STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate two of two sampled residents (Resident 1 and Resident 2) with their personal needs, as indicated in the facility's policy by failing to: a Ensure Resident 1's call light (device used by a patient to signal his or her need for assistance from professional staff) was within her reach. Resident 1's call light was on the floor on 8/6/20 (not within Resident 1's reach). b Ensure that staff answered Resident 2's call light promptly. Resident 2 stated that he used his call light but he could not remember the date and that he waited approximately forty five minutes for the staff to come and assist him and that it happened frequently. These deficient practices had the potential to result in delay of services. Findings: a. A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on 5/2/19 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's history and physical examination [REDACTED]. A review of Resident 1's Fall Risk Care Plan dated 5/15/20 indicated the resident was at risk for fall related to cognitive impairment and poor safety awareness. The care plan interventions included to place a call light within reach, staff to answer promptly and to maintain a safe environment for the resident. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 5/17/20 indicated the resident was severely impaired in cognitive skills (ability to make decisions). The MDS indicated Resident 1 required supervision for bed mobility and transfers. The MDS indicated the resident required extensive assistance for personal hygiene and toilet use. A review of Resident 1's Departmental Notes dated 8/1/20 and timed at 3:54 p.m., indicated the resident had an unwitnessed fall and a staff (unidentified) found the resident laying on the floor. The notes indicated the resident had redness to the left cheek and no swelling and bruising. During an observation on 8/6/20 at 2:08 p.m., Resident 1 was lying in bed and had her eyes closed and was not able to answer any questions. During a concurrent observation and interview, Certified Nursing Assistant 1 (CNA 1) stated Resident 1's call light was on the floor. During an interview and a review of Resident 1's medical record on 8/6/20/ at 2:16 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 sustained a fall on 8/1/20 and was supposed to have her call light within reach regardless if the resident was confused. b. A review of Resident 2's Face Sheet indicated the facility admitted the resident on 6/15/12 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 2's history and physical examination [REDACTED]. A review of Resident 2's MDS dated [DATE] indicated the resident required extensive assistance for transfers, toileting, and personal hygiene. During an observation and interview on 8/6/20 at 12:38 p.m., Resident 1 was awake sitting in a wheelchair and stated the staff took about forty five minutes to answer his call light for toileting assistance. During a telephone interview on 10/1/20 at 12:31 p.m., the facility's Director of Nursing (DON) stated staff were supposed to answer the residents' call lights within five minutes so that the residents received assistance. A review of the facility's policy and procedure titled Answering the Call Light, with a revised date of October 2010, indicated for staff to be sure the call light was within reach of the resident when the resident was in bed or confined to a chair and to answer the call light as soon as possible.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a specific plan of care for one of two sampled residents (Resident 1), as indicated in the facility's policy and procedure. Resident 1 did not have a plan of care to indicate the resident had an actual fall on 8/1/20. This deficient practice had the potential for Resident 1 not to receive appropriate interventions or assistance to prevent further falls. *Cross reference F689 Findings: A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on 5/2/19 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Physician order [REDACTED]. A review of Resident 1's history and physical examination [REDACTED]. A review of Resident 1's Fall Risk Care Plan dated 5/15/20 indicated the resident was at risk for fall related to cognitive impairment and poor safety awareness. The care plan interventions included to place a call light within reach, staff to answer promptly and to maintain a safe environment for the resident. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 5/17/20 indicated the resident was severely impaired in cognitive skills (ability to make decisions). The MDS indicated Resident 1 required supervision for bed mobility and transfers. The MDS indicated the resident required extensive assistance for personal hygiene and toilet use. A review of Resident 1's Departmental Notes dated 8/1/20 and timed at 3:54 p.m., indicated the resident had an unwitnessed fall and a staff (unidentified) found the resident lying on the floor. The notes indicated the resident had redness to the left cheek and no swelling and bruising. During an observation on 8/6/20 at 2:08 p.m., Resident 1 was lying in bed, had her eyes closed and was not able to answer any questions. During a concurrent observation and interview, Certified Nursing Assistant 1 (CNA 1) stated Resident 1's call light was on the floor and the resident did not have a bed pad alarm. CNA 1 stated there was a chair next to the resident's bed and was blocking the resident's path and was also used to prevent the resident from getting up unassisted. CNA 1 stated she did not know if the resident needed a bed alarm. During an interview and a review of Resident 1's medical record on 8/6/20 at 2:16 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 sustained a fall on 8/1/20 and was supposed to have a bed alarm and her call light within reach regardless if the resident was confused. LVN 1 stated there was no documented evidence of an actual fall care plan and stated there should be one in place. During a telephone interview on 10/1/20 at 12:31 p.m., the facility's Director of Nursing (DON) stated care plans were important to have safe continuity of care and to have interventions for the residents' safety. A review of the facility's policy and procedure titled Care Plans-Comprehensive, with a revised date of September 2010, indicated care plan interventions were designed after careful consideration of the relationship between the resident's problem areas and their causes. The policy indicated each resident's comprehensive care plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, and build on the resident's strengths.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to conduct complete neurological assessments (an assessment of brain functions and level of consciousness) after a fall for one of two sampled residents (Resident 1) as indicated in the facility's policy and procedure. This deficient practice had the potential to result in a delay in

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

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.

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) identifying a resident's change of condition in mental status. Findings: A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on 5/2/19 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Physician order [REDACTED]. A review of Resident 1's history and physical examination [REDACTED]. A review of Resident 1's Fall Risk Care Plan dated 5/15/20 indicated the resident was at risk for fall related to cognitive impairment and poor safety awareness. The care plan interventions included to place a call light within reach, staff to answer promptly and to maintain a safe environment for the resident. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 5/17/20 indicated the resident was severely impaired in cognitive skills (ability to make decisions). The MDS indicated Resident 1 required supervision for bed mobility and transfers. The MDS indicated the resident required extensive assistance for personal hygiene and toilet use. A review of Resident 1's Departmental Notes dated 8/1/20 and timed at 3:54 p.m., indicated the resident had an unwitnessed fall and a staff (unidentified) found the resident lying on the floor. The notes indicated the resident had redness to the left cheek and no swelling and bruising. During an observation on 8/6/20 at 2:08 p.m., Resident 1 was lying in bed, had her eyes closed and was not able to answer any questions. During an interview and a review of Resident 1's medical record on 8/6/20/ at 2:16 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 sustained a fall on 8/1/20. A review of Resident 1's Neurological Assessment Flowsheet indicated neuro check scheduled every 15 minutes times four, every 30 minutes times two, every one hour times 2, every 2 hours times 2, every 4 hours times four, and every 8 hours times six. During a telephone interview and record review of Resident 1 on 10/1/20 at 12:31 p.m., the facility's Director of Nursing (DON) stated the resident's Neurological Assessment Flowsheet was missing information for 8/1/20 timed at 2:45 p.m. and timed at 3:45 p.m., 8/3/20 timed at 12:45 p.m., and 8:45 p.m. DON stated staff were supposed to document assessment completely. The DON stated the purpose of the neurological assessments was to see if the resident had any changes or any injuries to the head. A review of the facility's policy titled Neurological Assessment, with a revised date of October 2010 indicated staff to conduct neurological assessment upon an unwitnessed fall.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow safety measures to prevent falls for one of two sampled residents (Resident 1) as indicated in the resident's plan of care. The facility failed to: 1. Ensure Resident 1 had a pad alarm while in bed as ordered. 2. Ensure Resident 1 had her call light (device used by a patient to signal his or her need for assistance from professional staff), within her reach. 3. Ensure to provide Resident 1 with a safe uncluttered environment. These deficient practices had the potential for Resident 1 to experience further falls. *Cross reference F656 Findings: A review of Resident 1's Face Sheet (admission record) indicated the facility admitted the resident on 5/2/19 and readmitted on [DATE] with [DIAGNOSES REDACTED]. A review of Resident 1's Physician order [REDACTED]. A review of Resident 1's history and physical examination [REDACTED]. A review of Resident 1's Fall Risk Care Plan dated 5/15/20 indicated the resident was at risk for fall related to cognitive impairment and poor safety awareness. The care plan interventions included to place a call light within reach, staff to answer promptly and to maintain a safe environment for the resident. A review of Resident 1's Minimum Data Set ((MDS), a resident assessment and care-screening tool), dated 5/17/20 indicated the resident was severely impaired in cognitive skills (ability to make decisions). The MDS indicated Resident 1 required supervision for bed mobility and transfers. The MDS indicated the resident required extensive assistance for personal hygiene and toilet use. A review of Resident 1's Departmental Notes dated 8/1/20 and timed at 3:54 p.m., indicated the resident had an unwitnessed fall and a staff (unidentified) found the resident laying on the floor. The notes indicated the resident had redness to the left cheek and no swelling and bruising. During an observation on 8/6/20 at 2:08 p.m., Resident 1 was lying in bed and had her eyes closed and was not able to answer any questions. During the concurrent observation and interview, Certified Nursing Assistant 1 (CNA 1) stated Resident 1's call light was on the floor and the resident did not have a bed pad alarm. CNA 1 stated there was a chair next to the resident's bed and was blocking the resident's path and was also used to prevent the resident from getting up unassisted. CNA 1 stated she did not know if the resident needed a bed alarm. During an interview and a review of Resident 1's medical record on 8/6/20/ at 2:16 p.m., Licensed Vocational Nurse 1 (LVN 1) stated Resident 1 sustained a fall on 8/1/20 and was supposed to have and a bed pad alarm and her call light within reach regardless if the resident was confused. LVN 1 stated the room should be uncluttered and the chair should not be blocking the resident's path. A review of the facility's policy and procedure titled Falls and Fall Risks, Managing, with a revised date of 2018 indicated staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 maintain a safe, sanitary environment to prevent the spread of infections, including Coronavirus-19 (COVID-19 an illness caused by [MEDICAL CONDITION] that can spread from person to person) for residents, staff members and visitors, by failing to ensure: 1. Staff and/or visitors follow safe infection control procedure by having separate areas to put on and to take off personal protective equipment (PPE- gloves, gown, mask, face shield). 2. Water fountains for public use were closed. 3. To have a separate entrance used for assigned staff in the COVID-19 positive unit from the non-COVID unit assigned staff. 4. Sanitary practices being implemented while preparing food. 5. Screening process for staff and visitors obtained all the signs and symptoms of COVID-19 before entering the facility. 6. Residents maintained social distancing. 7. Staff wear the personal protective equipment as recommended. These deficient practices placed an increased risk in the development and transmission of communicable diseases and infections, including Covid-19, which could result in hospitalization and/or death. Findings: A review of the facility's census, dated 8/5/20, indicated the facility had 204 residents residing in the facility. During an observation and record review on 8/6/20 at 11:05 a.m., the facility's screening for COVID-19 symptoms, form did not list the GI symptoms. During an interview on 8/6/20 at 11:14 a.m., the facility's Administrator (ADM) stated the facility had 18 residents in the Red Zone (area for residents who tested positive for COVID-19) and 186 residents in the Yellow Zone (area for residents who have been in close contact with known cases of COVID-19, newly admitted or readmitted residents, those who have symptoms of possible COVID-19 pending test results and for residents with indeterminate tests). During an interview with the facility's ADM on 8/6/20 at 11:30 a.m., she stated the staff assigned for COVID-19 positive unit entered and exited the main entrance of the building. The ADM stated the entrance was also used by staff assigned in the Non-COVID unit to enter and exit. During an interview with Medical Doctor 1 (MD1) on 8/6/20 at 11:35 a.m., he stated that a separate entrance, exit and screening area should be set up for COVID-19 positive unit assigned staff in order to prevent contamination and spread of Covid-19. During an observation and interview with MD1 on 8/6/20 at 11:50 a.m., a water fountain in the hallway for resident use was observed. It was recommended by MD1 that a barrier be used to prevent the use of the water fountain and potential spread of COVID-19. During an observation on 8/6/20 at 12:55 p.m., four residents were observed eating lunch together, sharing one table. The space between residents eating and sharing the same table was less than 6 feet apart. During an observation in the kitchen and interview on 8/6/20 at 12:59 p.m., Dietary Aide (DA) was observed without a mask on, eating food while cutting up fruit (watermelon) for residents without gloves. During an interview with DA1 she stated that the mask does not stay on her nose and that she was cutting watermelon for the residents. During an interview with the facility's Dietary Supervisor (DS) on 8/6/20 at 1:02 p.m., she stated staff must wear a mask and should not eat food while preparing food for the residents. During an observation on 8/6/20 at 1:20 p.m., another water fountain for public use was observed without a barrier to prevent its use. During an interview on 8/6/20 at 1:26 p.m., LVN 5 stated that he re-used his N95 (a respiratory protective device designed to achieve a very close facial fit for efficient filtration of airborne particles) mask for as long as two to four weeks. During an observation and concurrent interview on 8/6/20 at 1:40 p.m., the entrance to the COVID-19 positive unit did not have a separate donning and doffing area. MD1 stated that the area should be separated to prevent the spread of COVID-19. During an observation in the Red Zone on 8/6/20 at 2:08 p.m., Certified Nursing Assistant 1 (CNA 1) had a surgical mask on and an N95 mask on top of the surgical mask. The surgical mask was not covering CNA1's nose. During a concurrent observation and interview, MD 1 stated CNA 1 should wear N95 mask instead of the surgical mask and that the N95 mask should cover her mouth and nose. During an observation on 8/6/20 at 2:20 p.m., one resident was observed using a water fountain. The water fountain was not closed for public use. A review of the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) facility's record titled, Covid-19 Mitigation Plan, indicated the Skilled Nursing Facility (SNF) has policies in place for dedicated spaces within the facility to ensure separation or infected patients and for eliminating movement of HCP (health care providers) among those spaces to minimize the transmission risk. A review of the facility's record titled, Covid-19 Mitigation Plan, indicated there is no communal dining, or, in accordance with CMS guidance, eating in dining areas with appropriate social distancing is only used as a last resort. A review of the Centers for Disease Control and Prevention Pandemic Planning Recommended Guidance for the extended use and Limited Reuse of N95 Filtering Face piece Respirators in Healthcare Setting dated 3/27/2020 indicated limiting the number of reuses (N95) to no more than five uses per device to ensure an adequate safety margin.