

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review the facility failed to ensure proper care was provided to prevent a pressure ulcer/injury (Pressure ulcers are injury that breaks down the skin and underlining tissue. They are caused when an area of skin is placed under pressure), from developing a stage 4 pressure injury to the coccyx (tailbone area), left heel dry blister, open blister left thigh, blister to right thigh, and open blister to lower back for one of three sampled residents (Resident 1). This failure placed a clinically compromised Residents (Resident 1) health and safety at risk. When the facility failed to prevent the formation of pressure ulcers to Resident 1 skin. 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: encephalopathy (alters brain function or structure, causes stroke, tumor .), dysphagia (difficulty swallowing), dementia (forgetfulness, impaired thinking abilities), difficulty walking, hypertension (high blood pressure), history of urinary tract infections (infection of urine), immunodeficiency (immune system compromised). During a review concurrent interview and record review of Resident 1's Medical Record with the Assistant Director of Nursing (ADON), reviewed are as follows: 1. Careplan on admission Prevention: Date Initiated: December 15,2023, At risk for skin breakdown r/t Decreased mobility/ anemia, will have no further complication: Interventions: Apply protective lotion/skin moisturizers after shower/pericare, Clean the resident's skin after each episode of incontinence, Dietary consult per protocol, Float/offload heels as tolerated, Labs per doctor order, Occupational Therapy eval to increase functional ability, Pharmacy consult per protocol, Pressure reducing mattress, Provide activities that allow for skin improvement, Provide skin care frequently (daily bath, shower 2x per week and pm). 2. NURSING - COMPREHENSIVE SKIN EVALUATION/ASSESSMENT - V 2(Skin evaluation) dated December 16, 2023, at 0740: Complete skin check done no pressure injuries skin is intact. BRADEN SCALE (predicting pressure ulcer risk)=10 (high risk). (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Change in Condition (COC) Note dated January 05, 2024, at 1244: Nursing observations, evaluation, and recommendations are: Treatment nurse notified about resident having black fungus noted to bilateral toenails. +2 pulses noted to the bilateral lower extremities, no pain noted, no tenderness to the feet, no warmth, no discoloration. Normal responses noted to tactile and painful stimuli. No pain to the bilateral calves. MD notified. New orders received for podiatry referral and Ketoconazole 2% to all toes for two times daily for 4 weeks. Orders placed and carried out. 4. COC Note January 18, 2024, at 1929: Skin breakdown Coccyx Nursing observations, evaluation, and recommendations are: upon ADL Certified Nursing Assistant (CNA) notified charge nurse of coccyx breakdown. Registered Nurse (RN) notified about the change in condition and doctor notified. Treatment order initiated. 5. Nurse Note dated January 19, 2024, at 2024, Resident alert nonverbal, no distress noted, no signs and symptoms of pain ., skin warm/dry to touch. noted to have Blister on right heel with open skin, sock was saturated with blood. Kept clean and dry, Continue to float heals, all needs met by staff, will continue to monitor. 6. NURSING - COMPREHENSIVE SKIN EVALUATION/ASSESSMENT - V 2 SKIN EVAL January 24, 2024, at 9:39, coccyx pressure injury stage 4 measuring 3.0cm x 2.2cm x 1.0cm with tunneling at 12 o'clock 4.0cm. Tissue quality 90% sough 10% granulation (healing process, pink new connective tissue) moderate drainage with no foul odor. left heel dry blister measuring 7.0cm x9.0cm x Unstageable Full Thickness Tissue Loss (UTD) with tissue quality 100% epithelial with maroon color to area. 7. Progress Note dated March 01, 2024, Open Blister Left thigh, March 11, 2024, (COC) Blister right thigh rear. April 22, 2024, (COC) Open blister to lower back, April 27, 2024, Right shin abrasion. 8. NURSING - COMPREHENSIVE SKIN EVALUATION/ASSESSMENT - V 2 SKIN EVAL July 02, 2024, at 1755: right hip Kennedy ulcer measuring 3.0cm x 5.0cm x (UTD) 100% slough (yellow/white material in wound) scant moderate drainage no foul odor with maroon color to surrounding area. coccyx pressure injury stage 4 measuring 2.0cm x 1.0cm x 1.0cm with tunneling at 12 o'clock of 2.5cm with tissue quality 80% granulation, 20% slough with moderate drainage no foul odor no swelling, no s/s of infection right lateral ankle arterial wound measuring 5.0cm x 3.3cm x 0.2cm tissue quality 20% slough 80% granulation moderate drainage no foul odor right lateral foot arterial wound measuring 2.5cm x 8.5cm x (UTD)with tissue quality 100% eschar (scab) with moderate drainage mild odor foul odor foley catheter 14f x 10cc for wound management draining yellow urine without any sediments (particles in urine). Resident transfer out to hospital. 9. Progress Note (Nurse Note) dated July 02, 2024, at 1647: Resident [family] at bedside and requested to send patient out to hospital for wound evaluation. [Family] stated that wound smelled. Patient skin warm to touch. Patient was clean and dry. Patient had no grimaces to pain. No SOB breathing was even and unlabored. Patient vitals Within Normal Limits (WNL). Hospice was notified recommended sent out to hospital. RN notified American Medical Response (AMR) called and patient was sent out to [acute hospital] for further evaluation. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on July 16, 2024, with the Treatment Nurse, Treatment nurse stated, Resident 1 did not have wounds on admission. The wounds should not have developed here, it was unavoidable due to all her comorbidities, poor meal intake incontinence, immunodeficiencies. It was getting worse which is why we had a meeting with family, and they were made aware of deterioration, it got bad within a week. During an interview on July 16, 2024, with the Assistant Director of Nursing (ADON), ADON stated, When Resident 1 was admitted , she was clean, no wounds, then developed a coccyx and heel wound around January 19 and 20th 2024. No, she did not come in with these wounds, we did had interventions for skin breakdown when they developed, further interventions were made for the wounds. The family requested resident to be sent out due to the wounds and hospice gave the order to be sent out. During an interview on July 16, 2024, with the Director of Nursing (DON), DON stated, Resident 1 did not come in with the any wounds, yes, they did develop in facility. With her condition she has poor circulation, it could have been prevented and it happens, and she is immunocompromised plus she is not eating well. We did reposition and turn, still developed the wounds. During a review of the facility's policy and procedure titled, Prevention of Pressure Injuries revised April 2020, the policy and procedure indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. During a review of the facility's policy and procedure titled, Pressure Ulcers/Skin Breakdown revised April 2018, the policy and procedure indicated, 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s).		