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	08/27/2021

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to notify the physician that the resident had episodes of pulling out the Tracheostomy tube (a tube surgically created in the neck to the trachea to allow oxygen delivery) for one of two sampled residents (Resident 1) in accordance with the facility policy and procedure. This deficient practice resulted in not having an alteration of the resident's treatment, plan of care, and/or nursing interventions that could potentially have benefited the resident's clinical outcome. On [DATE] at 11:25 pm, LVN 1 found Resident 1 lying on the floor unresponsive, with no pulse (heartbeat) and no respiration (not breathing). The resident's tracheostomy tube was not in place (inserted in resident's neck). Resident 1 was transferred to the general acute care hospital (GACH 1) via [DATE] (emergency services) after cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) was attempted. Resident 1 remained unconscious in the GACH for three (3) days. On [DATE] at 5:37 pm, Resident 1 died in the GACH. The resident's immediate cause of death was respiratory failure (a serious condition that develops when the lungs cannot get enough oxygen into the blood) and anoxic encephalopathy (caused by a complete lack of oxygen to the brain, which results in the death of brain cells). Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure, hypoxia (lack of oxygen in the tissues), with tracheostomy tube, and non-traumatic intracranial hemorrhage (bleeding in the brain due to ruptured or leaked in blood vessels). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], indicated Resident 1's cognitive skills (ability to think, understand, and reason) for daily decision making was severely impaired. Resident 1 was also assessed totally dependent with bed mobility moving side to side while in bed, transferring from bed to chair, getting dressing, and personal hygiene. (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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's Physician's Order, dated [DATE], indicated to titrate (continuously measure and adjust the balance) oxygen saturation (test that measures the amount of oxygen being carried by red blood cells) greater than 92 percent (%) and to monitor tracheostomy site every shift. A review of Resident 1's care plan titled, Respiratory Care, dated [DATE], indicated Resident 1 had impaired gas exchanged related to accidental extubation (removal of tracheostomy tube) or decannulation (removal of tracheostomy tube) and the goal was to maintain a patent airway, optimal oxygenation and ventilation and to reduce the incidence of accidental extubation or decannulation. The care plan interventions included were for the nursing staff to assess for any changes in respiratory status as needed and during patient care rounds, monitor oxygen saturation, tracheostomy site care daily and as needed, and to check and secure tracheostomy tie every two hours and as needed. During an interview with the Director of Nursing (DON) on [DATE] at 3pm, DON stated, Resident 1 was found unresponsive on the floor without her tracheostomy tube in place on [DATE] at 11:25 pm. DON stated Resident 1 was transferred to the acute hospital on [DATE] where Resident 1 later died on [DATE]. During an interview on [DATE] at 6:54 am, Licensed Vocational Nurse 1 (LVN 1) stated, he found Resident 1 unresponsive to any stimuli while lying on the floor on [DATE] at 11:25 pm. LVN 1 stated Resident 1 did not have a pulse and tracheostomy was not in place. LVN 1 stated, Resident 1 was transferred to bed, and the unidentified Respiratory Therapist (RT - medical professionals who treat problems of the lungs or breathing) reinserted the tracheostomy tube back to the resident and started CPR. LVN 1 stated, Registered Nurse 1 (RN 1) called [DATE] (emergency services) and Resident 1 was transferred to GACH. LVN 1 further stated Resident 1 was at risk and had attempted to pull out her tracheostomy tube at least twice in the past. LVN 1 then stated, Resident 1 had weakness to one side of the body and had made attempts to sitting on the side of the bed without assistance. During a telephone interview on [DATE] at 8:51am, LVN 3 stated, on [DATE], Resident 1 had an episode of pulling out her tracheostomy tube and noted bleeding on the site. LVN 3 stated, Resident 1 needed close monitoring to prevent pulling out the tracheostomy tube. During a telephone interview on [DATE] at 9:39 am, RN 1 stated, she found Resident 1 lying on the floor on her back the night of [DATE]. RN 1 stated Resident 1 was unresponsive, did not have a pulse, and was not breathing. RN 1 stated, Resident 1 had a history of trying to get out of bed unassisted with episodes of pulling out tracheostomy tube. RN 1 also stated, Resident 1 needed frequent visual checks and monitoring and would have benefitted from one-to-one supervision (continuous observation) for frequent monitoring but was never provided. During an interview on [DATE] at 10:24 am, RT 1 stated, Resident 1 had a history of pulling out her tracheostomy tube. RT 1 stated she had to reinsert the tracheal tube at least two times in early ,d+[DATE]. During an interview on [DATE] at 10:54 am, Nurse Practitioner (NP) stated, there was no documented evidence or verbal report of Resident 1 having episodes of pulling out her tracheostomy tube or any change of condition on [DATE] and [DATE]. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review of Resident 1's clinical record and interview with the Assistant Director of Nursing (ADON) on [DATE] at 11:18 am, ADON stated, Resident 1 pulled out her tracheostomy tube on [DATE] and on [DATE]. ADON stated Resident 1's care plan should have been updated and implemented on [DATE] to include interventions such as frequent visual check and 72-hour monitoring, which could have prevented Resident 1 from pulling her tracheostomy tube on [DATE]. A review of Resident 1's clinical record for the month of [DATE] indicated no documented evidence that the NP or Physician was made aware of Resident 1's episodes of pulling out the tracheostomy tube or attempts of sitting up on the side of the bed unassisted. A notification to the NP or Physician could have allowed for an alteration of the resident's treatment, plan of care, and/or nursing interventions that could potentially have benefited the resident's clinical outcome. A review of a facility form titled, Departmental Notes (Progress Notes), dated [DATE], at 5:21 am, it indicated on [DATE] at 11:20 pm, Resident 1 was found on the floor lying on her back, unresponsive, with no pulse and no respirations. The notes also indicated Cardiopulmonary Resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) was started. The notes indicated that RN 1 called [DATE] at 11:25 pm and Resident 1 was transferred to GACH at 12:02 am. A review of GACH laboratory chemistry (screening blood test that measures the levels of several substances in the blood) result dated [DATE] timed at 12:43 am, result showed critical high Lactate venous, the blood level result lactic acid (produced when oxygen levels become low in cells within the areas of the body) of 11. 6 millimoles per liter (mmol/L - shows the concentration of a substance in a specific amount of fluid) with reference range of 0.5 to 2.2 mmol/L. (According to https://labtestsonline.org/tests/lactate , high levels of lactate in the blood indicated lack of oxygen in the blood.) A review Emergency Department (ED) Note Physician, dated [DATE], timed at 4:32 am, indicated Resident 1 was brought in the ED after being found down next to her bed, tracheostomy was apparently somewhat dislodged (removed) and was unresponsive. ED Physician notes indicated paramedics were able to get return of pulses after two rounds of CPR and epinephrine (indicated in the treatment of cardiac arrest. It also indicated Resident 1 had lactic acidosis (lactic acid build up in the bloodstream). A review of the Discharge Summary at GACH, dated [DATE] and timed 6:02 pm, indicated the MRI test (Magnetic Resonance Imaging is a test that uses a magnetic field and radio waves to produce images of the brain and the brain stem) obtained on [DATE] at 4:15 pm, showed Resident 1 had global hypoxic injury (type of brain injury that occurs when the whole brain is deprived of oxygen, causing severe damage). A review of Resident 1's Certificate of death, dated [DATE] and timed at 5:37 pm, indicated the immediate cause of death was respiratory failure and anoxic encephalopathy (caused by a complete lack of oxygen to the brain, which results in the death of brain cells). A review of the undated Policy and Procedure (P&P) titled, Ventilator Flow Sheet Charting Guidelines, indicated to monitor the patient or resident ventilator system (machines that blow air-or air with extra oxygen-into airways and lungs) and identify changes in the patient or resident's condition and to verify that the ventilator is operating properly, assuring patency of the airway and maintaining the ordered settings. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the P&P titled, Change in a Resident's Condition or Status, dated ,d+[DATE], indicated the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status.

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 0695 Level of Harm - Actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 1) requiring a tracheostomy tube (a T shaped tube surgically created in the neck to the trachea to allow oxygen delivery) with continuous oxygen therapy to breathe maintained a patent airway (ability of a person to breathe) by: 1. Preventing accidental extubation (removal of tracheostomy tube) or decannulation (removal of tracheostomy tube) and maintained open airway in accordance with Resident 1's care plan (process that identifies individual's existing needs, as well as recognizing potential needs or risks. Communication among nurses, their patients and other healthcare providers to achieve health care outcomes). 2. Monitoring Resident 1's tracheostomy site to ensure placement of tracheostomy tubing in accordance with the resident's physician's orders. 3. Implementing facility's policy and procedure by identifying changes in Resident 1's medical condition assuring patency of the resident's airway. 4. Addressing and identifying Resident 1's episodes of pulling out the tracheostomy tube to prevent further accidental decannulation and injury to the resident. On [DATE] at 11:25 pm, LVN 1 found Resident 1 lying on the floor unresponsive, with no pulse (heartbeat) and no respiration (not breathing). The resident's tracheostomy tube was not in place (inserted in resident's neck). Resident 1 was transferred to the general acute care hospital (GACH 1) via [DATE] (emergency services) after cardiopulmonary resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) was attempted. Resident 1 remained unconscious in the GACH for three (3) days. On [DATE] at 5:37 pm, Resident 1 died in the GACH. The resident's immediate cause of death was respiratory failure (a serious condition that develops when the lungs cannot get enough oxygen into the blood) and anoxic encephalopathy (caused by a complete lack of oxygen to the brain, which results in the death of brain cells). Findings: A review of Resident 1's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses of chronic respiratory failure, hypoxia (lack of oxygen in the tissues), with tracheostomy tube, and non-traumatic intracranial hemorrhage (bleeding in the brain due to ruptured or leaked in blood vessels). A review of Resident 1's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated [DATE], indicated Resident 1's cognitive skills (ability to think, understand, and reason) for daily decision making was severely impaired. Resident 1 was also assessed totally dependent with bed mobility moving side to side while in bed, transferring from bed to chair, getting dressing, and personal hygiene. (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 0695 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Physician's Order, dated [DATE], indicated to titrate (continuously measure and adjust the balance) oxygen saturation (test that measures the amount of oxygen being carried by red blood cells) greater than 92 percent (%) and to monitor tracheostomy site every shift. A review of Resident 1's care plan titled, Respiratory Care, dated [DATE], indicated Resident 1 had impaired gas exchanged related to accidental extubation (removal of tracheostomy tube) or decannulation (removal of tracheostomy tube) and the goal was to maintain a patent airway, optimal oxygenation and ventilation and to reduce the incidence of accidental extubation or decannulation. The care plan interventions included were for the nursing staff to assess for any changes in respiratory status as needed and during patient care rounds, monitor oxygen saturation, tracheostomy site care daily and as needed, and to check and secure tracheostomy tie every two hours and as needed. A review of Respiratory Therapy Progress Notes (Respiratory therapists care for patients who have trouble breathing), dated [DATE] at 4:10 pm, indicated Resident 1 had no shortness of breath (difficulty of breathing) during this time, was on oxygen therapy of four (4) liters per minute (LPM) T-piece tracheostomy tube. Resident 1's oxygen saturation was 97%, heart rate was 68 beats per minute, and respiration breathing rate was 18 breaths per minute. A review of the Nursing Flow Sheet Form, dated [DATE] at 8 pm, indicated Resident 1 was alert, receiving three liters of oxygen per minute via Tracheal T bar (T-shaped tubing connected to a tracheal tube to deliver oxygen) and with oxygen saturation of 98%. During an interview with the Director of Nursing (DON) on [DATE] at 3pm, DON stated, Resident 1 was found unresponsive on the floor without her tracheostomy tube in place on [DATE] at 11:25 pm. DON stated Resident 1 was transferred to the acute hospital on [DATE] where Resident 1 later died on [DATE]. During an interview on [DATE] at 6:54 am, Licensed Vocational Nurse 1 (LVN 1) stated, he found Resident 1 unresponsive to any stimuli while lying on the floor on [DATE] at 11:25 pm. LVN 1 stated Resident 1 did not have a pulse and tracheostomy was not in place. LVN 1 stated, Resident 1 was transferred to bed, and the unidentified Respiratory Therapist (RT - medical professionals who treat problems of the lungs or breathing) reinserted the tracheostomy tube back to the resident and started CPR. LVN 1 stated, Registered Nurse 1 (RN 1) called [DATE] (emergency services) and Resident 1 was transferred to GACH. LVN 1 further stated Resident 1 was at risk and had attempted to pull out her tracheostomy tube at least twice in the past. LVN 1 then stated, Resident 1 had weakness to one side of the body and had made attempts to sitting on the side of the bed without assistance. During a telephone interview on [DATE] at 8:51am, LVN 3 stated, on [DATE], Resident 1 had an episode of pulling out her tracheostomy tube and noted bleeding on the site. LVN 3 stated, Resident 1 needed close monitoring to prevent pulling out the tracheostomy tube. During a telephone interview on [DATE] at 9:39 am, RN 1 stated, she found Resident 1 lying on the floor on her back the night of [DATE]. RN 1 stated Resident 1 was unresponsive, did not have a pulse, and was not breathing. RN 1 stated, Resident 1 had a history of trying to get out of bed unassisted with episodes of pulling out tracheostomy tube. RN 1 also stated, Resident 1 needed frequent visual checks and monitoring and would have benefited from one-to-one supervision (continuous observation) for frequent monitoring but was never provided. (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 0695 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:24 am, RT 1 stated, Resident 1 had a history of pulling out her tracheostomy tube. RT 1 stated she had to reinsert the tracheal tube at least two times in early ,d+[DATE]. During an interview on [DATE] at 10:54 am, Nurse Practitioner (NP) stated, there was no documented evidence or verbal report of Resident 1 having episodes of pulling out her tracheostomy tube or any change of condition on [DATE] and [DATE]. During a concurrent record review of Resident 1's clinical record and interview with the Assistant Director of Nursing (ADON) on [DATE] at 11:18 am, ADON stated, Resident 1 pulled out her tracheostomy tube on [DATE] and on [DATE]. ADON stated Resident 1's care plan should have been updated and implemented on [DATE] to include interventions such as frequent visual check and 72-hour monitoring, which could have prevented Resident 1 from pulling her tracheostomy tube on [DATE]. A review of Resident 1's clinical record for the month of [DATE] indicated no documented evidence that the NP or Physician was made aware of Resident 1's episodes of pulling out the tracheostomy tube or attempts of sitting up on the side of the bed unassisted. A notification to the NP or Physician could have allowed for an alteration of the resident's treatment, plan of care, and/or nursing interventions that could potentially have benefited the resident's clinical outcome. A review of a facility form titled, Departmental Notes (Progress Notes), dated [DATE], at 5:21 am, it indicated on [DATE] at 11:20 pm, Resident 1 was found on the floor lying on her back, unresponsive, with no pulse and no respirations. The notes also indicated Cardiopulmonary Resuscitation (CPR, an emergency lifesaving procedure performed when the heart stops beating) was started. The notes indicated that RN 1 called [DATE] at 11:25 pm and Resident 1 was transferred to GACH at 12:02 am. A review of Resident 1's Prehospital Care Report Summary (Paramedic Report), dated [DATE], indicated emergency services arrived at the facility on [DATE] at 11:41 pm. Resident was in cardiac arrest (the abrupt loss of heart function, breathing and consciousness [being awake]). Prehospital Care Report Summary indicated epinephrine (a medication that can help to open up air passages and make breathing easier for people with various lung problems) was administered by the paramedics on 11:45 pm and 11:50 pm while the resident was in the facility. Report summary indicated at [DATE], at 11:51 pm pulse rate and respiration were restored. A review of GACH laboratory chemistry (screening blood test that measures the levels of several substances in the blood) result dated [DATE] timed at 12:43 am, result showed critical high Lactate venous, the blood level result lactic acid (produced when oxygen levels become low in cells within the areas of the body) of 11. 6 millimoles per liter (mmol/L - shows the concentration of a substance in a specific amount of fluid) with reference range of 0.5 to 2.2 mmol/L. (According to https://labtestsonline.org/tests/lactate , high levels of lactate in the blood indicated lack of oxygen in the blood.) A review Emergency Department (ED) Note Physician, dated [DATE], timed at 4:32 am, indicated Resident 1 was brought in the ED after being found down next to her bed, tracheostomy was apparently somewhat dislodged (removed) and was unresponsive. ED Physician notes indicated paramedics were able to get return of pulses after two rounds of CPR and epinephrine (indicated in the treatment of cardiac arrest. It also indicated Resident 1 had lactic acidosis (lactic acid build up in the bloodstream). (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 0695 Level of Harm - Actual harm Residents Affected - Few	A review of the Discharge Summary at GACH, dated [DATE] and timed 6:02 pm, indicated the MRI test (Magnetic Resonance Imaging is a test that uses a magnetic field and radio waves to produce images of the brain and the brain stem) obtained on [DATE] at 4:15 pm, showed Resident 1 had global hypoxic injury (type of brain injury that occurs when the whole brain is deprived of oxygen, causing severe damage). A review of Resident 1's Certificate of death, dated [DATE] and timed at 5:37 pm, indicated the immediate cause of death was respiratory failure and anoxic encephalopathy (caused by a complete lack of oxygen to the brain, which results in the death of brain cells). A review of the undated Policy and Procedure (P&P) titled, Ventilator Flow Sheet Charting Guidelines, indicated to monitor the patient or resident ventilator system (machines that blow air-or air with extra oxygen-into airways and lungs) and identify changes in the patient or resident's condition and to verify that the ventilator is operating properly, assuring patency of the airway and maintaining the ordered settings. A review of the P&P titled, Care Plans-Comprehensive dated ,d+[DATE], indicated the Care Planning/Interdisciplinary Team is responsible for the review and update of care plan when there has been a significant change in the resident's condition. A review of the P&P titled, Change in a Resident's Condition or Status, dated ,d+[DATE], indicated the facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status.