

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 06/21/2022
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)
<p>F 0698</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781</p> <p>Based on interview and record review, the facility failed to provide hemodialysis (HD, removing of waste, salt, and extra water to prevent build up in the body for residents who have loss of kidney function) treatment for one (1) of two (2) residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> 1) Carry out the physician's order for Resident 1 to receive HD treatment every Tuesday, Thursday and Saturday. 2) Implement consistent transportation to HD center as indicated on the care plan titled, Transportation/Missing Dialysis. <p>As a result, Resident 1 missed 18 HD treatments from 11/23/2021 to 3/3/2022. On 3/4/2022 at 6:30 am, Resident 1 had shortness of breath (SOB), was transferred to the general acute care hospital 1 (GACH 1) via 911 (emergency services) and admitted to Intensive Care Unit (ICU, specialized treatment given to patients who are acutely unwell and require critical medical care).</p> <p>Findings:</p> <p>A review Resident 1's Face Sheet (Admission Record), indicated Resident 1 was initially admitted to the facility on [DATE] and with a most recent readmission on 2/25/2022. Resident 1's diagnoses were end stage renal disease (ESRD, when kidneys are no longer able to work as they should to meet the needs of the body), type 2 diabetes mellitus (adult onset diabetes, a chronic condition that affects the way the body processes blood sugar), morbid (severe) obesity (weight more than 80 to 100 pounds [lbs] above ideal body weight), and anemia (low blood count). Resident 1's weight on initial admission was 370 lbs.</p> <p>A review of Resident 1's Physician's Order, dated 11/17/2022, indicated an order for HD on Tuesdays, Thursdays, and Saturdays at 9:45 am to 1:30 pm with pick up time at 8:30 am.</p> <p>A review of Resident 1's care plan titled, Renal Dialysis, dated 11/18/2021, indicated Resident 1 needed dialysis every Tuesday, Thursday, and Saturday and the goal was to be free of substance and have fluid regulated through scheduled dialysis. Staff intervention included was to notify primary doctor of possible complications that may occur.</p> <p>(continued on next page)</p>

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 0698 Level of Harm - Actual harm Residents Affected - Few	<p>A review of Resident 1's Minimum Data Set (MDS, a comprehensive standardized assessment and care-screening tool), dated 11/23/2021, indicated Resident 1's brief interview of mental status (BIMS, screening that aids in detecting cognitive impairment) score was 15 (a score of 13-15 represents intact cognition [mental action or process of acquiring knowledge and understanding]). The MDS also indicated Resident 1 required extensive one person assist for dressing, toilet use and personal hygiene. Resident 1 required total dependence for bed mobility from 1 staff.</p> <p>A review of the Departmental Notes, dated 12/4/2021, timed at 6:42 pm, Resident 1 was sent out to GACH via 911 due to missed HD treatment.</p> <p>A review of the Departmental Notes, dated 12/5/2021, timed at 3:15 pm, Resident 1 was readmitted from GACH with no new orders. It indicated Resident 1 was dialyzed at GACH on 12/4/2021.</p> <p>A review of the Departmental Notes dated 12/13/2021 at 12:07 pm, Resident 1 was sent out to GACH via 911 for further evaluation due to missed HD treatment.</p> <p>A review Resident 1's Face Sheet, indicated Resident 1 was readmitted to the facility on [DATE].</p> <p>A review of Resident 1's Doctors Progress Notes, dated 2/2/2022, indicated assessment/plan for ESRD was for Resident 1 not to miss hemodialysis. Progress notes also indicated Resident 1 declined HD treatment due to transportation issue secondary to gurney being too small.</p> <p>A review of the Departmental Notes (Progress Notes), dated 2/24/2022, timed at 5:30 pm, Resident 1 was sent out to GACH via 911 due to SOB.</p> <p>A review of Resident 1's Physician's Order, upon readmission on 2/25/2022, indicated an order for HD on Tuesdays, Thursdays, and Saturdays with a pick up time at 8:30 am.</p> <p>During an interview on 4/22/2022 at 2:55 pm, LVN 1 stated Resident 1 had missed episodes of HD treatment (unable to verify dates) because the facility could not find a transportation to accommodate Resident 1's size. LVN 1 stated Resident 1 would have agreed to go for his HD treatment if the appropriate size of gurney was provided by the transportation company.</p> <p>During a concurrent interview with Registered Nurse 1 (RN 1) and record review of the Departmental Notes on 6/14/2022 at 2:44 pm, RN 1 stated Resident 1's Departmental Notes, dated 2/1/2022 at 7:19 pm indicated Resident 1 missed his scheduled hemodialysis due to transportation issues. RN 1 stated transportation did not arrive to pick up Resident 1 to go to his HD appointment. RN 1 stated, if Resident 1 continue to miss his HD treatments, he might end up with fluid overload (the condition of having too much water in your body), difficulty of breathing, or eventually lead to death.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview with SSD and record review of Resident 1's Vendor Request form, dated 1/5/2022, on 6/15/2022 at 12:27 pm, SSD stated the form included description of specific services requested to be provided by the vendor. SSD stated, Resident 1's Vendor Request form indicated request for dialysis transportation, however it should have included the request for bariatric gurney so the company would know what kind of transportation the resident needed. SSD stated, it was important that the proper gurney should have been requested from the transportation company to ensure Resident 1 could be transferred to the HD center safely.</p> <p>During an interview with SSD and concurrent record review of Resident 1's Progress Notes on 6/15/2022 at 11:48 am, SSD stated due to Resident 1's medical insurance, securing a transportation with bariatric gurney to accommodate Resident 1's size was difficult.</p> <p>During an interview on 6/15/2022 at 2:53 am, physician stated, he was aware Resident 1 missed his HD treatment schedule due to transportation issues. The physician stated facility should have tried to accommodate Resident 1's need to be transported to HD by providing the proper gurney size.</p> <p>During a concurrent interview with RN 3 and record review of Resident 1's Departmental Notes on 6/17/2022 at 8:02 am, RN 3 stated the Departmental Notes, dated 3/4/2022 at 7:28 am, indicated Resident 1 had difficulty breathing and was transferred to GACH via 911 since he missed most of his HD treatment as ordered. RN 3 stated, mostly due to transportation issues, Resident 1 could not get his HD treatments.</p> <p>A review of Resident 1's Situation-Background-Assessment-Recommendation (SBAR - a technique provides a framework for communication between members of the health care team about a patient's condition), dated 3/4/2022 at 7:41 am, indicated Resident 1 complained of SOB, with oxygen saturation (test that measures the amount of oxygen being carried by red blood cells) of 88 percent (%) and sent to GACH via 911.</p> <p>A review of Resident 1's GACH History and Physical (H&P) Reports, dated 3/4/2022 timed 3:53 pm, indicated Resident 1 was brought in by ambulance to the emergency department on 3/4/2022 at 12:16 am due to Resident 1 missing hemodialysis treatment for one week and a half due to difficulty with transportation.</p> <p>A review of Resident 1's GACH Operative Procedural Documentation, dated 3/6/2022 timed 5:25 pm, indicated Resident 1 was found to have cardiac tamponade and 1000 cubic centimeter (cc) of hemorrhagic fluid (bloody fluid from the heart) was obtained via ultrasound guided pericardiocentesis (procedure done to remove fluid that has built up in the sac around the heart (pericardium)).</p> <p>A review of Resident 1's Certificate of Death, dated 3/6/2020 and timed at 10 pm, indicated Resident 1's immediate cause of death were cardiac arrest (the abrupt loss of heart function, breathing and consciousness [being awake]), cardiac tamponade and chronic renal failure.</p>		