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	06/09/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the allegation of abuse for one of two sampled residents (Resident 1) was reported to the California Department of Public Health (CDPH), Ombudsman (agency that helps residents and families with complaints about healthcare services), and the local police within two hours in accordance with the facility's Policy and Procedure (P&P) titled Abuse Reporting and Investigation, when: On 6/3/2026, Certified Nursing Assistant 2 (CNA 2) reported to Licensed Vocational Nurse 2 (LVN 2) that CNA 2 witnessed Resident 2 threw a pitcher filled with water at Resident 1 and hit Resident 1.On 6/4/2026, Resident 1 reported to Registered Nurse 1 (RN 1) that Resident 2 threw a pitcher filled with water at Resident 1 on 6/3/2026, which hit Resident 1's head. These deficient practices resulted in the failure to timely report an allegation of abuse to the required agencies/authorities within two hours and had the potential to result in further abuse. Findings: During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including paraplegia (a condition involving partial or complete loss of movement and sensation in the lower half of the body) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1's History and Physical Examination (H&P) dated 1/8/2026, 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 resident assessment tool) dated 4/9/2026, the MDS indicated Resident 1 had intact cognition (ability to understand) and was dependent (a helper does all the effort to complete the activity) on staff for toileting hygiene and shower/bathe. The MDS indicated Resident 1 required maximal assistance (a helper does more than half of the effort) for lower body dressing and putting on/taking off footwear. During a review of Resident 1's Health Status Note (HSN - a progress note about a resident that is documented by licensed nurses) dated 6/4/2026, the HSN indicated Resident 1 reported that Resident 1's roommate threw a water pitcher filled with water and hit Resident 1 in the head, yesterday (6/3/2026) between 2:50 PM - 3:00 PM and was witnessed by a CNA. Upon assessment, there was no tenderness noted but the resident complained of pain upon palpation (examining the body using the sense of touch); Administrator and DON were made aware. During a review of Resident 2's AR, the AR indicated Resident 2 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including history of traumatic brain injury (a disruption in normal brain function caused by an outside physical force) and bipolar disorder (a mental health condition that causes extreme, uncontrollable shifts in mood, energy, and activity levels). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident had severely impaired cognition for daily decision making. During a concurrent observation and interview on 6/9/2026 at 10:13 AM with Resident 1 inside Resident 1's room, Resident 1 was sitting in bed. Resident 1's room had two beds. Resident 1's bed was located farthest from the room door, while Resident 2's (roommate) bed was located closest to the door. Resident 1 stated that on 6/3/2026 between 2:00 PM to 3:00 PM, Resident 1 had woken up from sleep when CNA 2 enter the room that Resident 1 shared with Resident 2. Resident 1 stated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2 was lying in bed. Resident 1 stated when CNA 2 entered, Resident 2 suddenly grabbed the water pitcher that was on top of Resident 2's bedside table and threw it at Resident 1, hitting the left side of Resident 1's head. Resident 1 stated cold water splashed all over Resident 1. Resident 1 stated the water pitcher was heavy, so it hurt when it hit Resident 1. Resident 1 stated Resident 2 looked mad and was cussing after Resident 2 threw the water pitcher at Resident 1. Resident 1 stated Resident 1 told CNA 2 to report the incident right away. Resident 1 stated CNA 2 replied CNA 2 was going to report what had happened and CNA 2 exited the room. Resident 1 stated Resident 1 did not see any other nursing staff, besides CNA 2, come to Resident 1's room on 6/3/2026 after the incident. Resident 1 stated the following day on 6/4/2026, Resident 1 went to Nursing Station 4 and reported to RN 1 the incident involving Resident 2 that occurred on 6/3/2026. Resident 1 stated Resident 1 told RN 1 that Resident 2 threw a water pitcher that hit Resident 1's head. Resident 1 stated Resident 1 told RN 1 that Resident 1 did not want Resident 2 to be Resident 1's roommate and requested Resident 2 be moved to another room. During an interview on 6/9/2026 at 10:47 AM with CNA 2, CNA 2 stated on 6/3/2026 at around 2:00 PM, CNA 2 went to Resident 1's room with the intention of changing/cleaning Resident 1. CNA 2 stated as CNA 2 entered Residents 1 and 2's shared room, CNA 2 saw Resident 2 grab a water pitcher while in bed and toss it at Resident 1, which hit Resident 1. CNA 2 stated Resident 2 then turned Resident 2's body toward Resident 1, and Resident 2 started speaking really fast. CNA 2 stated CNA 2 told Resident 2 not to throw things, and Resident 2 replied by yelling at CNA 2 to get out of the room. CNA 2 stated CNA 2 picked up the water pitcher which landed on Resident 1's left side and placed it away from Resident 2's reach. CNA 2 stated Resident 1 was upset and told CNA 2 to tell the nurse. CNA 2 stated CNA 2 exited Residents 1 and 2's shared room and reported the incident to LVN 2. CNA 2 stated CNA 2 told LVN 2 that CNA 2 saw Resident 2 grab a water pitcher, threw it, and hit [Resident 1] with it. CNA 2 stated LVN 2 replied it was Resident 2's usual behavior. CNA 2 stated after reporting to LVN 2, CNA 2 returned to Resident 1's room and changed/cleaned Resident 1. CNA 2 stated the facility's abuse policy required certified nursing assistants to report to the charge nurse right away when they see or suspect resident abuse. CNA 2 stated the facility was supposed to report within two hours if it's violence. During an interview on 6/9/2026 at 11:26 AM with LVN 2, LVN 2 stated CNA 2 reported to LVN 2 that Resident 2 threw a water pitcher, and the floor in Resident 1 and Resident 2's shared room was wet. LVN 2 stated right after CNA 2 reported, LVN 2 went to Resident 1's room and saw water on the floor between Residents 1 and 2's beds. LVN 2 stated Resident 1 did not state Resident 2 threw a water pitcher at Resident 1 which hit Resident 1's head. LVN 2 stated Resident 1 stated Resident 1 got wet. LVN 2 stated LVN 2 did not document the incident because [Resident 2] was known to throw things on the floor all the time. LVN 2 stated LVN 2 did not report the incident to anyone. LVN 2 stated a few days after the incident, Resident 1 reported to RN 1 that Resident 2 threw a water pitcher that hit Resident 1's head. LVN 2 stated nursing staff needed to report allegations of abuse within two hours. LVN 2 stated even if it was a suspicion of abuse or complaints, it should be reported within two hours. During a subsequent interview on 6/9/2026 at 12:14 PM with CNA 2, CNA 2 stated on 6/3/2026, CNA 2 reported to LVN 2 that CNA 2 saw Resident 2 grab a water pitcher and threw it at Resident 1, which hit Resident 1. CNA 2 stated: I told [LVN 2] what I saw that [Resident 2] threw the pitcher and it hit [Resident 1]. During an interview on 6/9/2026 at 12:35 PM with the Interim Administrator (IA), the IA stated on 6/5/2026 at approximately 11:30 PM, the IA entered the shared room of Residents 1 and 2 to check on Resident 2 because Resident 2 had recently bit a staff member. The IA stated Resident 2 was asleep when IA entered the room, but Resident 1 was awake. The IA stated the IA asked how Resident 1 was doing and Resident 1 replied that Resident 2 had grabbed a water pitcher and threw it at Resident 1 which landed on [Resident 1's] head. The IA stated the IA completed the SOC 341 form (a specific form facilities use to report suspected dependent adult/elder abuse to designated public agencies/authorities) regarding what Resident 1 reported to the IA, and IA submitted the form via fax to CDPH, Ombudsman and the local police on 6/5/2026. During a review of the facility's submitted (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	SOC 341 involving Residents1 and 2, dated 6/5/2026, the facility submitted the SOC 341 to CDPH via fax on 6/5/2026 at 1:27 PM. During a phone interview on 6/9/2026 at 1:19 PM with RN 1, RN 1 stated on 6/4/2026 at approximately 8:00 PM, Resident 1 reported to RN 1 that on 6/3/2026, Resident 2 threw a pitcher filled with water which hit the left side of Resident 1's head. RN 1 stated Resident 1 also reported that CNA 2 was present and saw the incident. RN 1 stated residents and staff who were involved in an incident should be interviewed, and the incident should be reported to the abuse coordinator, which is the facility's administrator. RN 1 stated there was a two-hour window to report the incident to the Department of Public Health, Ombudsman, and the police. RN 1 stated an SOC 341 form should have been completed regarding the incident involving Residents 1 and 2. During a concurrent interview and record review on 6/9/2026 at 2:02 PM with the Director of Nursing (DON), the facility's P&P titled, Abuse Reporting and Investigation dated 5/2025 was reviewed. The P&P indicated it was the responsibility of any and all staff members to exercise their right as a mandated reporter to ensure the SOC 341 is sent to appropriate authorities within two hours and to notify the facility APC [abuse prevention coordinator] and their supervisor immediately. The DON stated all staff members were mandated reporters (required by law, rule, or authority to report) anytime they suspect or see an abuse. The DON stated staff members have been instructed to report to the abuse coordinator and to the DON. The DON stated nursing staff should know how to complete and submit the SOC 341 form. During an interview on 6/9/2026 at 2:48 PM with the IA, the IA stated the timeframe to report allegations of abuse was within two hours from becoming aware of the allegation. The IA stated anybody could complete and submit the SOC 341 form. During a review of the facility's P&P titled, Abuse Reporting and Investigation, dated 5/2025, the P&P indicated The Facility staff will report ALL allegations of abuse, unless indicated below, as required by law and regulations to the appropriate agencies within two hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control for one of two sampled residents when two urinals (a handheld plastic container designed for residents to urinate into) were observed on top of Resident 3's bedside tray table next to a food tray containing Resident 3's breakfast meal. This deficient practice had the potential to spread infection in the facility. Findings: During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including epilepsy (repeated and uncontrolled electrical activity in the brain that changes a person's muscle movements, sensations, and behavior), polyneuropathy (nerve damage), and morbid obesity (a chronic disease in which a person weighs 100 pounds or more over his/her ideal body weight). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool) dated 10/26/2025, the MDS indicated Resident 3 had intact cognition (ability to understand) and was dependent (a helper does all the effort to complete the activity) on staff for toileting hygiene, shower/bathe, and lower body dressing. During an observation on 6/5/2026 at 9:29 AM inside Resident 3's room, two urinals were observed on top of Resident 3's bedside tray table. One urinal contained approximately 600 milliliters (ml - a unit of measurement for liquid) of amber-colored fluid. The second urinal was empty. Both urinals were located next to a food tray that contained one plate and two bowls of food that were not yet eaten. During a concurrent observation and interview on 6/5/2026 at 9:38 AM with Licensed Vocational Nurse 1 (LVN 1) inside Resident 3's room, LVN 1 stated LVN 1 there were two urinals on Resident 3's bedside tray table next to a breakfast food tray that had not been eaten. LVN 1 stated there was no urinal holder at Resident 3's bedside. LVN 1 stated the urinals should not be on top of a bedside tray table next to food for infection control and the possibility of spreading infection in the facility. During an interview on 6/5/2026 at 2:15 PM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated urinals should not be placed in areas where a resident would eat because the urine can spill from the urinal and spread germs which could lead to infection. CNA 1 stated nursing staff should be monitoring the residents' rooms to ensure toileting items such as urinals were emptied and not placed next to food. During an interview on 6/9/2026 at 2:02 PM with the Director of Nursing (DON), the DON stated urinals should not be left on a bedside tray table next to food due to the potential of spreading infection. The DON stated if a resident would want to place the urinal on a bedside tray table, nursing staff needed to discuss the infection risks with the resident and documented it in the resident's care plan. During a review of Resident 3's entire nursing Care Plan (CP), the CP did not indicate Resident 3 requested to place urinals on Resident 3's bedside tray table. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Policy, dated 12/2023, the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P further indicated infection prevention include[s]. instituting measures to avoid complications or dissemination of infection, and educating staff and ensuring that they adhere to proper techniques and procedures.