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	07/29/2021

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27785 Based on observation, interview, and record review the facility failed to protect one of two sampled residents (Resident 1) from physical abuse (an intentional act causing injury or trauma to another person by way of bodily contact) who had a restraining order (a criminal protection order issued by a state court which requires one person to stay away and stop harming another person) against a male individual prior to admission on 6/11/2021. The facility was aware of the Resident 1's restraining order but did not have a plan of care to address the restraining order to protect Resident 1 from physical harm. In addition, the facility did not prevent the male individual from an unlawful entry (when a person enters the property of another without consent from the owner) to the facility. This deficient practice resulted in Resident 1 to experience physical abuse and feeling afraid with the potential for serious harm to the resident and other residents in the facility (two hundred-eleven). On 7/28/2021 at 4:15 pm, the Department called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirement of participation has caused or is likely to cause serious injury, impairment or death to a resident) situation in the presence of the Director of Nursing (DON) and the Administrator (ADM). The DON and ADM were informed of the facility's failure to have systems in place to ensure Resident 1 was protected from physical abuse. On 7/30/2021 at 12:45 pm, during an onsite visit, the Department verified and confirmed the IJ was removed after the facility presented an acceptable plan of action (POA). The POA included: 1. Resident 1 was assessed and did not have signs and symptoms of injuries and was placed on a one to one staff supervision (to provide continuous observation for an individual) to protect the resident from further abuse. 2. Care plans were developed related to incident and police was contacted. 3. On 7/28/2021 Resident 1 was moved to a different room that did not have a sliding glass door. 4. The facility conducted every two hours door checks by assigned staff and monitored 140 entry points, including but not limited, windows, and doors. (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
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Education and training for staff was initiated with regards to intruders and the safety & security of facility doors and windows. 6. Facility obtained a description of the male intruder and have included that information on a No-Access List, maintained at the front desk and nurse's stations and advised all staff to be on the look-out for a person matching those descriptions and to prohibit such persons from entering the facility. 7. Facility implemented a security guard to monitor the exterior of the premises. Cross Reference F689 Findings: On 7/27/2021 at approximately 3:35 am, Certified Nursing Assistant 1 (CNA 1) and Licensed Vocational Nurse 1 (LVN 1) observed an unknown male individual inside Resident 1's room sitting on the floor to the left side of the resident's bed. LVN 1 told the unknown male that she was going to call the police and left the resident's room to notify Registered Nurse 1 (RN 1) to call 911 emergency (a life or death emergency that requires the immediate response of emergency service such as police, fire or paramedic). Resident 1 alleged the unknown male hit her on the left lower side of her face before leaving the room. The male individual then left the room using the sliding door located in the resident's room. Resident 1 stated the male individual could have been the male individual whom she had a restraining order against. A review of Resident 1's Police Incident Report dated 6/10/2021, and timed at 2:04 pm, indicated Resident 1 was a victim of a domestic violence (violent or aggressive behavior within the home, typically involving the violent abuse of a spouse or partner) felony that occurred on 6/10/2021 while the resident resided at another facility. The police report indicated the suspect was Resident 1's ex-boyfriend. The police report indicated that a 100 yard stay away order (restraining order) was issued to the ex-boyfriend on 12/23/2020 and expires on 12/23/2023. A review of the Admission Record for Resident 1 indicated the facility originally admitted the resident on 6/11/2021, and readmitted on [DATE] with diagnoses that included chronic embolism (occurs when a piece of a blood clot, foreign object, or other bodily substance becomes stuck in a blood vessel) and thrombosis (occurs when a thrombus, or blood clot, develops in a blood vessel and reduces the flow of blood through the vessel) of unspecified deep veins of the lower extremities, and chronic osteomyelitis (a severe, persistent, and sometimes incapacitating infection of bone and bone marrow (a soft fatty substance in the cavities of bones, in which blood cells are produced). A review of the Minimum Data Set (MDS, an assessment and care screening tool) for Resident 1, dated 6/17/2021, indicated Resident 1 had the ability to make self-understood and understand others with intact cognitive skills (ability to think, understand, and reason). The MDS indicated Resident 1 required limited assistance from staff for mobility, transfer to and from bed or wheelchair, walk between locations in her room and corridors of the unit, dressing, toilet use, and personal hygiene, and needed supervision for eating. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's clinical record indicated no documented evidence the resident had a restraining order with a history of domestic violence from 6/11/2021 (date of admission) to 7/27/21 (date of incident). A review of Resident 1's Progress Notes (PN), dated 7/27/2021 and timed late entry at 12:17 pm by RN 1, indicated LVN 1 reported to RN 1 there was an unknown person in Resident 1's bed on 7/27/2021 at approximately 3:35 am. The PN indicated CNA 1 witnessed an unknown male person entering Resident 1's room and immediately notified the charge nurse, LVN 1. The PN indicated LVN 1 immediately checked Resident 1's room and ask Resident 1 if there was somebody with the resident, and the resident responded, No. As LVN 1 got closer to Resident 1's bed, she noted that there was an unknown male person on the floor by the left side of Resident 1's bed. The PN indicated LVN 1 notified RN 1 regarding the situation and at 3:38 am, 911 was immediately activated. The PN indicated two police officers arrived at 3:42 am. The police officers interviewed Resident 1 and looked around the resident's room and out the sliding door but did not see anyone. The PN indicated, as per Resident 1, she alleged that the unknown person hit the left side of her jaw. The PN indicated that Resident 1 told RN 1 to tell police that she had a restraining order on a person named Boyfriend 1 but was unable to state whether the unknown person was the person she had restraining order against. During an interview on 7/28/2021 at 11:15 am, the Quality Assurance Nurse, LVN 2, stated that Resident 1 was transferred to another unit and room after the incident. LVN 2 stated Resident 1's former roommate, Resident 2, was asked about the incident but stated that she did not know anything about the incident. LVN 2 stated that Resident 2 was also assessed (physical and psychosocial assessment) and monitored for safety after the incident. LVN 2 stated that on 7/27/2021, at around 3:35 am, CNA 1 saw a man enter Resident 1's room and sat on the resident's bed next to the Resident 1. LVN 2 stated CNA 1 reported to the charge nurse, LVN 1. LVN 2 stated LVN 1 checked Resident 1's room and saw the man under the resident's bed. LVN 2 stated that all the exit/entrance doors were locked 24/7 and they did not know how the male intruder entered the building. During an observation of Resident 1's previous room at the time of the incident, and interview with LVN 2, on 7/28/2021 at 11:40 am, it was noted that Resident 1's bed was beside a sliding door leading outside to a small patio. This sliding door was locked and opened to a small patio with block fence and a locked iron gate leading to the street. The room was one room away to the end of the unit hallway. At the end of the hallway was a double glass door which lead to the outside of the facility. The double glass door was locked at the time of the observation. LVN 2 stated that the double glass doors are always locked and was only opened for 911 emergency personnel. LVN 2 stated that only the Registered Nurse (RN) supervisor on duty had the key to disarm the alarm and open the door. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation on 7/28/2021 at 12:05 pm, and interview with Resident 1 inside Resident 1's new room, Resident 1 stated at the time of the incident, the resident's bed was in bed A. Bed A was next to the front door entrance of the room leading to the end of the unit hallway which had a double glass door exit to the outside of the facility. The double glass door was locked. The sliding glass window, which was locked at the time of the visit, opened to a small patio that had a block fence and gated access to the outside of the facility. There was no one to one (continuous observation) staff supervision (a staff staying with the resident at all times) with Resident 1 or any staff present at the vicinity of Resident 1's room at the time of the visit. Resident 1 was observed in bed awake and was snacking on some chips. Resident 1 had a cast (a supportive bandage that is solid and wraps all the way around the extremity) with internal fixation rods (large nails surgically inserted into the center of the bone to stabilize and support the fractured bone until it heals) on her left leg. Resident 1 stated that she could get up from bed by herself and did not need help to transfer to and from her wheelchair. When asked about the incident, Resident 1 stated she was asleep and was awaken when the man came in the room through the front bedroom door and touched her arm. Resident 1 stated the man came in the room through the front door not the sliding door. Resident 1 said the man told her to move aside and wanted to lay down by her side when a staff came by outside her room and asked how she was doing. She stated she answered that she was okay because she was afraid. Resident 1 said moments later CNA 1 and LVN 1 came in her room to check on her, but the staff did not see the man. When CNA 1 and LVN 1 walked away, the man hit her on the left side of her face and left the room through the sliding glass door. The resident stated she got scared when she heard noises outside her room thinking the man might come back and hurt her. Resident 1 stated the man who entered her room could have been her ex-boyfriend whom she had a restraining order against. During record review and interview with LVN 2 on 7/28/2021 at 12:55 pm, Resident 1's care plans regarding resident's safety was reviewed. LVN 2 stated Resident 1 did not have a plan of care for safety in relation to the restraining order or a safety care plan specific for people wanting to hurt resident. LVN 2 stated they were not aware of any restraining order and reason to develop a care plan for people wanting to hurt the resident. LVN 2 stated before a resident was admitted to the facility, nursing staff are supposed to review the residents' medical history and reason for admission to verify if facility can provide care services to residents. LVN 2 stated, Resident 1 was admitted from another skilled nursing facility but there was no mention in the resident's medical history of physical abuse while the resident resided at the other facility. During an interview with ADM on 7/28/2021 at 1:40 pm, she stated she knew Resident 1 had a restraining order when the resident was admitted to the facility and validated no safety measures were placed to protect the resident from the male individual coming in the building prior to the incident. ADM stated that the police officer who came to investigate also confirmed to her that the restraining order was still in effect. ADM stated they were not able to establish how the unknown individual got in the building but have started checking every couple of hours to make sure windows and doors were locked. Although, she was aware of the restraining order, she stated no attempts were made to retrieve the restraining order or history of abuse from the other facility where the resident was transferred from. A review of the facility's policy and procedure on abuse reporting and investigation, updated on November 2018, indicated the facility promptly and thoroughly investigated report of resident abuse. The facility's policy and procedure indicated that when the Abuse Prevention Coordinator (APC, administrator of the facility) received a report of incident, the APC would initiate an investigation immediately and provide for a safe environment for the resident as indicated by the situation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy and procedure on safety and supervision of residents, revised on December 2007, indicated staff should use various sources to identify risk factors for residents, including information obtained from medical history, physical exam, observation of the resident, and the MDS. The policy and procedure indicated the interdisciplinary care team (a group of health care professionals with various areas of expertise who work together toward the wellbeing of the residents) should analyze the information obtained to identify any specific accident hazards or risk for that resident and target interventions to reduce the potential for accidents.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 27785 Based on observation, interview, and record review the facility failed to supervise and ensure one of two sampled residents (Resident 1) who had a restraining order (a criminal protection order issued by a state court which requires one person to stay away and stop harming another person) and was a victim of domestic violence (violent or aggressive behavior within the home, typically involving the violent abuse of a spouse or partner), was free from physical harm by a male individual who entered the facility on [DATE] at approximately 3:35 am,. The facility was aware of the Resident 1's restraining order but did not have a plan of care to address the restraining order to supervise and protect Resident 1 from physical harm. In addition, the facility did not prevent the male individual from an unlawful entry (when a person enters the property of another without consent from the owner) to the facility. This deficient practice resulted in an unlawful entry (When a person enters the property of another without consent from the owner) of a male individual to the facility inflicting harm, with potential for serious physical and psychosocial (mental and social wellbeing) harm to Resident 1 and other residents who reside in the facility. On [DATE] at 4:15 pm, the Department called an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirement of participation has caused or is likely to cause serious injury, impairment or death to a resident) situation in the presence of the Director of Nursing (DON) and the Administrator (ADM). The DON and Administrator were informed of the facility's failure to have systems in place to ensure Resident 1 was safe and protected from physical harm. On [DATE] at 12:45 pm, during an onsite visit, the Department verified and confirmed the IJ was removed after the facility presented an acceptable plan of action. The plan of action included: 1. Resident 1 was assessed and did not have signs and symptoms of injuries and was placed on a one to one staff supervision (to provide continuous observation for an individual) to protect the resident from further abuse. 2. Care plans were developed/triggered related to incident and police was contacted. 3. On [DATE] Resident 1 was moved to a different room that did not have a sliding glass door. 4. The facility conducted every two hours door checks by assigned staff and monitored 140 entry points, including but not limited, windows, doors, sliding. 5. Education and training for staff was initiated with regards to intruders and the safety & security of facility doors and windows. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. The facility obtained a description of the male intruder and have included that information on a No-Access List maintained at the front desk and nurse's stations and advised all staff to be on the look-out for a person matching those descriptions and to prohibit such persons from entering the facility. 7. The facility implemented a security guard to monitor the exterior of the premises. Cross Reference F600 Findings: On [DATE] at approximately 3:35 am, Certified Nursing Assistant 1 (CNA 1) and Licensed Vocational Nurse 1 (LVN 1) observed an unknown male individual inside Resident 1's room sitting on the floor to the left side of the resident's bed. LVN 1 told the unknown male that she was going to call the police and left the resident's room to notify Registered Nurse 1 (RN 1) to call 911 emergency (a life or death emergency that requires the immediate response of emergency service such as police, fire or paramedic. Resident 1 alleged the unknown male hit her on the left lower side of her face before leaving the room. The male individual then left the room using the sliding door located in the resident's room. Resident 1 stated the male individual could have been her ex-boyfriend whom she had a restraining order against. A review of a police report provided by the local police department, dated [DATE], indicated Resident 1 was a victim of a domestic violence felony that occurred on [DATE], while the resident resided at another facility. The police report indicated the suspect was Resident 1's ex-boyfriend. The police report indicated that a 100 yard stay away order (restraining order) was issued to the ex-boyfriend on [DATE] and expired on [DATE]. A review of the Admission Record for Resident 1 indicated the facility originally admitted the resident on [DATE], and readmitted on [DATE] with diagnoses that included chronic embolism (occurs when a piece of a blood clot, foreign object, or other bodily substance becomes stuck in a blood vessel) and thrombosis (occurs when a thrombus, or blood clot, develops in a blood vessel and reduces the flow of blood through the vessel) of unspecified deep veins of the lower extremities, and chronic osteomyelitis (a severe, persistent, and sometimes incapacitating infection of bone and bone marrow). A review of the Minimum Data Set (MDS, an assessment and care screening tool) for Resident 1, dated [DATE], indicated Resident 1 had the ability to make self-understood and understand others with intact cognitive skills (ability to think, understand, and reason). The MDS indicated Resident 1 required limited assistance from staff for mobility, transfer to and from bed or wheelchair, walk between locations in her room and corridors of the unit, dressing, toilet use, and personal hygiene, and needed supervision for eating. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's Progress Notes (PN), dated [DATE] and timed late entry at 12:17 pm by RN 1, indicated LVN 1 reported to RN 1 that there was an unknown person in Resident 1's bed. The PN indicated CNA 1 witnessed an unknown male person entering Resident 1's room and immediately notified the charge nurse, LVN 1. The PN indicated LVN 1 immediately checked Resident 1's room and ask Resident 1 if there was somebody with her and she responded No, As LVN 1 got closer to Resident 1's bed, she noted that there was an unknown male person on the floor by the left side of Resident 1's bed. The PN indicated LVN 1 notified RN 1 regarding the situation and at 3:38 am, 911 was immediately activated. The PN indicated two police officers arrived at 3:42 am. The police officers interviewed Resident 1 and looked around the Resident 1's room and out the sliding door but did not see anyone. The PN indicated, as per Resident 1, she alleged that the unknown person hit the left side of her jaw. The PN indicated that Resident 1 told RN 1 to tell police that she had a restraining order on a person named Boyfriend 1 but was unable to state whether the unknown person was the person she had restraining order against. During an interview on [DATE] at 11:15 am, the Quality Assurance Nurse, LVN 2, stated that Resident 1 was transferred to another unit and room after the incident. LVN 2 stated Resident 1's former roommate, Resident 2, was asked about the incident but stated that she did not know anything about the incident. LVN 2 stated that Resident 2 was also assessed (physical and psychosocial assessment) and monitored for safety after the incident. LVN 2 stated that on [DATE], at around 3:35 am, CNA 1 saw a man enter Resident 1's room and sat on the resident's bed next to the Resident 1. LVN 2 stated CNA 1 reported to the charge nurse, LVN 1. LVN 2 stated LVN 1 checked Resident 1's room and saw the man under the resident's bed. LVN 2 stated that all the exit/entrance doors were locked ,d+[DATE] and they did not know how the male intruder entered the building. During an observation of Resident 1's previous room at the time of the incident, and interview with LVN 2, on [DATE] at 11:40 am, it was observed that Resident 1's bed was beside a sliding door leading outside to a small patio. This sliding door was locked and opened to a small patio with block fence and a locked iron gate leading to the street. The room was one room away to the end of the unit hallway. At the end of the hallway was a double glass door which lead to the outside of the facility. This double glass door was locked at the time of the observation. LVN 2 stated the double glass doors are always locked and was only opened for 911 emergency personnel. LVN 2 stated that only the Registered Nurse (RN) supervisor on duty had the key to disarm the alarm and open the door. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During observation on [DATE] at 12:05 pm, and interview with Resident 1, inside of Resident 1's new room, Resident 1 stated at the time of the incident on [DATE] at approximately 3:35 am , the resident's bed was in bed A. Bed A was next to the front door entrance of the room leading to the end of the unit hallway which had a double glass door exit to the outside of the facility. The double glass door was locked. The sliding glass window, which was locked at the time of the visit, opened to a small patio that had a block fence and gated access to the outside of the facility. There was no one to one (continuous observation) staff supervision (a staff staying with the resident at all times) with Resident 1 or any staff present at the vicinity of Resident 1's room at the time of the visit. Resident 1 was observed in bed awake and was snacking on some chips. Resident 1 had a cast (a supportive bandage that is solid and wraps all the way around the extremity) with internal fixation rods (large nails surgically inserted into the center of the bone to stabilize and support the fractured (broken) bone until it heals) on her left leg. Resident 1 stated that she could get up from bed by herself and did not need help to transfer to and from her wheelchair. When asked about the incident, Resident 1 stated she was asleep and was awaken when the man came in the room through the front bedroom door and touched her arm. Resident 1 stated the man came in the room through the front door not the sliding door. Resident 1 said the man told her to move aside and wanted to lay down by her side when a staff came by outside her room and asked how she was doing. She stated she answered that she was okay because she was afraid. Resident 1 said moments later two CNA 1 and LVN 1 came in her previous room to check on her, but the staff did not see the man. When the two staff walked away, the man hit her on the left side of her face and left the room through the sliding glass door. The resident stated she got scared when she heard noises outside her room thinking the man might come back and hurt her. Resident 1 stated the man who entered her room could have been the male individual whom she had a restraining order against. During record review and interview with LVN 2 on [DATE] at 12:55 pm, LVN 2 stated Resident 1 did not have a plan of care for safety in relation to the restraining order or a safety care plan specific for people wanting to hurt resident. LVN 2 stated they were not aware of any restraining order and reason to develop a care plan for people wanting to hurt the resident. LVN 2 stated before a resident was admitted to the facility, nursing staff are supposed to review the residents' medical history and reason for admission to verify if facility can provide care services to residents. LVN 2 stated, Resident 1 was admitted from another skilled nursing facility but there was no mention in the resident's medical history of physical abuse while the resident resided at the other facility. During an interview with ADM on [DATE] at 1:40 pm, she stated she knew Resident 1 had a restraining order when the resident was admitted to the facility and validated no safety measures were placed to protect the resident from the male individual coming in the building prior to the incident. ADM stated that the police officer who came to investigate also confirmed to her that the restraining order was still in effect. ADM stated they were not able to establish how the unknown individual got in the building but have started checking every couple of hours to make sure windows and doors were locked. Although, she was aware of the restraining order, she stated no attempts were made to retrieve the restraining order or history of abuse. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's policy and procedure on safety and supervision of residents, revised on [DATE], indicated staff should use various sources to identify risk factors for residents, including information obtained from medical history, physical exam, observation of the resident, and the MDS. The policy and procedure indicated the interdisciplinary care team (a group of health care professionals with various areas of expertise who work together toward the wellbeing of the residents) should analyze the information obtained to identify any specific accident hazards or risk for that resident and target interventions to reduce the potential for accidents.