

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/28/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pressure related injury prevention practices for four of five sampled residents (Residents 2, 3, 5 and 6) by failing to ensure nursing staff set residents' low air loss mattress ([LALM], a mattress that provides airflow to help keep skin dry, as well as to relieve pressure, treat pressure sores and prevents pressure sores) according to Residents 2, 3, 5 and 6's weight. These deficient practices placed Residents 2, 3, 5 and 6 at risk for developing pressure injuries (localized area of tissue damage that develops when prolonged pressure or shear forces are applied to the skin and underlying tissues) and put these residents at risk for further skin damage. Findings: 1. During an observation on 7/23/2026 at 1:20 p.m. in Resident 3's room, Resident 3's LALM was set to 400 pounds. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body, causing trouble breathing and fatigue) and diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine). During a review of Resident 3's History and Physical (H&P), dated 3/26/2026, the H&P indicated Resident 3 did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 7/14/2026, the MDS indicated Resident 3's cognitive skills cognitive skills (reasoning, learning, and problem-solving) for daily decision making was severely impaired. The MDS indicated Resident 3 required moderate assistance (helper does more than half the effort) for eating and oral hygiene. The MDS indicated Resident 3 was dependent on staff for toileting hygiene, shower/bathing, dressing, putting on/taking off footwear, and personal hygiene. During a review of resident 3's Weights Summary, dated 7/2/2026, the weight summary indicated Resident 3 weighed 211 pounds. During a review of Resident 3's Order Summary Report, dated 7/21/2026, the order summary report indicated Resident 3 had an order for a low air loss mattress for skin management. Monitor pressure settings according to patient's weight and comfort every shift. 2. During an observation on 7/23/2026 at 1:30 p.m. in Resident 5's room, Resident 5's LALM was set to 250 pounds. During a review of Resident 5's AR, the AR indicated Resident 5 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included chronic respiratory failure and end stage of renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). During a review of Resident 5's H&P, dated 4/3/2026, the H&P indicated Resident 5 had significant neurologic and communication impairment and may not be able to demonstrate full medical decision-making capacity consistently. During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 5 was dependent on staff for all activities of daily living. During a review of Resident 5's Order Summary Report, for July 2026, the order summary report indicated Resident 5 had an order for a low air loss mattress for skin management. Monitor pressure settings according to patient's weight and comfort every shift. During a review of resident 5's Weights Summary, dated 7/6/2026, the weight summary indicated Resident 5 weighed 135 pounds. 3. During an observation on 7/23/2026 at 1:39 p.m. in Resident 6's room, Resident 6's LALM was set for 450 pounds. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood) and respiratory failure. During a review of Resident 6's H&P, dated 4/2/2026, the H&P indicated Resident 6 had During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was intact. The MDS indicated Resident 6 required supervision for eating, toileting hygiene and oral hygiene. The MDS indicated Resident 6 required maximal assistance for dressing and personal hygiene. The MDS indicated Resident 6 was dependent on staff for shower/bathing and putting on/taking off footwear. During a review of Resident 6's Order Summary Report, for the month of 2026, the order summary report indicated Resident 6 had an order for a low air loss mattress for wound management. Monitor pressure settings according to patient's weight and comfort every shift. During a review of resident 6's Weights Summary, dated 7/20/2026, the weight summary indicated Resident 6 weighed 87 pounds. 4. During an observation on 7/23/2026 at 1: 47 p.m. in Resident 2's room, Resident 2's LALM was set to 200 pounds. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included right side hemiparesis (neurological condition characterized by weakness, reduced muscle strength, or partial paralysis on one side of the body, affecting the arm, leg, and sometimes the face) and right side Hemiplegia a condition caused by a brain injury, that results in a varying degree of weakness, stiffness and lack of control in one side of the body. During a review of Resident 2's H&P, dated 11/30/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living. During a review of Resident 2's Order Summary Report, for the month of July 2026, the order summary report indicated Resident 2 had an order for a low air loss mattress for skin management/history of pressure injury. Monitor pressure settings according to patient's weight and comfort every shift. During a review of resident 2's Weights Summary, dated 7/21/2026, the weight summary indicated Resident 2 weighed 122 pounds. During an interview on 7/28/2026 at 11:21 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Treatment Nurse (TN) was responsible to check residents LALM. LVN 1 stated LALM pumps must have a sticker labeled with residents' weight to indicate where the LALM pump should be set at. LVN1 stated all licensed nurses can adjust LALM to the correct setting. LVN 1 stated if LALM was underinflated the resident would develop skin wounds because resident would be lying on a low-pressure mattress and it would be like lying on a regular mattress. LVN 1 stated if the LALM was overinflated the mattress would be too hard, uncomfortable, cause pain and had the potential for the resident to fall out of bed. LVN 1 stated it was important to set the LALM to the correct weight for it to be beneficial to residents in preventing skin breakdown. During an interview on 7/28/2026 at 12:42 p.m. with TN, TN stated a LALM was used for wound healing, wound prevention and wound maintenance. TN stated all licensed staff were responsible for checking if LALM was set to resident weight. TN stated if the LALM was overinflated it could cause pain to the resident and it (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would not help with skin wound prevention or skin wound healing. During a review of Proactive Protekt Aire 2000 operation manual, the manual indicated the Protekt Aire 2000 pump and overlay system, was for the prevention and treatment of any and all stage pressure ulcers. The manual indicated step 6 of the operation instructions was to determine the patient's weight and set the control knob to that weight setting on the control unit.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer enteral feeding (delivering liquid food and nutrients directly into the stomach or small intestine) per physician's order for two of four sampled residents (Residents 7 and 8) by failing to ensure Resident 7 and Resident 8 received the correct enteral feeding formula per the physician's order. This deficient practice caused enteral feeding error for Resident 7 and Resident 8, and potentially placed Resident 7 and Resident 8 at risk for adverse effects of the wrong feeding formula (liquid medical food delivered directly into the stomach through an abdominal opening). Findings: 1. During a review of Resident 7's admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine) and respiratory failure (serious condition that makes it difficult for a person to breathe on their own, lungs can't get enough oxygen into the blood). During a review of Resident 7's Medication Administration Record (MAR) for the month of July 2026, the MAR indicated on 7/12/2026 Resident 7 received Nutren 2.0 feeding formula at 40 ml over 18 hours. The MAR indicated the feeding formula was to start at 2:00 p.m. and was to be stopped at 8:00 a.m. During a review of Resident 7's Order Summary Report dated 7/9/2026, Order Summary Report indicated Resident 7 had an order for Nutren 2. 0 (feeding formula for those with elevated caloric requirements and/or a fluid restriction) feeding formula at 40 milliliters (a metric unit of liquid volume equal to one-thousandth of a liter) over 18 hours. The Order Summary Report indicated the feeding formula was to start at 2:00 p.m. and was to be stopped at 8:00 a.m. During a review of Resident 7's Change of Condition Evaluation, dated 7/12/2026, the Change of Condition Evaluation indicated Resident 7 received an incorrect feeding formula. The Change of Condition Evaluation indicated Resident 7 received feeding formula on 7/11/2026 at 8:00 p.m. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 7/13/2026, the MDS indicated Resident 7's cognitive skills for daily decision making was intact. The MDS indicated Resident 7 required maximal assistance (helper does more than half the effort) for oral hygiene and upper body dressing. The MDS indicated Resident 7 was dependent on staff for toileting hygiene, shower/bathing, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 7's nutritional approach was a feeding tube (medical device used to deliver liquid nutrients, fluids, and medications directly into the stomach). During a review of Resident 7's History and Physical (H&P), dated 7/24/2026, the H&P indicated Resident 7 had a diagnosis of gastrostomy status (artificial opening (stoma) into the stomach with a feeding tube, used to receive food, liquids, or medications directly through the stomach. 2. During a review of Resident 8's AR, the AR indicated Resident 8 was admitted to the facility on 6/17/2025 and was readmitted to the facility on [DATE] with diagnoses that included respiratory failure and dysphagia (difficulty or discomfort in swallowing). During a review of Resident 8's Order Summary Report dated 6/17/2026, Order Summary Report indicated Resident 8 had an order for isosource 1.5 at 35 ml over 20 hours. The MAR indicated feeding formula was to start at 2:00 p.m. and end at 10:00 a.m. During a review of Resident 8's MDS, dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decision making was intact. The MDS indicated Resident 8 had no speech. The MDS indicated Resident 8 was dependent on staff for all activities of daily living. The MDS indicated Resident 8's nutrition approach was a feeding tube During a review of Resident 8's MAR, for the month of July 2026, the MAR indicated on 7/12/2026 Resident 8 (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enteral nutrition label against order before administration, they must check for resident name, ID, room number, and the type of formula.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide safe oxygen administration practices ([oxygen therapy], is the medical practice of delivering oxygen at a concentration greater than ambient air) for three of four sampled residents (Residents 4, 5, 6) by failing to: 1. Ensure Residents 5, and 6's nasal cannulas (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) were dated with an open/change dates and did not ensure nasal cannula was not touching the floor. 2. Ensure Resident 4 had an order for oxygen administration before administering oxygen to Resident 4. 3. Ensure Resident 4's nasal cannula was dated and placed in a bag when not in use and did not ensure humidifier bottle (a medical device that adds water vapor to dry supplemental oxygen before it reaches a patient) was changed. These deficient practices increased the risk for Residents to acquire a respiratory infection (infectious disease caused by bacteria, viruses, or fungi that affects the respiratory tract, including the nose, sinuses, throat, airways, and lungs) and placed resident 4 at risk for unnecessary oxygen administration. Findings: 1. During an observation on 7/23/2026 at 1:30 p.m. in Resident 5's room, Resident 5 received oxygen therapy at two liters per minute (LPM) a metric unit used to measure volumetric flow rate, tracking the volume of fluid or gas passing a point in one minute) Resident 5's nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not labeled with an open date and was touching the floor. During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included respiratory failure (serious condition that makes it difficult for a person to breathe on their own, lungs can't get enough oxygen into the blood) and end stage of renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). During a review of Resident 5's History and Physical (H&P), dated 4/3/2026, the H&P indicated Resident 5 had significant neurologic and communication impairment and may not be able to demonstrate full medical decision-making capacity consistently. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 5/21/2026, the MDS indicated Resident 5's cognitive skills (reasoning, learning, and problem-solving) for daily decision making was severely impaired. The MDS indicated Resident 5 was dependent on staff for all activities of daily living. 2. During an observation on 7/23/2026 at 1:39 p.m. in Resident 6's room, Resident 6 received oxygen therapy at two LPM. Resident 6's nasal cannula was not labeled with an open date. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] and was readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (problem in the brain caused by a chemical imbalance in the blood) and respiratory failure. During a review of Resident 6's H&P, dated 4/2/2026, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was intact. The MDS indicated Resident 6 required supervision for eating, toileting hygiene and oral hygiene. The MDS indicated Resident 6 required maximal assistance (helper does more than half the effort) for dressing and personal hygiene. The MDS indicated Resident 6 was dependent on staff for shower/bathing and putting on/taking off footwear. 3. During an observation on 7/24/2026 at 11:10 a.m. in Resident 4's room, Resident 4's oxygen tubing was not attached to resident, it was hung on top of oxygen concentrator (a medical device that pulls in room air, removes nitrogen, and delivers 90% to 95% pure oxygen to people who (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. RT 1 stated oxygen tubing must have a sticky tab that is used to label it with open date. RT 1 stated there was a risk of using undated oxygen equipment because staff would not know how old it was and could be contaminated and cause a respiratory infection. RT 1 stated oxygen equipment must be changed weekly. During a concurrent interview and record review o 7/28/2026 at 4:42 p.m. with RT, Resident 4's Order summary Report was reviewed. RT 1 stated Resident 4 did not have an order for oxygen therapy. RT 1 stated RT 1 thought Resident 4 had an order. RT 1 stated RT 1 had not verified if Resident 4 had orders for oxygen therapy. RT 1 stated Resident 4 required an order for oxygen therapy because Resident 4 required oxygen therapy every night. During an interview on 7/28/2026 at 4:47 p.m. with Registered Nurse (RN) 2, RN 2 stated oxygen therapy required a doctor's order before the start of oxygen therapy. RN 2 stated oxygen therapy required a doctor's order because doctors prescribe it to residents. RN 2 stated if there was no oxygen therapy order, staff would not know how much oxygen to deliver to a resident. RN 2 stated oxygen equipment must dated with open date for infection control. During a review of facility's Policy and Procedure (P&P) titled Oxygen Administration, dated 10/2010, the P&P indicated staff would verify if there was a physician order for oxygen administration. During a review of facility's P&P titled Changing/Cleaning of Disposable and Non-Disposable Equipment, dated 12/1/2019, the P&P indicated its purpose was to minimize risk of infection. The P&P indicated disposable equipment was single patient use only and would be changed as regularly scheduled and on as needed bases. The P&P indicated residents receiving respiratory care would be given a separate and complete set up, no items would be shared by residents and oxygen equipment must be labeled with date. The P&P indicated RTs, RNs, Licensed Vocational Nurses (LVN) were the responsible discipline for these actions. The P&P indicated humidifiers must be changed once a week or as needed.		

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 07/28/2026
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)		
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 interview and record review the facility failed to implement its abuse reporting and investigating policy by failing to report an alleged abuse for one of two sampled residents (Resident 9) by failing to: 1. Report an allegation of abuse to the Department of Public Health (DPH) after Resident 9 notified facility's staff of an alleged abuse. 2. Ensure to notify DPH within two hours of an alleged abuse allegation. These deficient practices violated Resident 9's right and resulted in unidentified alleged abuse in the facility and failed to protect Resident 9 from further abuse. Findings: During a review of Resident 9's admission Record (AR), the AR indicated Resident 9 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath) and fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue and muscle stiffness). During a review of Resident 9's History and Physical (H&P), dated 7/9/2025, the H&P indicated Resident 9 had the capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 9's cognitive skills for daily decision making was intact. The MDS indicated Resident 9 required set up or clean-up assistance for eating and oral hygiene. The MDS indicated Resident 9 required moderate assistance (helper does less than half the effort) for upper body dressing. The MDS indicated Resident 9 required maximal assistance (helper does more than half the effort) for shower/bathing, lower body dressing, putting on/taking off footwear and for personal hygiene. The MDS indicated Resident 9 was dependent on staff for toileting hygiene. During an interview on 7/27/2026 at 2:50 p.m. with Resident 9, Resident 9 stated on Friday night (7/24/2026) Certified Nursing Attendant (CNA) 4 was assigned to Resident 9. Resident 4 stated CNA 4 grabbed Resident 9's arm without warning and hurt Resident 9. Resident 9 stated CNA 4 was rushed during care and was rude toward Resident 9. Resident 9 stated Resident 9's back was wet after CNA 4 wiped Resident 9's buttocks and Resident 9 informed CNA 4 that Resident 9's back was wet. Resident 9 stated CNA 4 insisted Resident 9's back was dry and grabbed Resident 9's arm and stretched it back to touch Residents 9's back. Resident 9 stated Resident 9 informed the night shift Licensed Vocational Nurse (LVN) 6 about the CNA 4 being rough during a diaper change and that CNA 4 hurt Resident 9. Resident 9 stated Resident 9 hoped LVN 6 reported the situation because CNA 4 might hurt another resident that is more vulnerable than Resident 9. During an interview on 7/28/2026 at 11:21 a.m. with LVN 1, LVN 1 stated on 7/27/2026 LVN 1 was notified that Resident 9 was talking to surveyor about an alleged abuse that happened with night shift CNA 4. LVN 1 stated she attempted to talk to Resident 9 about the alleged abuse and Resident 9 did not want to talk about it and it was close to the end of LVN 1's shift and LVN 1 decided to talk to Resident 9 about the alleged abuse the following day (7/28/2026). LVN 1 stated on 7/28/2026 LVN 1 attempted to talk to Resident 9 about the alleged abuse but Resident 9 did not want to talk about it. LVN 1 stated LVN 1 did not report the alleged abuse to anyone because LVN 1 did not have any information about the alleged abuse since Resident 9 did not want to talk about it. LVN 1 stated she was supposed to report alleged abuse but LVN 1 did not report it because LVN 1 did not have the details of the alleged abuse. During an interview on 7/28/2026 at 3:24 p.m. with Social Service Assistant (SSA), SSA stated Resident 9 stated during peri care Resident 9 informed CNA 4 that Resident 9's back was still wet. The SSA stated Resident 9 stated CNA 4 grabbed Resident 9's arm and pulled arm back to touch Resident 9's (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	back. The SSA stated Resident 9 stated CNA 4 hurt Resident 9. The SSA stated Resident 9 stated Resident 9 informed the incoming LVN (LVN 6) about the alleged abuse. The SSA stated SSA reported the alleged abuse to the Administrator (Admin), but the SSA did not know if the alleged abuse was reported to the Department of Public Health (DPH). The SSA stated this was an alleged abuse and should have been reported right away. The SSA stated anything that dealt with an alleged abuse must be reported to protect residents. During an Interview on 7/28/2026 at 4:02 p.m. with Admin, the Admin stated on 7/24/2026 Resident 9 notified staff that Resident 9 was not happy with the care Resident 9 received but Resident 9 never said it was an alleged abuse. The Admin stated the Admin was not aware LVN 1 knew of Resident 9's alleged abuse. The Admin stated the Admin did not know Resident 9 told the SSA that it was an alleged abuse. The Admin stated the Admin did not think it was an alleged abuse and that was why it was not reported. During an interview on 7/28/2026 at 4:47 p.m. with Registered Nurse (RN) 2, RN 2 stated all potential abuse must be investigated and reported to the Admin as soon as possible. RN 2 stated alleged abuse must be reported to the DPH within 2 hours. RN 2 stated if alleged abuse was not investigated and not reported within two hours, facility could not prevent abuse from reoccurring again. During an interview on 7/29/2026 at 11:17 a.m. with CNA 4, CNA 4 stated CNA 4 was assigned to Resident 9 on 7/24/2026. CNA 4 stated during Resident 9's diaper change, Resident 9 stated Resident 9's back was still wet. CNA 4 stated CNA 4 told Resident 9 that CNA 4 had dried Resident 9's back three times. CNA 4 stated Resident 9 stated CNA 4 was lying and Resident 9 still felt back wet. CNA 4 stated CNA 4 attempted to touch Resident 9's wrist and Resident 9 screamed and stated CNA 4 hurt Resident 9. CNA 4 stated CNA 4 barely touched Resident 9's wrist when Resident 9 screamed. CNA 4 stated CNA 4 wanted to grab Resident 9's hand to have Resident 9 touch Resident 9's back. CNA 4 stated CNA 4 did not inform or warn Resident 9 before touching Resident 9's hand. CNA 4 stated CNA 4 informed the night nurse (LVN 6) about the situation with Resident 9, and LVN 6 stated it was ok and there was no need to report it. During an interview on 7/30/2026 at 8:38 a.m. with LVN 6, LVN 6 stated Resident 9 told LVN 6 that Resident 9 did not want CNA 4 to provide care for her anymore. LVN 6 stated Resident 9 stated CNA 4 was rushing during care and did not want CNA 4 assigned to care for Resident 9 anymore. LVN 6 stated Resident 9 stated Resident 9 did not like CNA 4. LVN 6 stated Resident 9 informed LVN 6 because Resident 9 wanted someone to know about Resident 9's CNAs request. LVN 6 stated Resident 9 did not mention Resident 9 got hurt. LVN 6 stated CNA 4 did not share any information about the interaction between Resident 9 and CNA 4. During a review of facility's Policy and Procedure (P&P) titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 9/2022, the P&P indicated all reports of resident abuse are to be reported to local, state and federal agencies and thoroughly investigated by facility management. The P&P indicated if resident abuse was suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The P&P indicated an abuse allegation must be reported within 2 hours of an allegation involving abuse or 24 hours of an allegation that did not involve abuse. The P&P indicated after receiving any allegations of abuse the administrator was responsible for determining what actions are needed for the protection of residents. The P&P indicated all allegations are investigated and are administrator-initiated investigation.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility staff failed to assist a dependent resident who was unable to carry out activities of daily living (ADLs) for one of three sampled residents (Resident 2) when: 1. Facility's staff did not ensure Resident 2's nails were clean and trimmed. This deficient practice caused Resident 2's fingernails to dig into Resident 2's palm and had the potential to result in a negative impact on Residents 2's quality of life and Resident 2's quality of care. Findings: During a review of Resident 2's admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included right side hemiparesis (neurological condition characterized by weakness, reduced muscle strength, or partial paralysis on one side of the body, affecting the arm, leg, and sometimes the face) and right side Hemiplegia (a condition caused by a brain injury, that results in a varying degree of weakness, stiffness and lack of control in one side of the body). During a review of Resident 2's History and Physical (H&P), dated 11/30/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 4/13/2026, the MDS indicated Resident 2's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 2 was dependent on staff for all activities of daily living. During an observation on 7/23/2026 at 1: 47 p.m. in Resident 2's room, Resident 2's fingernails were yellow in color, thick, long, and dirty. Resident 2's hand was contracted, closed and Resident 2's nails were digging into the palms of Resident 2's hands. During an interview on 7/28/2026 at 11:51 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated CNAs were responsible to check residents' nails during shower time. CNA 2 stated CNAs were responsible for cleaning and trim nails as needed. CNA 2 stated it was important to keep residents' nails clean and trimmed to prevent infections and for residents' hygiene. During an observation and interview on 7/28/2026 at 12:42 p.m. with Treatment Nurse (TN) 1 in Resident 2's room, Resident 2's fingernails were yellow in color, thick, long, dirty and were digging into Resident 2's palms of her hands. TN 1 stated Resident 2's nails needed to be cut because the nails were cut into Resident 2's hands. TN 1 stated it was important to keep Resident 2's nails clean and trimmed for infection control and to protect resident from injury. TN 1 stated TN 1 was supposed to check Resident 2's nails when TN 1 provided care for Resident 2 but did not do that (checked Resident 2's fingernails). TN 1 stated TN 1 did not remember the last time when TN 1 checked Resident 2's fingernails. TN 1 stated all staff that provided care to Resident 2 should have noticed Resident 2's nails and had them trimmed. During an interview on 7/28/2026 at 1:05 p.m. with CNA 3, in Resident 2's room, CNA 3 stated she had not noticed Resident 2's nails. CNA 3 stated she was not aware that Resident 2's fingernails were digging into Resident 2's hands. During the review of facility's Policy and Procedure (P&P) titled, Fingernails/Toenails, Care of dated 2/2018, the P&P indicated its purpose was to clean the nail bed, to keep nails trimmed and to prevent infections. The P&P indicated nail care included daily cleaning and regular trimming. The P&P indicated to stop and report to the nurse supervisor if there was evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease. During the review of facility's P&P titled, Activities of Daily Living (ADL), Supporting, dated 3/2018, the P&P indicated residents who are unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.		