STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055619	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Colinas Post Acute	800 East 5th Street Ontario, CA 91764

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 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** 44262 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), was discharged home with the correct medication packs as ordered by physician. This failure contributed to a clinically compromised Resident 1 being discharged with 4 medications packs not prescribed and belonging to another resident. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: heart failure (heart does not pump blood as well), hypothyroidism (thyroid gland doesn't produce enough hormone, symptoms of fatigue, cold sensitivity, and weight gain), acute kidney failure (kidneys can't filter waste from blood). During a concurrent interview and record review of Resident 1's Medical Record with the Assistant Director of Nursing (ADON) and the License Vocational Nurse (LVN 1) reviewed and verified the following: 1. Post Discharge Plan of Care: Dated April 04, 2024: 6. Medications list: 1. hydralazine 50 mg 1 tab by mouth (amount released 15) (given for high blood pressure).2. minoxidil 2.5 mg 1 tab by mouth (amount released 11) (can treat for high blood pressure). 3.famotidine 20 mg 1 tab by mouth (amount released 30) (to treat and prevent stomach ulcers).4. omeprazole 40 mg 1 capsule by mouth (amount released 26) (to treat heart burn).5. MISSING medication, Levothyroxine 50mcg tablet as prescribed (to treat hypothyroidism). 2. Medication Orders for as of April 04, 2024, does not show the 4 medications shown in Post Discharge Plan of Care documentation provided to resident on discharge. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on April 10, 2024, with (LVN 1), LVN 1 stated, The normal process on discharging residents with their medications, is usually when resident is alert, I explain the medications, how many pills are left, and how they will be taken, all the medication. Or we give the Responsible Party the information. We use the medication list and check for the name and match the name on their wrist band. We have the Registered Nurse, another nurse and me checking the medications. I don't remember giving (Resident 1) another residents medication (bubble pack). After reviewing (R1) orders and comparing to the Post Discharge Plan of Care document, I don't see the 4 medications in question in the physician orders, I don't remember if there was an emergency, but we were helping each other with the RN supervisor. I see the discrepancy and it should not have happened. During a concurrent interview and record review on April 10, 2024, with the Assistant Director of Nursing (ADON), the ADON stated, This should not have happened, no resident should go with another resident's medication packs. If the resident might have taken the medication, they could have potential for adverse reaction and HIPPA (Health Insurance Portability and Accountability Act, privacy safeguarding medical information) because they have another resident information. During an interview on April 10, 2024, with the Director of Nursing (DON), the DON stated, The LVN, gathers all the residents' medications from the physician order and from there you write down the medications. I give them the medications and give info to resident I read it and check with the resident. I put a check mark with the family and patient, I want to make sure they agree with the medications and education, and they sign. Giving another resident's bubble pack medication to (Resident 1), it should not have happened. He could have had adverse reaction to the medications and HIPPA due to someone else's information. During a review of the facility's policy and procedure titled, Discharge Medications revised August 2018, the policy and procedure indicated: Unless otherwise specified by the facility policy, or contrary to current law or regulation, medications shall be sent with the resident upon discharge. Controlled substances may not be released to the resident upon discharge. Policy Interpretation and Implementation . 2. The charge nurse shall verify that the medications are labeled consistent with current physician orders including instructions for . 4. The nurse will reconcile pre-discharge medications with the resident's post-discharge medications. The medication reconciliation will be documented.