

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/04/2024
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 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 interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), had documented foley catheter monitoring was completed per shift as ordered. This failure resulted in a late entry documentation over 30 days and placed Resident 1's health and safety at risk when Resident 1 was sent out to acute hospital for further evaluation. 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: hemiplegia (partial or complete paralysis on one side of body), epilepsy (nerve activity causing seizures), chronic obstructive pulmonary disease (blocking airflow, hard to breath), personal history of urinary tract infections (urine/bladder infection). During a concurrent interview and record review of Resident 1's Medical Record with the Assistant Director of Nursing (ADON), reviewed are as follows: 1. Care plan: The resident has impaired immunity r/t .sepsis unspecified organism .The resident will not display any complications .Monitor/documents/report PRN any s/s of infection: Fever, Redness, drainage or swelling around wounds or catheter sites; Dysuria, hematuria, flank pain and foul-smelling urine. 2. Treatment Administration Record (TAR) September 2024: ORDER: Indwelling catheter: Monitor for change in urine character Document 0=none/C=Cloudiness, S=Sediments, F/S=Foul smell, B=Blood in urine, D/C= Deepening or Concentrating urine output, notify MD for potential UTI every shift. ORDER: Monitor proper placement, no kinking or compression that could obstruct urine flow to gravity bag during catheter care every shift. (From 15th-29th handwritten signatures and scanned into electronic chart, not electronically signed the day due . 3 missing electronic signatures from PM shift and 12 missing electronic signatures from NOC shift noted.) 3. Change of Condition (COC) dated October 07, 2024: Tachycardia, ALOC vital signs BP 126/83, Pulse 150, RR 20, Temp 98.2 .Doctor order to send to acute hospital, family made aware. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055619	Facility ID: 055619 If continuation sheet Page 1 of 2

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the License Vocational Nurse (LVN 1), (LVN1) stated, I did not notice any changes to urine or foley. I did sign late entry, I forgot to sign, it's on (TAR). So, they printed the (TAR) and they did in-service. I work the 11PM-7AM shift. Yes, I should have signed the day of, I missed to document the (ETAR) but I got in-serviced, because I do check all my residents, I just forgot to sign it off. During an interview with the Assistant Director of Nursing (ADON), ADON stated, we identified the (TAR) September 2024, missing signatures, this was on November 04, 2024, when the Ombudsman asked for it, that's when we noticed the missing signatures. We have 30 days for late entries, we did In-services for the nurses and started QUAPI. We are allowed to do late entry, we talked to the licensed nurses, they attested that they did check the foley. We asked the nurses . If you are signing the paper (TAR), you are signing you did do the assessment, they stated yes! They should have signed it when they did their assessment, and it was late. During a review of the facility's policy and procedure titled, Charting and Documentation revised July 2017, the policy and procedure indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .The following information is to be documented in the resident medical record: a. Objective observations b. Medications administered c. Treatments or services performed .Documentation of procedures and treatments will include care-specific details, including a. The date and time the procedure/treatment was provided b. The name and title of the individual(s) who provided the care c. The assessment data and/or any unusual findings obtained during the procedure/treatment f. The signature and title of the individual documenting. During a review of the facility's policy and procedure titled, Charting Errors and or Omissions revised December 2006, the policy and procedure indicated, Accurate medical records shall be maintained by this facility . 2. If it is necessary to change or add information in the resident's medical record, it shall be completed by means of an addendum and signed and dated by the person making such change or addition. 3. Late entries in the medical record shall be dated at the time of entry and noted as a late entry. 5. All corrections, changes, or addenda must be signed and dated by the person making such entries. During a review of License Vocational Nurse Job Description .Human Resources 11-2018; Essential duties: Charting and Documentation: Complete and file required recordkeeping forms/charts upon the resident's admission, transfer, and/or discharge. Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care. Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. Sign and date all entries in the resident's medical record.		