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	06/21/2022

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 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 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: 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. 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). Findings: 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. 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. 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. (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 0698 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. A review Resident 1's Face Sheet, indicated Resident 1 was readmitted to the facility on [DATE]. 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. 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. 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. 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. 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. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview with RN 2 and record review of Resident 1's Departmental Notes on 6/14/2022 at 2:56 pm, RN 2 stated she worked on 12/2/2021 and verified Resident 1 missed his HD treatment due to transportation issues, which was documented on the Departmental Notes on 12/2/2021 at 6:58 pm. RN 2 stated transportation did not show up to pick up Resident 1. RN 2 stated she also worked on 1/22/2022 and verified Resident 1 refused HD treatment on that day. RN 2 stated the gurney brought by the transportation company was too small for Resident 1. RN 2 stated this was documented on the Departmental Notes on 1/22/2022 at 4:33 pm. RN 2 stated if Resident 1 continued to miss his dialysis, resident could have sepsis (life-threatening condition that occurs when the body's response to an infection damages its own tissues), fluid overload, and cardiac tamponade (happens when extra fluid builds up in the space around the heart and puts pressure on the heart and prevents it from pumping well). During a concurrent interview with Director of Nursing (DON) and record review of Resident 1's Departmental Notes on 6/15/2022 at 10:39 am, DON stated the Department Notes indicated Resident 1 missed his scheduled HD treatments as ordered on the following dates with the following reasons: 1) 11/23/2021 - Per transportation company (Transport 1), Resident 1 was not on the list for 8:30 am pickup time. It was rescheduled to a later time, at 10 am, but transportation company did not come to pick up Resident 1. 2) 11/27/2021 - Transport 1 did not show up as scheduled. Resident 1 refused to go to a later time for HD treatment. 3) 12/2/2021 - Transport 1 did not show up as scheduled to pick up Resident 1. Physician was made aware and gave order to reschedule HD treatment. 4) 12/4/2021 - Transport 1 did not show up as scheduled to pick up Resident 1. Physician ordered to transfer Resident 1 to GACH via 911. 5) 12/11/2021 - Transport 1 went to Resident 1's home address instead of the facility. Physician was made aware and ordered GACH transfer, but Resident 1 refused. 6) 12/30/2021 - Missed HD treatment due to Resident 1 testing positive for Corona Virus 19 (COVID-19, a respiratory illness that can spread from person to person), a change in the HD center was needed since current HD center did not cater to Residents who were Covid 19 positive. 7) 1/2/2022 - Transportation issue (unspecified) 8) 1/12/2022 - Transportation company (unspecified) did not pick up Resident 1 as scheduled. Physician was made aware and ordered to continue monitoring Resident 1. HD treatment rescheduled for the next day, 1/13/2022 9) 1/22/2022 - Transport 2 arrived at the facility to pick up Resident 1 but brought a small sized gurney. Resident 1 refused to be transported since he did not want to be in pain and felt unsafe due to inability to raise the siderails. 10) 1/29/2022 - Transport 1 did not show up. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	11) 2/1/2022 - Transportation issue (unspecified) 12) 2/2/2022 - Transportation company (unspecified) arrived with a bariatric wheelchair (suitable for larger or heavier users with a wider seating and a higher weight capacity), however Resident 1 preferred bariatric gurney (a flat, padded stretcher with a variable-height and collapsible sturdy wheeled frame used by medical professionals to accommodate and transport patients of 300 pounds or more who require medical care). 13) 2/7/2022 - Transportation company (unspecified) did not show up. HD treatment was rescheduled arranged with a different transportation company. 14) 2/18/2022 - Transport 3 did not show up. Facility staff followed up and was made aware, transportation company will not be able to pick up due to Resident's weight. 15) 2/19/2022 - Transportation issue (unspecified). Resident refused to be transferred to GACH per physician's recommendation. 16) 2/21/2022 - Transportation company (unspecified) did not show up. 17) 2/23/2022 - Missed HD treatment due to unspecified reason. Resident refused to be transferred to GACH as per physician's recommendation. 18) 2/28/2022 - Missed HD treatment scheduled to be given at GACH due to Ambulance refusal to transport Resident 1 since this was not an emergency. During an interview on 6/15/2022 at 10:51 am, DON stated if Resident 1 continued to miss his HD treatment, resident could have a potential for fluid overload, SOB and could lead to death. DON also stated they should have arranged transportation from other transportation company that could provide the proper gurney size for Resident 1. DON added, they should have tried more resources to ensure Resident 1 not miss his HD treatment. During an interview on 6/15/2022 at 10:54 am, Administrator (Adm) stated, facility should have arranged a different transportation company, talk to Resident 1's family to encourage resident to be transferred to GACH until transportation issues have been resolved. Adm stated, the facility should have tried harder to find other alternatives to ensure a more consistent transportation to meet Resident 1's needs. Adm stated, the facility should have paid a different transportation company to ensure Resident 1 does not miss HD treatment as ordered. During a concurrent interview with Social Services Director (SSD) and record review of Resident 1's Departmental Notes on 6/15/2022 at 11:26 am, SSD stated social services was responsible to look for appropriate transportation to bring resident to HD center. SSD stated, administration should have paid for the transportation services that could provide a bariatric gurney on a consistent basis so Resident 1 would not miss any HD treatment scheduled days. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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). A review of Resident 1's Certificate of Death, dated 3/6/2020 and timed at 10 pm, indicated Resdient 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.