulmonary disease (COPD-obstructed airflow and breathing difficulties), and anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear). During a review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 3/1/2026, the MDS indicated Resident 1's cognition (ability to think and process information) was intact and Resident 1 was dependent (helper does all the effort) from staff for toileting hygiene. During a review of Resident 1's History & Physical (H&P) dated 4/1/2026, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility 4/24/2026 with diagnoses including urinary tract infection, asthma (chronic respiratory condition), and depression (persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities). During a review of Resident 3's H&P dated 4/26/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 1's cognition was intact and Resident 3 required partial/moderate assistance (helper does less than half the effort) from staff with toileting hygiene. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility 11/5/2024 with diagnoses including end stage renal disease (kidneys can no longer filter waste and excess fluids), Type 2 diabetes mellitus (elevated blood sugar levels) and epilepsy (seizure disorder). During a review of Resident 4's H&P dated 3/29/2026, the H&P indicated Resident 4 had the capacity to understand and make medical decisions. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognition was moderately impaired and Resident 4 required substantial/maximal assistance (helper does more than half the effort) from staff with toilet hygiene. During a concurrent observation and interview on 5/20/26 at 2:30 p.m. with Resident 1, Resident 1 stated Resident 1 had to wait for one to two hours to be changed. Resident 1 stated Resident 1 had a rash on Resident 1's left side and back. Resident 1 stated Resident 1's bed became wet when Resident 1 had to wait long period of time for staff to change Resident 1. Resident 1 stated Resident 1 had not been changed all day since 7:00 a.m. today (5/20/2026). Resident 1 stated Resident 1 had not been checked by a staff member nor changed since 7:00 a.m. During an interview on 5/20/2026 at 3:10 p.m. with Resident 4, Resident 4 stated the Certified Nurse Assistants (CNAs) in Unit 6 do not do (continued on next page)

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
	056431	A. Building B. Wing	05/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anything for the residents. Resident 4 stated Resident 4 was on dialysis. Resident 4 stated CNAs do not help Resident 4 when Resident 4 come back from dialysis, feeling tired from the dialysis treatment. During a concurrent observation and interview on 5/20/2026 at 3:30 p.m., during Resident 1's adult brief change and peri care, Resident 1's bed was wet up to Resident 1's lower back area. Resident 1's blanket, red T-shirt that the resident was wearing (mid-bottom area of shirt), all beddings (top and bottom sheet), and pillow covered by pillowcase that was positioned under Resident 1's left leg were all wet from urine. Resident 1's blue mattress underneath the bottom fitted sheet was wet from urine. CNA 4 stated the facility's policy was to check/change the residents every two to four hours. CNA 4 stated nobody changed Resident 1 or Resident 1 would not be in the situation as observed. The smell of urine was observed from the bed linens and throughout Resident 1's room. During an interview on 5/20/26 at 4:20 p.m., with CNA 2, CNA 2 stated Resident 1 could not have been changed since last night for Resident 1 to be that wet. The ADL Flow Sheet (ADLFS) was reviewed with CNA 2. The ADLFS indicated Resident 1 had not been provided peri care since 6:21 a.m. (on 5/20/26). CNA 2 stated based on the condition of Resident 1, Resident 1 could not have been checked or changed in the last two to four hours. CNA 2 stated it was important to check/change the residents every two to four hours for changing needs. During an interview on 5/20/26 at 5:53 p.m. with the Director of Nursing (DON), the DON stated checking and changing the resident should be done at least every two hours at a minimum and as needed. The DON stated checking and changing the resident should be provided every two hours whether the resident called for an adult brief change or not. The DON stated this was important for hygiene, infection control and prevention of skin breakdown. During a concurrent interview and record review on 5/21/2026 at 12:29 p.m. with CNA 1, CNA 1 stated CNAs (in general) were required to document tasks completed on the ADLFS at the end of every shift. CNA 1 stated there was no documentation Resident 1 was checked and changed during CNA 1's shift, 7:00 a.m.-3:00 p.m., on 5/20/26. The ADLFS did not indicate Resident 1 was checked or changed during 7:00 a.m.- 3:00 p.m. shift. The ADLFS did not indicate Resident 1 refused to be checked or changed. CNA 1 stated it was important to document CNA 1's completed tasks during CNA 1's shift as evidence that the tasks assigned were completed. CNA 1 stated the residents could get bed sores/wounds if their adult briefs were not changed regularly. During an interview on 5/22/2026 at 11:55 a.m. with Resident 1, Resident 1 stated Resident 1 did not refuse to be checked or changed. Resident 1 stated the CNAs did not ask Resident 1 if Resident 1 needed to be changed. Resident 1 stated the CNAs did ask today and Resident 1 was just changed by the CNA for the first time since the start of the shift at 7:00 a.m. During a concurrent observation and interview on 5/22/2026 at 12:00 p.m. with Resident 3, Resident 3 ?s hair was unkept and appeared matted. Resident 3 had noticeable body odor and smell of stool. Resident 3 stated Resident 3 had to wait for two hours for staff to answer the call light. Resident 3 stated the CNA (unidentified) checked Resident 3 about an hour ago and stated to Resident 3 that Resident 3 did not need to be changed. Resident 3 stated Resident 3 needed to be changed and had a wet adult brief and stool at that time (11:00 am). Resident 3 stated Resident 3 had a bowel movement in Resident 3's adult brief. Resident 3 also stated the facility staff did not assist Resident 3 with oral hygiene. Resident 3 stated Resident 3 has sore gums on the front top and bottom of Resident 3's mouth. During an interview on 5/22/2026, at 2:41 p.m. with the Director of Staff Development (DSD), the DSD stated CNAs (in general) were aware that they had to check their assigned residents regularly. The DSD stated oral care should be provided every shift and as needed. The DSD stated all required ADL care should be provided to the residents every shift. The DSD stated a resident should not go an entire shift without being checked, changed and provided oral care. The DSD stated it was important to maintain oral hygiene to prevent oral infection. The DSD stated staff should ensure the residents were neat and clean. The DSD stated leaving the residents soiled could cause skin breakdown and keeping the resident dry, clean and comfortable would avoid skin issues. During a review of the facility's Policy and Procedure (P&P), titled, Dignity, revised February 2021, the P&P indicated each resident shall be cared for in a manner that promoted and (continued on next page)

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	05/22/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.

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	05/22/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the call light system was functioning for one of one sampled resident (Resident 2).This deficient practice placed Resident 2 at risk for delays in care and services affecting the resident's quality of life.Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertensive urgency (severe blood pressure elevation), transient ischemic attack (brief, temporary blockage of blood flow to the brain), and Type 2 diabetes mellitus (elevated blood sugar levels). During a review of Resident 2's Minimum Data Set (MDS, a standardized assessment and care planning tool) dated 3/15/2026, the MDS indicated Resident 2's cognition (ability to think and process information) was moderately impaired. The MDS indicated Resident 2 required substantial/moderate assistance with personal hygiene and sit-to-stand and was totally dependent for toileting hygiene. During a review of Resident 2's History & Physical (H&P) dated 4/11/2026, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During an observation and interview on 5/21/2026, at 2:19 p.m. with Resident 2, Resident 2's call light was observed on and there was no audible sound heard. Resident 2 stated no one has come to help and Resident 2's call light doesn't make a sound. During a concurrent interview with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated the facility staff knew Resident 2 needed help when they pass by the resident's room or through the panel in the Nurse Station. During a concurrent observation and interview on 5/21/2026, at 2:55 p.m., with Maintenance Staff (MAINT 2), Resident 2's call light did not have a sound heard when Resident 2's call light was illuminated outside Resident 2's door. The call light panel in Nurse Station 6 was observed with MAINT 2 and Resident 1's call light was not illuminated, and no sound was heard from the panel. During a concurrent observation and interview on 5/21/2026, at 3:00 p.m., with MAINT 1, a small black hole was observed in Station 6 hallway. MAINT 1 stated Resident 2's call light was disconnected in the ceiling. During a subsequent interview on 5/21/2026, at 3:25 p.m., with MAINT 1, MAINT 1 stated the hole in the ceiling in Station 6 was the reason Resident 2's call light had no sound. MAINT 1 stated the sound of the call light could not be heard in the hallway in Station 6. During a concurrent observation, on 5/21/2026, at 3:35 p.m., with MAINT 1, the Station 6 ceiling was observed. The Station 6 call light mechanism was pushed up into an opening in the ceiling and no sound was heard. During an interview, on 5/22/2026, at 1:41 p.m., with MAINT 1, MAINT 1 stated it was the speaker that was pushed up in the ceiling and the sound was heard in the attic not in the hallways. MAINT 1 stated the speaker in the ceiling had to be pushed up manually by someone. MAINT 1 stated it was important to have a functional call light system During a review of the facility's Policy and Procedure (P&P), titled, Maintenance Service, revised December 2009, the P&P indicated the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. The maintenance director is responsible for developing and maintaining a schedule of maintenance services to assure the buildings, grounds, and equipment are maintained in safe and operable manner.