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	06/12/2026

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the gastrostomy tube (GT, a tube surgically placed through the abdomen and into the stomach, and used to administer nutrition, liquids, or medications) flush water bag (used to administer water through the GT) and tubing was changed before exceeding the expiration date (within 24 hours) for one of three sampled residents (Resident 2).This deficiency practice resulted in Resident 2 not receiving the appropriate care and services on feeding tube and placing Resident 2 at risk for health complications.During a review of Resident 2's admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 11/23/2022 and readmitted on [DATE] with diagnoses which included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), encounter for attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and respiratory failure with hypoxia (when the lungs suddenly fail to supply enough oxygen to the body).During a review of Resident 2's History and Physical (H&P), dated 10/31/2025, the H&P indicated that the resident did not have the capacity to make decisions.During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool), dated 5/17/2026, the MDS indicated Resident 2 had severely impaired cognitive skills (ability to make daily decisions). The MDS indicated Resident 2 was dependent on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 2's Order Summary Report (OSR), the OSR indicated an active physician's order for Resident 2 to receive continuous water through the GT at 35 milliliters (ml, a measurement unit) per hour for 20 hours to provide 700 ml per 24 hours via water pump and run from 2 PM and continue until 10 AM or until dose limit is met.During an observation on 6/11/2026 at 11:51 AM inside Resident 2's room at Resident 2's bedside, there was a GT flush water bag, dated 6/10/2026 and timed at 5 AM, hanging on a metal pole and attached to a feeding pump. The manufacturer instruction indicating Do not use for greater than 24 hours was observed on the water bag.During a concurrent observation and interview on 6/11/2026 at 12:12 PM with Licensed Vocational Nurse (LVN) 1 at the bedside of Resident 2 there was a GT water flush bag, dated 6/10/2026 and timed at 5 AM, hanging on a metal pole and attached to a feeding pump. LVN 1 stated the GT flush water bag should be changed within 24 hours and Resident 2's GT flush water bag and tubing exceeded the expiration time and should have been changed before 6/11/2026 at 5 AM.During an interview on 6/12/2026 at 1:30 PM with the Director of Nursing (DON), the DON stated Resident 2's GT flush water bag hanging on the pole and attached to the feeding pump should have been changed before exceeding 24 hours. The DON stated it was important to make sure to change the water bag within 24 hours to prevent infection. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings - Safety Precautions revised 11/2018, the P&P indicated, Change administration sets for open-system enteral feedings at least every 24 hours, or as specified by the manufacturer, and Change administration sets for closed-system enteral feedings according to manufacturer's instructions.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to monitor one of three sampled residents' (Resident 1's) response to pain medication when Resident 1's heart rate (HR, the number of times the heart beats in a minute, also known as the pulse rate) was not assessed one hour after pain medication was given to Resident 1.This deficiency practice resulted in Resident 1 not receiving the appropriate care and services on pain management and placed Resident 1 at risk for ineffective pain control.During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 6/4/2026 with diagnoses which included chronic respiratory failure with hypoxia (when the lungs suddenly fail to supply enough oxygen to the body), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing),and end stage renal disease (ESRD-irreversible kidney failure). The AR indicated Resident 1 had a tracheostomy (a surgically created opening in the neck [stoma] and into the windpipe [trachea] to provide an alternative airway for breathing), was dependent on ventilator (medical device to help support or replace breathing) and on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2026, the MDS indicated Resident 1 had severely impaired cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent on staff with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 1's Order Summary Report (OSR), the OSR indicated an active physician's order, dated 6/4/2026, to give Resident 1 two (2) tablets of acetaminophen (medication used as pain reliever and fever reducer) oral tablet 325 milligrams (mg, a measurement unit) via G-Tube (gastrostomy tube is a tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) every 6 hours as needed for mild pain (1-3)- (scores to measure pain intensity, 0 means no pain, 10 means the worst pain, and 1-3 means mild pain).During a review of Resident 1's Medication Administration Record (MAR), dated 6/2026, the MAR indicated Resident 1 was given two tablets of acetaminophen 325mg for pain level of 3 on 6/9/2026 at 8:12 PM.During a review of Resident 1's Progress Note (PN), dated 6/9/2026 and timed at 8:13 PM, the PN indicated Resident 1's HR was 116 beats per minute which was elevated and acetaminophen was given for pain as ordered.During a review of Resident 1's medical record, including the MAR, there was no follow up HR documented in the medical record after acetaminophen was given to Resident 1 on 6/9/2026 at 8:12 PM.During a phone interview on 6/12/2026 at 2:42 PM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LVN 3 gave Resident 1 (acetaminophen) for pain and elevated HR per Resident 1's family request on 6/9/2026. LVN 3 stated LVN 3 should have reassessed and documented Resident 1's HR within one hour after giving (acetaminophen) for pain and elevated HR on 6/9/2026.During a concurrent interview and record review on 6/12/2026 at 1:30 PM with the Director of Nursing (DON), Resident 1's medical record was reviewed. The DON stated there was no follow up HR documented in the medical record after Resident 1 was given acetaminophen on 6/9/2026 at 8:12 PM. The DON stated Resident 1's HR should have been checked and documented to verify the effectiveness of pain medication (acetaminophen) as follow up assessment within one hour after pain medication administration.During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, revised 10/2022, the P&P indicated pain management is a multidisciplinary care process that includes assessing the potential for pain, recognizing the presence of pain, and monitoring for the effectiveness of interventions and the resident's response to interventions. The P&P indicated tachycardia (fast heart rate) is a possible physiological sign of pain.