

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

Printed: 07/18/2026
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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to label the food belonging to one unsampled resident (Resident 121). This deficient practice could potentially raise the risk of foodborne illnesses among residents, due to staff inability to verify the safety and freshness of the food. During an observation in the facility family room and concurrent interview with Kitchen Staff (KS) on 8/27/25 at 6:00 AM., a closed black bag containing noodles and one plastic container of soup without label were found inside the shared residents' refrigerator for food brought in by family and visitors. A posting outside the shared residents' refrigerator stated All food must have resident's name, room number and date. If any information is missing, it will be thrown out. The KS stated that all food stored inside the residents' refrigerator must be labeled with the room number and resident's name. During an interview with the Director of Food and Nutritional Services (DFNS) on 8/27/25 at 8:40 AM, the DFNS confirmed that all food inside the shared residents' refrigerator is supervised by kitchen staff and must be labeled with resident's name and room number. A review of the facility's policy and procedure titled, Food Receiving and Storage dated 1/2024, indicated, .a. The facility has the right to dispose of any food from outside sources that is not labelled and dated accordingly.		

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: 055619	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control and prevention measures when: Certified Nursing Assistant (CNA) 1 did not perform handwashing before and after handling nasal cannula (flexible tube to deliver oxygen into the nose) to Resident 186. The incentive spirometer (a handheld device that exercises your lungs and measures how much air you can breathe in) placed at Resident 148's bedside, was unlabeled and not properly stored. The temperature settings for two of three dryers in the laundry area were below the normal range. The glucometer machine (a device used to measure how much sugar is in the blood) used for Residents 131, 93, and 69 was not sanitized. Licensed Vocational Nurse (LVN) 9 did not disinfect the blood pressure (BP) device prior to measuring the BP of Resident 110. These failures had the potential for cross contamination and spread of infection which can adversely affect the health and wellbeing of 207 medically compromised residents, staff, and visitors. 1. During an initial tour observation, outside Resident 186's room, on 8/25/25, at 9:15 AM, Resident 186 was observed in a wheelchair, assisted by CNA 1. Noted CNA 1 pushing Resident 186's wheelchair into the hallway and then applying a nasal cannula to Resident 186's nostrils. Did not observe CNA 1 perform handwashing before and after applying the nasal cannula. During an interview with CNA 1, on 8/25/25, at 9:17 AM, CNA 1 stated that handwashing should be performed before and after applying nasal cannula to a resident to prevent bacterial infection. During an interview with Licensed Vocational Nurse (LVN) 1, on 8/25/25, at 9:18 AM, LVN 1 stated that staff should do handwashing or wear gloves before and after applying nasal cannula to a resident. During an interview with the Infection Preventionist (IP), on 8/27/25, at 9:25 AM, the IP confirmed the importance of handwashing before and after handling nasal cannula to prevent infection. During an interview with the Director of Nursing (DON), on 8/28/25, at 10:51 AM, the DON confirmed that staff must wash their hands during each resident care for infection control and prevention. A review of Resident 186's Face Sheet (front page of the chart that contains a summary of basic information about the resident), indicated that resident was admitted to the facility on [DATE], with diagnoses which included Shortness of Breath and Orthostatic Hypotension (a condition where blood pressure drops significantly upon standing or sitting up from a lying position). A review of facility's policies and procedures titled, Handwashing/Hand Hygiene, revised in October 2023, indicated, Policy Interpretation and Implementation. Administrative Practices to Promote Hand Hygiene. 1. All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Indications for Hand Hygiene. Hand hygiene is indicated: a. immediately before touching the resident; .c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment. 5. The use of gloves does not replace handwashing/hand hygiene. 2. During an initial tour observation, in Resident 148's room, on 8/25/25, at 8:55 AM, Resident 148 was noted asleep in bed. A shelf was observed by Resident 148's bedside, where an incentive spirometer was placed. The incentive spirometer was unlabeled, uncovered, and not stored in a protective bag. (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the Infection Preventionist (IP), on 8/25/25, at 9:06 AM, in Resident 148's room, the IP verified that the incentive spirometer was unlabeled and not stored appropriately. The IP stated that the incentive spirometer should not be left exposed, as it could cause an infection if placed in the resident's mouth. A review of Resident 148's Order Summary Report for August 2025, indicated no order of incentive spirometer. A review of Resident 148's Face Sheet (front page of the chart that contains a summary of basic information about the resident), indicated that resident was admitted to the facility on [DATE], with diagnoses which included Essential Hypertension (high blood pressure) and Type 2 Diabetes Mellitus (a long-term condition that causes high blood sugar levels). A review of Resident 148's Care Plan Report, initiated on 7/31/25, indicated, Focus. Respiratory: Resident requires pulmonary hygiene interventions due to an acute complication of the respiratory system. Interventions. Incentive Spirometer as ordered. A review of Resident 148's Order Summary Report for 7/1/25 through 7/31/25, indicated, Initiate Incentive Spirometer TID (three times a day) for 5 to 10 breath cycles or as tolerated for 10 days with volume metric/goal based on resident's Predictive Nomogram (a tool that represents as scoring system) value of 1550ml (milliliters), related to: (diminished lung sounds). May start at 1000ml until Predictive Nomogram goal is achieved. Instructions: Provide 15 minutes to include the time the Respiratory Therapist/Nurse spends with the resident including evaluation/assessment, treatment administration and monitoring, and setup and removal of equipment. With start date of 7/31/25 and end date of 8/10/25. During an interview and concurrent record review with Registered Nurse (RN) 2, on 8/28/25, at 9:46 AM, Resident 148's physician's order and Medication Administration Record (MAR) were reviewed. The records indicated that Resident 148's incentive spirometer order was started on 7/31/25 and completed on 8/10/25. RN 2 stated that once completed, the incentive spirometer should be discarded or, if retained, it must be stored appropriately. During an interview with the Director of Nursing (DON), on 8/28/25, at 10:51 AM, the DON stated that licensed nurses were responsible for assisting residents with the use of the incentive spirometer and discarding it upon completion of the order. The incentive spirometer should be labeled with names and dates and stored properly. The DON verified that Resident 148 could be at risk of developing a respiratory infection if the incentive spirometer was used continuously. A review of facility's policies and procedures titled, Prevention of Infection Respiratory Equipment, revised in November 2011, indicated, Purpose. The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff. Infection Control Considerations Related to Medication Nebulizers (a medical device that turns liquid medication into a fine, inhalable mist to be delivered deep into the lungs, primarily for treating respiratory conditions) / Continuous Aerosol (a suspension of fine solid particles or liquid droplets in a gas, usually air): .3. Store the circuit in plastic bag, marked with date and resident's name and replace tubing and plastic bag once a week. 3. During a tour of the laundry area, on 8/26/25 at 2:23 PM, all three dryers in the laundry were observed to be in use with settings on High. Dryer 1 had towels, Dryer 2 had bed sheets, and Dryer 3 (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	had residents' clothes. The temperatures of the dryers were noted as follows: Dryer 1 at 140 degrees Fahrenheit, Dryer 2 at 230 degrees Fahrenheit, and Dryer 3 at 100 degrees Fahrenheit. A review of the facility's laundry area Dryer Temperature Log for August 2025 revealed that the temperatures for all three dryers were recorded at 180 degrees Fahrenheit from 8/1/25 through 8/26/25. During an interview with the Environmental Services Director (ESD), on 8/26/25, at 2:31 PM, the ESD stated that the temperature issue should be reported to maintenance, as the dryer temperature was required to be at least 180 degrees Fahrenheit. During an interview with the Laundry Staff (LS), on 8/26/25, at 2:34 PM, the LS stated, The reason why it's low is because if it gets to 180 degrees the clothes will burn, and we need to open it every 15 minutes. The linen will have wrinkles if it's too hot and the residents don't like it. The LS added that during the morning, the dryer temperatures were at 180 degrees Fahrenheit, however, the temperatures decreased in the afternoon as the staff needed to open the dryers every 15 minutes to prevent the towels and linens from burning. During an interview with the Maintenance Director (MTD), on 8/26/25, at 2:45 PM, the MTD stated that there might be an issue with the thermostat, which could cause the low temperature. The MTD added, We need to replace it. Will check with my scanner. I did not receive any report with low temperature. The MTD confirmed and verified that the temperature of two dryers was below the normal range. During subsequent interview with the ESD, on 8/26/25 at 2:55 PM, it was stated that dryer temperatures of 100- and 140-degrees Fahrenheit were too low and needed immediate correction. The ESD confirmed and verified that the temperature of two dryers was below the normal range. The ESD added, We don't have policy for the dryers, we just follow the California regulations that dryer temperatures should be at 180 degrees and above. During an interview with the Infection Preventionist (IP), on 8/27/25, at 9:25 AM, the IP stated, We will have it fixed. With low temperature, there's a risk for the organism not being killed. We have to maintain the temperature to eliminate the organisms. The IP also stated there were no residents infected with scabies or other skin conditions requiring contact precautions. During an interview with the Director of Nursing (DON), on 8/28/25, at 10:51 AM, the DON confirmed and verified that dryer temperatures of 100- and 140-degrees Fahrenheit were low. The DON stated, It's the facility's responsibility to maintain the equipment in good condition. A review of facility's laundry dryer manual titled, 110 Pound Capacity. Installation Operation Maintenance Parts and Service Manual for Drying Tumblers, indicated, Temperature Control Thermostats. Located nearest the front of the dryer is the high heat thermostat calibrated to open at 185 degrees F +/- and close at 170F +/- 5F. This thermostat operates when the times is places in the A cycle for cotton and linens. A review of facility's policies and procedures titled, Laundry and Bedding, Soiled, revised in September 2022, indicated, Policy Statement. Soiled laundry/bedding shall be handled, transported (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and processed according to best practices for infection prevention and control. Storage. 4. Laundry equipment (e.g., washing machines, dryers) is used and maintained according to the manufacturer's IFU (Instructions for Use) to prevent microbial contamination of the system. A review of facility's policies and procedures titled, Departmental (Environmental Services) & Laundry and Linen, revised in January 2014, indicated, Purpose. The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen . Washing Linen and other Soiled Items. 5. Follow manufacturer's instructions for all laundry processing materials (equipment, detergents, rinses, etc.). A review of facility's policies and procedures titled, Maintenance Service, revised in December 2009, indicated, Policy Statement. Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 4. During a medication administration observation on 8/27/25 at 6:40 AM, 6:45 AM and 6:54 AM, with LVN 7 for Residents 131, 93, and 69, respectively, LVN 7 was observed using the glucometer to assess the residents' blood sugar level. However, LVN 7 did not disinfect the glucometer before and after use on each resident. During an interview with LVN 7 on 8/27/25 at 7:02 AM, LVN 7 stated the glucometer should be disinfected before and after use on each resident. LVN 7 verified she did not disinfect before or after use of the glucometer when she checked the blood sugars for Resident 131, Resident 93, and Resident 69. During an interview with the Director of Nursing (DON) on 8/29/25 at 10:54 AM, the DON stated the glucometer should have been disinfected before and after use for each resident. The DON acknowledged the finding. A review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces revised 6/2009, indicated .environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities. Most non critical items can be decontaminated where they are used. According to the Centers for Disease and Control (CDC)'s article titled Considerations for Blood Glucose Monitoring and Insulin Administration dated 8/7/24, the recommendations for blood glucose monitoring included to .clean and disinfect blood glucose meters after every use. 5. During a concurrent medication administration observation and interview with LVN 9 on 8/27/25 at 9:29 AM, LVN 9 stated Resident 110's BP needs to be checked prior to the administration of medications. LVN 9 proceeded to measure Resident 110's BP. LVN 9 acknowledged not disinfecting the BP device prior to applying it on Resident 110's wrist. LVN 9 further stated the BP device needs to be disinfected before and after measuring a resident's BP. During a concurrent interview and record review with the Infection Preventionist (IP) on 8/29/25 at 10:40 AM, the facility's policy and procedure (P&P) titled Cleaning and Disinfection of Environmental Surfaces with a revised date of June 2009 was reviewed. The P&P indicated, in part, . 1(c). Non-critical items are those that come in contact with intact skin but not mucous membranes. Most (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	non-critical items can be decontaminated where they are used. The IP acknowledges a BP device is considered a non-critical item. The IP stated the device needs to be disinfected before and after measuring a resident's BP. A review of the facility's policy and procedure (P&P) titled Administering Medications revised in April 2019 indicated, in part, . 25. Staff follows established facility infection control procedures for the administration of medications, as applicable.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure two out of three laundry dryers were heating properly as per the manufacturer's recommendations. This failure could prolong the heating cycle of the dryers, consequently delaying the availability of clean clothes and linens for residents. During a tour of the laundry area, on 8/26/25 at 2:23 PM, all three dryers in the laundry were observed to be in use with settings on High. Dryer 1 had towels, Dryer 2 had bed sheets, and Dryer 3 had residents' clothes. The temperatures of the dryers were noted as follows: Dryer 1 at 140 degrees Fahrenheit, Dryer 2 at 230 degrees Fahrenheit, and Dryer 3 at 100 degrees Fahrenheit. A review of the facility's laundry area Dryer Temperature Log for August 2025 revealed that the temperatures for all three dryers were recorded at 180 degrees Fahrenheit from 8/1/25 through 8/26/25. During an interview with the Environmental Services Director (ESD), on 8/26/25, at 2:31 PM, the ESD stated that the temperature issue should be reported to maintenance, as the dryer temperature was required to be at least 180 degrees Fahrenheit. During an interview with the Laundry Staff (LS), on 8/26/25, at 2:34 PM, the LS stated, The reason why it's low is because if it gets to 180 degrees the clothes will burn, and we need to open it every 15 minutes. The linen will have wrinkles if it's too hot and the residents don't like it. The LS added that during the morning, the dryer temperatures were at 180 degrees Fahrenheit, however, the temperatures decreased in the afternoon as the staff needed to open the dryers every 15 minutes to prevent the towels and linens from burning. During an interview with the Maintenance Director (MTD), on 8/26/25, at 2:45 PM, the MTD stated that there might be an issue with the thermostat, which could cause the low temperature. The MTD added, We need to replace it. Will check with my scanner. I did not receive any report with low temperature. The MTD confirmed and verified that the temperature of two dryers was below the normal range. During subsequent interview with the ESD, on 8/26/25 at 2:55 PM, it was stated that dryer temperatures of 100- and 140-degrees Fahrenheit were too low and needed immediate correction. The ESD confirmed and verified that the temperature of two dryers was below the normal range. The ESD added, We don't have policy for the dryers, we just follow the California regulations that dryer temperatures should be at 180 degrees and above. During an interview with the Director of Nursing, on 8/28/25, at 10:51 AM, the DON confirmed and verified that dryer temperatures of 100- and 140-degrees Fahrenheit were low. The DON stated, It's the facility's responsibility to maintain the equipment in good condition. A review of facility's laundry dryer manual titled, 110 Pound Capacity. Installation Operation Maintenance Parts and Service Manual for Drying Tumblers, indicated, Temperature Control Thermostats. Located nearest the front of the dryer is the high heat thermostat calibrated to open at 185 degrees F +/- and close at 170F +/- 5F. This thermostat operates when the times is places in the A cycle for cotton and linens. A review of facility's policies and procedures titled, Laundry and Bedding, Soiled, revised in September 2022, indicated, Policy Statement. Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Storage. 4. Laundry equipment (e.g., washing machines, dryers) is used and maintained according to the manufacturer's IFU (Instructions for Use) to prevent microbial contamination of the system. A review of facility's policies and procedures titled, Maintenance Service, revised in December 2009, indicated, Policy Statement. Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.		

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

Printed: 07/18/2026
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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to ensure the main entrance door frame was sealed and the door closed properly, creating entry points for pests. This failure had the potential to affect the health and well-being of 207 residents by allowing disease carrying pests an easy entry point into the facility, which could adversely affect residents' health and well-being. During an observation on 8/26/25 at 8:25 AM, at the facility's main entrance, gaps were noted in the door frame. During an interview with Resident 103 on 8/26/25 at 9:05 AM, Resident 103 stated being bitten by a mosquito three days prior and believed the mosquitoes were entering through the main entrance when people came and went. During a review of the Orkin pest control report dated 6/16/25 the Orkin report indicated open gaps in the front exterior door and recommended adding weather stripping. During an interview with Resident 22 on 8/27/25 at 7:49 AM, Resident 22 stated they do not see bugs every day, but do see them occasionally, particularly when food trays were in the room. During an observation on 8/27/25 at 11:59 AM near nursing station three, there was a fly spotted in the air. During a concurrent observation and interview with Receptionist 1 (R1) and Receptionist 2 (R2) on 8/27/25 at 12:31 PM, R2 stated that the door is not fully closed. R1 and R2 both stated the door does not close properly every time, especially when it is not opened fully by the person entering. During a concurrent observation and interview with R1 at the main entrance on 8/28/25 at 8:56 AM, R1 verified the main entrance door was not closed properly. During a concurrent observation and interview with the Maintenance Service Director (MTD) at the main entrance on 8/28/25 at 9:03 AM, the MTD stated they can see the gaps on the sides, middle, and bottom of the door and pests would be able to enter. During a concurrent interview and record review on 8/28/25 at 10:45 AM, with the MTD and Administrator (ADM) the Orkin pest control dated 6/16/25 was reviewed. The Orkin report indicated that there were open gaps in the front exterior door and recommended adding weather stripping. MTD stated a note was written in the maintenance book about weather stripping but could not provide documentation to verify the repair took place. During a concurrent observation and interview on 8/28/25 at 10:55 AM, with the ADM and MTD at the main entrance. The ADM stated that gaps were present in the main entrance door making it easier for pests to enter the facility. The ADM also stated the door does not always close properly. The ADM further stated that this would be an easy fix with weather stripping and the MTD will fix the weather stripping and adjust the door to close the gaps. A review of the facility's Pest Control policy, dated May 2008, indicated, This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure advance care planning was completed properly for 8 of 18 sampled residents (Residents 8, 10, 13, 15, 76, 96, 141 and 170) when: A Physician Orders for Life Sustaining Treatment (POLST, a medical form that documents a patient's wishes regarding end-of-life care) was not completed for Resident 141. There was no documentation to indicate Resident 170 received written information addressing advance directives (a document that communicates a person's wishes about health care decisions in the event the person becomes incapacitated of making health care decisions). Resident 13 was not reassessed properly for advance directive. There was no documentation to indicate Resident 96 received written information addressing advance directives. There was no documentation to indicate Resident 10 received written information addressing advance directives. There was no documentation to indicate Resident 76 received written information addressing advance directives. There was no documentation to indicate Resident 15 received written information addressing advance directives. There was no documentation to indicate Resident 8 received written information addressing advance directives. These failures could result in residents receiving unnecessary treatment during an emergency situation. 1. A review of Resident 141's Face Sheet (front page of the chart that contains a summary of basic information about the resident), indicated that resident was admitted to the facility on [DATE], with diagnoses which included Acute Respiratory Failure with Hypoxia (a serious medical condition where the lungs cannot provide enough oxygen to the body) and Hypertension (high blood pressure). A review of Resident 141's POLST form revealed that Section A (Cardiopulmonary Resuscitation - CPR, helps save a life when the heart stops beating), Section B (Medical Interventions) and Section C (Artificially Administered Nutrition) were left blank. Section D (Information and Signatures) had the physician's signature dated [DATE], but it did not include the signature of the patient or legal decision-maker. During an interview with Registered Nurse (RN) 3, on [DATE], at 8:44 AM, RN 3 stated the importance of timely signing and completing the POLST was to ensure accurate care for residents. During an interview with RN 4, on [DATE], at 8:49 AM, regarding the importance of timely completion of the POLST, RN 4 stated, In case of an emergency we know what to do. During an interview with the Director of Nursing (DON), on [DATE], at 10:51 AM, the DON stated that licensed nurses were responsible for contacting the physician and resident's family in completing the POLST. The DON added that POLST should be completed within 48 hours of admission. Additionally, it should be reviewed and discussed during the care conference meeting a few days following the admission. The DON mentioned that if the POLST was not completed on time, and full code treatment was provided to a resident while the family preferred Do Not Resuscitate (DNR - not to perform CPR if patient's heart or breathing stops), the facility could potentially face a lawsuit. The DON confirmed that it was essential to complete the POLST form within 48 hours of admission. A review of facility's undated policies and procedures titled, Physicians Orders for Life-Sustaining Treatment (POLST), indicated, Completing POLST. To be valid a POLST form must be signed by (1) physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Any incomplete section of POLST implies full treatment for that section. 2. A review of Resident 170's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 170's History and Physical Examination dated [DATE], indicated the resident had the capacity to understand and make decisions for the resident's care. A review of Resident 170's Physician's Orders for Life-Sustaining Treatment (POLST, a medical document that outlines a patient's wishes regarding end-of-life care) signed by a physician on [DATE] indicated the resident did not have an advance directive. During a concurrent interview and record review with the Social Services Director (SSD) on [DATE] at 4:31 PM, the facility's P&P (policy and procedure) titled Advance Directives with a revised date of [DATE] was reviewed. The policy indicated, in part, .2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. 3. The written information. is provided in a manner that is easily understood by the resident or representative. The SSD acknowledged the facility provides a document to a resident or the resident's representative titled Information Sheet Advance Care Directives, (a written information addressing advance directive) during admission assessment and annually to ensure such directives are still the wishes of the resident. During a concurrent interview and record review with the SSD on [DATE] at 6:35 AM, the SSD further reviewed Resident 170's medical record for a documentation indicating the resident received the written information about Advance Directive provided by the facility. The SSD stated, there was no documentation indicating Resident 170 received the written information for Advance Directive from the facility. The SSD also stated the information sheet is provided to the resident either electronically or physically. The SSD further stated the facility receives a confirmation report if the resident received the written information electronically. The SSD verified there was no documentation indicating that Resident 170 received the written information about Advance Directive electronically or physically. 3. A review of Resident 13's admission Record indicated the resident was admitted to the facility on [DATE]. A review of Resident 13's History and Physical Examination dated [DATE] indicated the resident did not have the capacity to understand and make decisions. During a concurrent interview and record review with the SSD on [DATE] at 4:31PM, Resident 13's POLST dated [DATE] was reviewed. The SSD stated a check mark on the Advance Directive in the resident's POLST form meant the resident had an advance directive. During a concurrent interview and record review with the SSD on [DATE] at 6:35 AM, Resident 13's IDT Conference Summary dated [DATE] was reviewed. The SSD stated the resident's current wishes and the resident's POLST was reviewed during the quarterly assessment of preferred intensity of care and advance directive. The SSD verified Resident 13 did not have an advance directive. The SSD confirmed that the check mark for the advance directive on the resident's POLST was completed inaccurately. (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. A review of Resident 96's admission Record (front page of the chart that contains a summary of basic information about the resident), indicated Resident 96 was admitted to the facility on [DATE]. A review of Resident 96's POLST dated [DATE], indicated Section D (Advance Directive) of the form was incomplete. The boxes indicating who the Advanced Directives were discussed with was left unchecked, and further review of the section showed Resident 96 did not have an Advance Directive. A review of Resident 96's MDS, dated [DATE], indicated Resident 96 had a Brief Interview for Mental Status, (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 12 (moderate cognitive impairment). A review of Resident 96's History and Physical, dated [DATE], indicated Resident 96 was able to make needs known, but could not make medical decisions. During a concurrent interview and record review with the SSD on [DATE] at 9:26 AM, Resident 96's ISO Report Sent Confirmation, dated [DATE] was reviewed. The ISO Report Sent Confirmation indicated Resident 96's sibling received general information of the facility; however, further review verified that the document, did not include written information regarding Advance Directives. The SSD stated that the residents and their families were asked to bring in a copy of their Advance Directive upon admission. If the residents did not have an Advance Directive, written information on how to formulate an Advance Directive would be provided. The SSD verified that the information on how to formulate the advance directive was not in Resident 96's medical record. 5. A review of Resident 10's admission Record (front page of the chart that contains a summary of basic information about the resident), indicated Resident 10 was initially admitted to the facility on [DATE] with original admission of [DATE]. A review of Resident 10's POLST (Physicians Orders for Life Sustaining Treatment) dated [DATE], indicated Section D (Advance Directive) of the form was incomplete. Additionally, the form indicated Advanced Directives were discussed with Resident 10; however further review of the section did not indicate if Resident 10 had an Advance Directive. A review of Resident 10's Minimum Data Sheet (MDS), dated [DATE], indicated Resident 10 had a Brief Interview for Mental Status, (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgment status of the resident) score of 12 (moderate cognitive impairment). A review of Resident 10's History and Physical, dated [DATE], indicated Resident 10 had the capacity to understand and make decisions. During a concurrent interview and record review with the SSD on [DATE] at 9:26 AM, Resident 10's ISO Report Sent Confirmation, dated [DATE] was reviewed. The ISO Report Sent Confirmation indicated Resident 10's sister received general information of the facility; however, further review verified that the document, did not include written information regarding Advance Directives. The SSD stated that the residents and their families were asked to bring in a copy of their Advance Directive upon admission. If the residents did not have an Advance Directive, written information on how to formulate an Advance Directive would be provided. The SSD verified that the information on how to formulate the advance directive was not in Resident 10's medical record. (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Resident 10 on [DATE] at 10:38 AM, Resident 10 stated, not being informed about Advance Directive. Resident 10 also confirmed not receiving any written information about how to formulate an Advance Directive. 6. A review of Resident 76's History and Physical (H&P) dated [DATE], indicated Resident has the capacity to make decisions. A review of Resident 76's quarterly MDS (Minimum Data Sheet & a standardized assessment and screening tool) dated [DATE], indicated Resident has a BIM score of 15 (an assessment uses a point system that ranges from 0-15; 0-7 points suggests severe cognitive impairment; 8-12 points suggests moderate cognitive impairment, and 13-15 points suggests that cognition is intact). During a concurrent interview and record review with the Social Services Director (SSD) on [DATE] at 8:12 AM, the SSD confirmed there was no written acknowledgement provided to the resident and/or family member to formulate an advance directive. During a concurrent interview and record review with the Director of Nursing (DON), on [DATE] at 11:21 AM, the DON confirmed there was no written acknowledgement given to the resident and/or family member to formulate an advance directive. 7. A review of Resident 15's admission record indicated the resident was admitted to the facility on [DATE] with diagnoses (identification of disease process) which included altered mental status (change in cognitive function). A review of Resident 15's history and physical notes dated [DATE] indicated Resident 15 had the capacity to make decisions. A review of Resident 15's Minimum Data Set (MDS - a resident assessment tool) dated [DATE] indicated a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation and judgement status of the resident) summary score of 12 out of 15. During an interview with the Director of Nursing (DON) on [DATE] at 10:38 AM, the DON confirmed there was no proof that an advance directive was offered to Resident 15. The DON also stated, it's unfortunate there was none (Advance Directive). During an interview with the Minimum Data Set Director (MDSD) on [DATE] at 2:35 PM, the MDSD confirmed there was no advance directive for Resident 15. A review of Resident 15's Physician's Orders for Life Sustaining Treatment (POLST & a medical form expressing the resident's wishes in the event of medical emergency) dated [DATE], indicated No advance Directive. 8. A review of Resident 8's admission Records dated [DATE], indicated resident was admitted on [DATE]. A review of Resident 8's History and Physical (H&P), dated [DATE], indicated, status post (S/P - is a medical or clinical shorthand that refers to a state after an intervention) Diabetic Ketoacidosis (DKA - a serious complication of diabetes that occurs when the body does not have enough insulin and starts breaking down fat for energy) and bacteremia (a condition where bacteria enter the bloodstream). (continued on next page)		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's quarterly MDS (Minimum Data Sheet &ndash; a standardized assessment and screening tool) dated [DATE], indicated Resident 8 has a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 suggesting moderate cognitive impairment. During a concurrent interview and record review with the Director of Nursing (DON), on [DATE] at 12:20 pm, the Advance Directive acknowledgement receipt form was reviewed. The DON stated that upon admission, resident or resident's Representative needs to sign acknowledgement receipt that advance directive was offered. The DON confirmed that Resident 8 or Resident 8's representative did not sign the acknowledgement form. A review of the facility's policy and procedures titled Advance Directives, dated [DATE], indicated .Determining Existence of Advance Directive.2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five residents (Residents 12 and 162) were kept free from unnecessary medications when:1. Resident 162 was not consistently offered non-pharmacological interventions prior to receiving Ativan (a medication used to treat anxiety) as ordered by the physician.2. Resident 12 received Depakote (a medication used as a mood stabilizer) without an accurate diagnosis.These failures put the residents at risk of adverse effects from the medications. 1. A review of Resident 162's Face Sheet (front page of the chart that contains a summary of basic information about the resident), indicated Resident 162 was admitted to the facility on [DATE], with diagnoses including anxiety.During a concurrent interview and record review with LVN 2 on 8/27/25 at 7:24 AM, Resident 162's Order Summary Report was reviewed. The Order Summary Report indicated an order dated 4/13/25, for non-drug intervention prior to administration of prn (as needed) anti-anxiety medication. The Medication Administration Record (MAR) dated August, 2025 was reviewed. The MAR indicated non-pharmacological interventions were not offered prior to Resident 162 receiving Ativan on the following dates and times:o 8/5/25 10:00 AM, 2:42 PMo 8/15/25 7:53 AM, 12:25 PMo 8/16/25 9:37 AM, 1:40 PMo 8/26/25 8:31 AM, 1:00 PMLVN 2 was unable to answer why the non-pharmacological interventions had not been offered, but stated they should have been.During a concurrent interview and record review with the Director of Nursing (DON) on 8/29/25 at 2:44 PM, the Order Summary Report and MAR were reviewed. The DON verified the above findings and stated non-pharmacological interventions should have been offered prior to each administration of Ativan.A review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 2001, indicated, Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest dose if indicated, and support efforts at gradual dose reduction. 2. A review of Resident 12's Face Sheet indicated Resident 12 was readmitted to the facility on [DATE], with diagnoses including dementia.During a concurrent interview and record review with the DON on 8/28/25 at 2:50 PM, Resident 12's admission Record (face sheet) was reviewed. The face sheet indicated a diagnosis of epilepsy was added on 8/22/25. When asked who would diagnose the resident, the DON stated the attending physician. The psychiatric follow-up note dated 8/22/25, was reviewed. The psychiatric follow up note indicated Resident 12 was taking Depakote for seizure disorder, not psychosis. The DON contacted Resident 12's physician via telephone. Resident 12's physician stated the seizure disorder diagnosis was an error, and the indication should be impulse control.A review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, dated 2001, indicated, Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest dose if indicated, and support efforts at gradual dose reduction.		

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

Printed: 07/18/2026
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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to comprehensively and accurately assess hearing for one of 35 sampled residents (Resident 68). This failure had the potential to result in Resident 68's care needs not being effectively met. During a concurrent observation and interview with Resident 68 on 8/25/25 at 11:16 AM, Resident 68 stated having hard of hearing and the need for people to speak loudly to hear them. Resident 68 also stated having hearing aids upon admission in September 2023, but they were broken. Resident 68 further stated informing Social Services (SS) about the need to replace hearing aid. A review of Resident 68's admission Records dated 8/27/25, indicated resident was admitted on [DATE]. A review of Resident 68's History and Physical (H&P), dated 10/2/24, indicated, diagnoses which include hearing loss. A review of Resident 68's Minimum Data Set (MDS - a standardized assessment tool) dated 9/26/23, and 6/28/25, indicated resident hears adequately and does not use hearing aids. A review of Resident 68's Inventory of Personal Effects Form dated 9/19/23 on 08/27/2025 at 6:45 AM, indicated Resident 68 had a right and left hearing aid upon admission. A review of Resident 68's Social History assessment dated [DATE], indicated under Adaptive Aids, Resident 68 used hearing aids and glasses. During a concurrent interview and record review with the Director of Nursing (DON) on 08/27/2025 at 9:35 AM, Resident 68's assessment records were reviewed. The DON verified information regarding Resident 68's hearing disability does not appear in the assessment records. The DON confirmed that the facility did not conduct an accurate comprehensive assessment of Resident 68's hearing disability. During a concurrent interview and record review with Minimum Data Set (MDS) Director (MDSD) on 08/27/2025 at 12:46 PM, dated 9/26/23 and 6/28/25 were reviewed. The MDSD explained that section B (hearing, speech and vision) of the MDS is coded as 0 if it is determined that the resident does not have hearing difficulties, indicating hearing is adequate. The MDSD stated that facility does not inquire whether residents have hearing aids. If the MDSD deemed the hearing adequate, hearing aid is coded as 0, meaning No. The MDSD confirmed that section B of the MDS for Resident 68 was not accurately assessed. During an interview on 08/29/2025 at 9:44 AM with Registered Nurse 4 (RN 4), RN 4 stated that assessments must be accurately conducted to identify and properly address the resident's needs. A review of the facility's policy and procedure (P&P) titled admission Assessment, dated September 2012, indicated, The purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment instruments, including the MDS. A review of the facility's policy and procedure (P&P) titled Comprehensive Assessment, dated October 2023, indicated, 1. The facility conducts comprehensive, accurate, and standardized, reproducible assessments of each residence functional capacity using the resident assessment instrument specified by CMS.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to develop and implement a comprehensive care plan needed to address hearing difficulty, for one of 35 sampled residents (Resident 68). This failure had the potential to result in the residents' care needs not being met effectively During a concurrent observation and interview with Resident 68 on 8/25/25 at 11:16 am, Resident 68 stated having hard of hearing and the need for people to speak loudly to hear them. Resident 68 also stated having hearing aids upon admission in September 2023, but they were broken. Resident 68 further stated informing Social Services (SS) about the need to replace hearing aid.A review of Resident 68's admission Records dated 8/27/25, indicated resident was admitted on [DATE].A review of Resident 68's History and Physical (H&P), dated 10/2/24, indicated, diagnoses which includes hearing loss.A review of Resident 68's Minimum Data Set (MDS - a standardized assessment tool) dated 9/26/23, and 6/28/25, indicated resident hears adequately and does not use hearing aids.A review of Resident 68's Inventory of Personal Effects Form dated 9/19/23 on 08/27/2025 at 6:45 AM, indicated Resident 68 had a right and left hearing aid upon admission.A review of Resident 68's Social History assessment dated [DATE], indicated under Adaptive Aids Resident 68 used hearing aids and glasses.During a concurrent interview and record review with the Director of Nursing (DON) on 08/27/2025 at 9:35 AM, Resident 68's care plans were reviewed. The DON confirmed Resident 68 does not have a comprehensive care plan for hearing disability.During a concurrent interview and record review with Minimum Data Set (MDS) Director (MDSD) on 08/27/2025 at 12:46 PM, dated 9/26/23 and 6/28/25 were reviewed. The MDSD explained that section B (hearing, speech and vision) of the MDS is coded as 0 if it is determined that the resident does not have hearing difficulties, indicating hearing is adequate. The MDSD stated that facility does not inquire whether residents have hearing aids. If the MDSD deemed the hearing adequate, hearing aid is coded as 0, meaning No. The MDSD confirmed that section B of the MDS for Resident 68 was not accurately assessed.During an interview on 08/29/2025 at 9:44 AM with Registered Nurse 4 (RN 4), RN 4 stated that assessments must be accurately conducted to identify and properly address the resident's needs.A review of the facility's policy and procedure (P&P) titled Comprehensive Assessment, dated October 2023, indicated, .1. The facility conducts comprehensive, accurate, and standardized, reproducible assessments of each residence functional capacity using the resident assessment instrument specified by CMS.A review of the facility's policy and procedure titled Care Plans, Comprehensive Person - Centered, dated December 2016, indicated, . 8. The comprehensive, person-centered care plan will, b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical mental and psychosocial well-being.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the plan of care for two of 35 sampled residents (Residents 12 and 162). This failure put the residents at risk for their care needs to go unmet.1.A review of Resident 12's Face Sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 12 was admitted on [DATE].During a concurrent interview and record review with RN 4 on 8/29/25 at 11:53 AM, Resident 12's Order Listing Report was reviewed. The Order Listing Report indicated Resident 12 had a peripheral IV started on 7/15/25, and the order was discontinued on 7/18/25. A review of the plan of care showed a care plan problem dated 7/15/25, for vascular access, resident at risk for complications due to the presence of a peripheral line. RN 4 stated Resident 12 did not have a current peripheral IV access line. RN 4 stated the care plan should have been revised because otherwise they are monitoring for something that is no longer an issue. A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 2001, indicated, assessments of residents are ongoing and care plans are revised as information about the residents' condition change.2. During a concurrent interview and record review with LVN 2 on 8/27/25 at 7:24 AM, Resident 162's plan of care was reviewed. The plan of care indicated Resident 162 was placed on enhanced barrier precautions. When asked how staff would know how to care for a resident, LVN 2 stated she would look at the plan of care. LVN 2 stated because the plan of care wasn't updated, she did not know the resident's order for enhanced barrier precautions had been discontinued. During an interview with LVN 3 on 8/27/25 at 7:53 AM, LVN 3 stated the nurse that discontinued the order should revise the plan of care, at least on the same day.During an interview with DON on 8/29/25 and 2:44 PM, the DON stated the care plan should have been updated at the time the order was changed.A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered dated 2001, indicated , Assessments of residents are ongoing and care plans are revised as information about the residents' condition change.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to replace the broken hearing aids for one of 35 sampled residents (Resident 68). This failure had the potential to prevent effective communication, diminished activities of daily living and resident becoming less engaged in their overall care and well-being. During a concurrent observation and interview with Resident 68 on 8/25/25 at 11:16 am, Resident 68 stated having hard of hearing and the need for people to speak loudly to hear them. Resident 68 also stated having hearing aids upon admission in September 2023, but they were broken. Resident 68 further stated informing Social Services (SS) about the need to replace hearing aid. A review of Resident 68's admission Records dated 8/27/25, indicated resident was admitted on [DATE]. A review of Resident 68's History and Physical (H&P), dated 10/2/24, indicated, hearing loss. A review of Resident 68's Inventory of Personal Effects Form dated 9/19/23 on 08/27/2025 at 6:45 AM, indicated Resident 68 had a right and left hearing aid upon admission. A review of Resident 68's Social History assessment dated [DATE], indicated under Adaptive Aids Resident 68 used hearing aids and glasses. A review of Audiology notes dated 8/6/25 indicated hearing abnormal by observation and Resident 68 also complained of hearing problems. During an interview with Certified Nurse Assistant (CNA 3) on 8/27/25 at 7:55 am, CNA 3 verified that Resident 68 has had hearing difficulties for the last seven months. CNA 3 stated reporting Resident 68's hearing difficulties to the LVN. During a concurrent interview and record review with Minimum Data Set (MDS) Director (MDSD) on 08/27/2025 at 12:46 PM, dated 9/26/23 and 6/28/25 were reviewed. The MDSD confirmed that section B of the MDS for Resident 68 was not accurately assessed. During an interview with the Director of Nursing (DON) on 08/29/2025 at 10:03 am, DON confirmed that Resident 68's needs for hearing aid have not been addressed. During a review of the facility's policy and procedure (P&P) titled Effective Communication, dated February 2018, indicated, . 4. Staff will help residents who have lost or damaged hearing devices in obtaining services to replace the devices as indicated. 7. J. Evaluate residents' adaptive needs and progress at regular intervals.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist in obtaining new hearing aid for one of the 35 sampled residents (Resident 68). This deficient practice has the potential to cause a decline in Resident 68's ability to communicate and participate in social activities. During a concurrent observation and interview with Resident 68 on 8/25/25 at 11:16 AM, Resident 68 stated having hard of hearing and the need for people to speak loudly to hear them. Resident 68 also stated having hearing aids upon admission in September 2023, but they were broken. Resident 68 further stated informing Social Services (SS) about the need to replace hearing aid. A review of Resident 68's admission Records dated 8/27/25, indicated resident was admitted on [DATE]. A review of Resident 68's History and Physical (H&P), dated 10/2/24, indicated, diagnoses which includes hearing loss. A review of Resident 68's Inventory of Personal Effects Form dated 9/19/23 on 8/27/2025 at 6:45 AM, indicated Resident 68 had a right and left hearing aid upon admission. A review of Resident 68's Social History assessment dated [DATE], indicated, under Adaptive Aids Resident 68 used hearing aids and glasses. A review of Audiology notes dated 8/6/25 indicated, hearing abnormal by observation. Resident 68 also complained of hearing problems. During an interview with Certified Nurse Assistant (CNA 3) on 8/27/25 at 7:55 AM, CNA 3 verified that Resident 68 has had hearing difficulties for the last seven months. CNA 3 stated reporting Resident 68's hearing difficulties to the LVN. During a concurrent interview and record review with Social Services (SS) on 8/27/25 at 10:04 AM, Audiology notes dated 8/6/25 were reviewed. SS stated that Resident 68 was examined by an audiologist, and an audiogram was recommended. SS mentioned they would follow up on the audiology recommendation and the need for hearing aid replacement for Resident 68. During an interview with the Director of Nursing (DON) on 08/29/2025 at 10:03 AM, the DON confirmed Resident 68's needs for hearing aid had not been addressed. A review of the facility's policy and procedure (P&P) titled Effective Communication, dated February 2018, indicated, .4. Staff will help residents who have lost or damaged hearing devices in obtaining services to replace the devices as indicated. 7. J. Evaluate residents' adaptive needs and progress at regular intervals.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure oxygen therapy was administered continuously in accordance with physician's order for one of two sampled residents investigated for oxygen treatment (Resident 141). This failure may cause Resident 141 to have difficulty breathing, potentially leading to respiratory failure. During an observation, on 8/25/25, at 2:47 PM, Resident 141 was in bed, awake, and showed no signs of pain, discomfort, or distress. An oxygen concentrator (a medical device that supplies up to 95% pure oxygen to patients through a mask or nasal tube) was noted by Resident 141's bedside. It was observed that the oxygen concentrator was turned off. During an interview with Licensed Vocational Nurse (LVN) 1, on 8/25/25, at 3:02 PM, LVN 1 stated that Resident 141's oxygen was supposed to be administered continuously. LVN 1 was asked why the oxygen concentrator was off. LVN 1 responded that the order should be reviewed to confirm if the order was continuous. During subsequent interview with LVN 1, on 8/25/25, at 3:21 PM, LVN 1 stated that Resident 141 might have low oxygen levels if the prescribed oxygen treatment was not administered. LVN 1 confirmed that oxygen was not continuously administered to Resident 141 as ordered. A review of Resident 141's Face Sheet (front page of the chart that contains a summary of basic information about the resident), indicated that resident was admitted to the facility on [DATE], with diagnoses which included Acute Respiratory Failure with Hypoxia (a serious medical condition where the lungs cannot provide enough oxygen to the body) and Hypertension (high blood pressure). A review of Resident 141's Order Details, indicated, Continuous: Oxygen to titrate to start at 2 LPM via NC / Mask to keep O2 saturation above 88% every shift for COPD (Chronic Obstructive Pulmonary Disease - a progressive lung disease which blocks air flow making breathing difficult) with order date of 5/28/25. This order was discontinued and changed to PRN (as needed) order, on 8/25/25, at 6:01 PM. A review of Resident 141's Care Plan Report, initiated on 5/28/25, indicated, Focus. Has Oxygen Therapy r/t (related to) Respiratory illness. Interventions. Give medications as ordered by physician. Focus. Oxygen: Resident requires the use of oxygen. Interventions. Educate the resident on the importance of keeping oxygen on and at the prescribed setting. During an interview and concurrent record review with Registered Nurse (RN) 1, on 8/25/25, at 3:13 PM, RN 1 checked Resident 141's current physician order which indicated, Continuous oxygen to titrate to start at 2 LPM (liters per minute) via NC (nasal cannula - flexible tube to deliver oxygen into the nose) / mask to keep O2 (oxygen) saturation above 88%. RN 1 stated that failure to administer oxygen as prescribed could potentially worsen the resident's respiratory condition and lead to an altered level of consciousness. During an interview with the Director of Nursing (DON), on 8/28/25 at 10:51 AM, the DON stated that if there was an order for continuous oxygen administration, oxygen should be kept on, to prevent shortness of breath and potential medical emergencies. The DON confirmed that oxygen was not continuously administered to Resident 141 as ordered. The DON added that Resident 141's physician was contacted, resulting in a modification of the oxygen therapy order from continuous to as needed. A review of facility's policies and procedures titled, Oxygen Administration, dated 2001, indicated, Oxygen Administration. Preparation. 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. A review of facility's undated policies and procedures titled, Physician Orders, indicated, Policy Interpretation and Implementation. 1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to replace e-Kits (e-Kit , a collection of prescription drugs, and related supplies, intended to provide immediate medical treatment for injuries and illnesses) in a timely manner, and to accurately complete the e-Kit Usage Slip form. This failure had the potential to delay medication administration for residents in need of emergency medical treatment. Findings: During a concurrent e-Kits inspection and interview with Registered Nurse (RN) 5 on 8/27/25 at 12:08 PM, multiple e-Kits secured with black-colored zip ties were noted. RN 5 acknowledged the findings. RN 5 stated the e-Kits that are secured with black-colored zip ties indicates a medication had been signed out and used for a resident. RN 5 explained that after a medication was signed out from an e-Kit, the licensed staff needs to inform the pharmacy about the usage of the kit. In addition, the licensed staff needs to complete an e-Kit Usage Slip form and leave a copy of the form in the e-Kit. RN 5 stated an e-Kit is usually replaced by the pharmacy within 72 hours from the time of use. The RN 5 further stated that the replacement of an e-kit is to ensure the availability of medications when needed by the residents. A review of the e-Kit Usage Slip forms with RN 5 indicated: 1. a lorazepam (anti-anxiety medication) 0.5 mg (milligram) was signed out on 8/13/25 for Resident 171; 2. a 1300-30 mg tablet, medication name not listed, was signed out on 8/22/25 for Resident 116; 3. a potassium chloride (supplement) 10 mEq (milliequivalent) was signed out on 8/14, no resident name written on the form; 4. two tablets of potassium chloride 10 mEq was signed out on 8/14/25 for Resident 71. RN 5 stated that the e-kits that were inspected and reviewed need to be replaced by the pharmacy. RN 5 verified the medication signed out for Resident 116 was for acetaminophen with codeine (a controlled pain medication), and the potassium chloride 10 mEq was signed out for Resident 237. RN 5 acknowledged that the usage slip needs to be completed properly including resident's name and medication name. During an interview with the DON on 8/28/25 at 11:04 AM, the DON stated the e-Kits need to be replaced promptly. The DON verified the e-Kits that had been used from 8/13/25 to 8/22/25 already needed replacement kits from the pharmacy. The facility was unable to provide specific P&P addressing emergency supply replacement for controlled and non-controlled oral medications.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored in a safe manner when: 1. Loose medications were found in the medication cart, 2. Expired medications were not removed and discarded from one medication room; and 3. The bleach wipes were found stored together with the medications. These failures posed the risk for medication errors, cross contamination, and for medications to have lost their integrity and potency and affect the residents' health outcomes. 1. During a medication cart inspection and concurrent interview with Licensed Vocational Nurse (LVN) 5 on 8/27/25 at 12:03 PM, three loose tablets (one round, white tablet; one round pink tablet, and one round, orange tablet) were observed at the bottom of the medication cart drawer. LVN 5 was not able to identify the medications. LVN 5 stated the medications should have been discarded into the appropriate bin, if they were not administered. 2. During a medication room inspection and concurrent interview with Registered Nurse (RN) 2 on 8/27/25 at 12:42 PM, a tube of Silvasorb gel (a gel that provides broad-spectrum antimicrobial protection for various types of wounds) with an expiration date of 6/2025 was observed. RN 2 verified the medication should have been removed from the medication room and discarded. 3. During a medication cart inspection and concurrent interview with LVN 5 on 8/27/25 at 12:03 PM, two containers of cleaning products were observed in the same compartment of oral medications. LVN 5 verified the cleaning products were in the same compartment as oral medications and stated it should have been separated. During a treatment cart inspection and concurrent interview with Treatment Nurse (TN) 1 on 8/27/25 at 1:15 PM, a container of cleaning product was observed in the same compartment as topical medications. TN 1 verified the cleaning product were in the same compartment as the topical medication and stated it should have been separated. During an interview with the Director of Nursing (DON) on 8/29/25 at 10:54 AM, the DON stated medications that have expired, have already been popped out from the bubble pack and not given to the resident should have been discarded into the correct receptacle by the charge nurses. The DON added cleaning solutions should have been kept in a separate compartment from the medications. The DON acknowledged the findings. A review of facility's policy and procedure titled, Storage of Medications with a revised date of 11/2020, indicated .2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 6. Hazardous drugs are clearly marked and stored separately from other medications.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure eight of 11 sampled residents (Residents 196, 83, 116, 34, 11, 146, 92, and 62) knew the location of the survey results binder. This failure had the potential to keep residents, family members, and visitors from easily reviewing the most recent survey results and the facility's plan of corrections, which are essential for making informed decisions about living at the facility. During an interview on 8/25/25 at 1:50 PM, eight of 11 residents polled at the resident council meeting did not know the location of the survey results binder. During a concurrent observation outside the activities/dining room and interview with the Director of Nursing (DON) and the Administrator (ADM) on 8/25/25 at 4:37 PM, the DON and the ADM verified the location of the survey results binder and confirmed there were no signs at the site as well as anywhere else in the facility indicating where to find it.		

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 08/29/2025
NAME OF PROVIDER OR SUPPLIER Las Colinas Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a minimum of 80 square feet (sq. ft.) of livable space per resident for five of 77 resident rooms. This failure had the potential to limit the freedom of movement of the residents that occupied these rooms, which may place them at risk for injury. During the entrance conference interview with the Administrator (ADM), on 8/25/25, at 9:23 AM, the ADM stated the facility had resident rooms with less than the required square footage (80 sq. ft. of livable space). During the environmental tour with the Maintenance Services Director (MTD) on 8/28/25, at 2:06 PM, five of the 77 resident rooms were observed to be less than 80 sq. ft. per resident. The residents' rooms and their measurements were noted as follows: a. room [ROOM NUMBER] (3 beds) measured 223.54 sq. ft. (74.5 sq. ft. per resident). b. room [ROOM NUMBER] (3 beds) measured 223 sq. ft. (74.3 sq. ft. per resident). c. room [ROOM NUMBER] (3 beds) measured 223 sq. ft. (74.3 sq. ft. per resident). d. room [ROOM NUMBER] (3 beds) measured 223 sq. ft. (74.3 sq. ft. per resident). e. room [ROOM NUMBER] (3 beds) measured 223 sq. ft. (74.3 sq. ft. per resident). These rooms were not crowded and did not impose any safety hazards. There were no complaints about space or room issues from the residents occupying these rooms. During an interview with the ADM, on 8/28/25, at 3:42 PM, the ADM confirmed that five out of 77 residents' rooms did not meet the required 80 square feet per resident requirement. The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency.		