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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Las Colinas Post Acute	800 E 5th St 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their Change in a Resident Condition or Status policy and procedure was implemented for one of three sampled residents (Resident 1) when Resident 1's spouse was not informed of Resident 1s transfer to the hospital.This failure had the potential to place Resident 1 and Resident 1's spouse in emotional distress.Findings:During a review of Resident 1's admission Record (general demographics information), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included fracture (broken leg bone) to left femur (upper leg), bone cancer (malignant tumor in bones), diabetes mellitus type 2 (chronic metabolic disorder characterized by high/low blood sugar), and hypertension (high blood pressure).During a review of Resident 1's Situation Background, Assessment, Review and Notify nursing notes, dated April 6, 2026, it indicated Other change in condition: ALOC, Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse). Resident noted to be responsive at 06:00AM. Certified Nursing Assistant (CNA) attempted to wake up resident and resident was unable to be aroused at 07:40AM as CNA was bringing meal tray to resident. CNA called out for charge nurse. Charge nurse assessed resident and noted to not be responsive to name and hard to arouse. Charge assessed resident's Vital Signs at 7:45AM Blood pressure 136/81, heart rate140, Blood Sugar 448, Oxygen 80% Room Air. Registered Nurse (RN) assessed resident and mask administered. At 07:50AM Vital Signs: blood pressure140/98, Blood sugar 440 oxygen 97% NRB 4L, pulse 126. Emergency response called.During a concurrent interview and record review, on April 15, 2026, at 12:15 PM, with the Director of Nursing (DON), the DON stated Resident 1's spouse was upset and claimed that she was not informed of Resident 1's transfer to the hospital. The DON reviewed Resident1's face sheet and Physician Orders for Life Sustaining Treatment (POLST), and stated the forms had different phone numbers listed for Resident 1's spouse. The DON further stated the Admissions Coordinator encoded the information on Resident 1's face sheet, which led to Resident 1's spouse not being notified of the transfer.During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status revised February 2021, the P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the residents medical/mental condition and or status.10. The business office manager or designee will verify the address and telephone number of the resident's family or representative (sponsor) on a quarterly basis. Any noted changes will be reported to the director of nursing services to ensure that such information is changed in the resident's medical record.

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

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	05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their Charting and Documentation, Change in a Resident Condition or Status policy and procedure was implemented for one of three sampled residents (Resident 1) when Resident 1's face sheet listed an incorrect phone number of Resident 1's spouse.This failure resulted in Resident's 1's spouse not being informed of Resident 1's transfer to the hospital. Findings:During a review of Resident 1's admission Record (general demographics information), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included fracture (broken bone) to left femur (upper leg), bone cancer (tumor to the bones in body), diabetes mellitus type 2 (chronic metabolic disorder characterized by high/low blood sugar), and hypertension (high blood pressure).During a review of Resident 1's Situation Background, Assessment, Review and Notify nursing notes, dated April 6, 2026, it indicated Other change in condition: ALOC, Altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse). Resident noted to be responsive at 06:00AM. Certified Nursing Assistant (CNA) attempted to wake up resident and resident was unable to be aroused at 07:40AM as CNA was bringing meal tray to resident. CNA called out for charge nurse. Charge nurse assessed resident and noted to not be responsive to name and hard to arouse. Charge assessed resident's Vital Signs at 7:45AM Blood pressure 136/81, heart rate140, Blood Sugar 448, Oxygen 80% Room Air. Registered Nurse (RN) assessed resident and Non- Re Breather mask administered. At 07:50AM Vital Signs: blood pressure140/98, Blood sugar 440 oxygen 97% NRB 4L, pulse 126. Emergency response called.During a concurrent interview and record review, on April 15, 2026, at 12:15 PM, with the Director of Nursing (DON), the DON stated Resident 1's spouse was upset and claimed that she was not informed of Resident 1's transfer to the hospital. The DON reviewed Resident1's face sheet and Physician Orders for Life Sustaining Treatment (POLST), and stated the forms had different phone numbers listed for Resident 1's spouse. The DON further stated the Admissions Coordinator encoded the information on Resident 1's face sheet, which led to Resident 1's spouse not being notified of the transfer.During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation revised on July 2017, the P&P indicated, .3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.