STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055693	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ontario Grove Healthcare & Wellness Centre, LP	933 East Deodar Street Ontario, CA 91764

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 provide accommodation of communication needs to one resident reviewed for language (Resident 24) when Resident 24's communication board was in a different language than the one spoken by Resident 24. This failure had the potential to delay Resident 24's request and did not provide Resident 24 with a method to communicate with facility staff. Findings: During a review of Resident 24's admission Record (contains demographic and medical information), it indicated Resident 24 was admitted to the facility on [DATE], with the diagnoses of atrial fibrillation (n irregular and often very rapid heart rhythm), tachycardia (heart beats faster than normal), and dysphagia (difficulty swallowing). During a review of Resident 24's History and Physical (H&P) dated April 2, 2025, the H&P indicated Resident 24 .speaks Cantonese. During an observation on June 2, 2025, at 11:29 AM, inside of Resident 24's room, Resident 24 had a communication board with her name on it. and Inside the board, it had various pictures labeled in Spanish. During a concurrent observation and interview, on June 2, 2025, at 11:30 AM, with Licensed Vocational Nurse (LVN 1), LVN 1 inspected Resident 24's communication board, and stated Resident 24 spoke Cantonese. LVN 1 further stated the communication board was not in Cantonese and it should have been. During a concurrent interview and record review, on June 5, 2025, at 11:12 AM, with Director of Nursing (DON), the facility's policy and procedure (P&P) titled Accommodation of Residents' Communication Needs, revised March 2017, was reviewed. The P&P indicated to assist residents' to express or communicate their requests, needs, opinions, urgent problems . with adaptive devices . VI. The following are examples of adaptive devices the staff may provide the resident: . B. Communication Boards/Charts . The DON stated the P&P was not followed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, label, and maintain food and food storage areas in a sanitary manner, as required by professional food service standards when: 1. One bunch of cilantro, which was turning black, was found inside of a plastic bag at the bottom shelf of the refrigerator. 2. One produce storage box that contained whole heads of lettuce was found with debris (dirt). 3. A box, containing fully cooked boneless pork ribs, dated May 9, 2025, was found open with its internal plastic liner unsealed and with freezer burn (food got too dry and frosty due to being exposed to air in the freezer for too long). 4. One 12 quart (qt- unit of measurement) clear plastic container labeled Noodles Pasta, did not have a Use by: date was found inside the dry storage room. These failures had the potential to increase the risk of contamination, bacterial growth (increase of harmful germs that can spoil food and make it unsafe to eat) and foodborne illness (sickness caused by eating food that has been contaminated by germs, like bacteria), and had the potential to affect 53 of 53 residents who receive meals prepared and served form the facility's kitchen. Findings: 1. During a concurrent observation and interview, on June 2, 2025, at 8:17 AM, with [NAME] 1, one bunch of cilantro was found inside a clear plastic bag at the bottom shelf of a six-door refrigerator. The cilantro was turning black in color and was wet to touch. [NAME] 1 stated the cilantro was no longer safe to consume and should have been discarded. During a concurrent interview and record review, on June 4, 2025, at 8:35 AM, with the Dietary Services Supervisor (DSS) and the Assistant Administrator, the facility's policy and procedure (P&P) titled Produce Storage Guidelines, dated 2023, was reviewed. The P&P indicated, May use longer if no signs of spoilage are visible . item Parsley, refrigerator 2 to 3 days. The DSS stated although the facility did not have specific guidance for cilantro, they typically followed the storage timeline for parsley. Both the DSS and Assistant Administrator acknowledged the cilantro found in the refrigerator was spoiled and confirmed it should have been discarded. The DSS stated the policy was not followed by staff. 2. During a concurrent observation and interview, on June 2, 2025, at 8:20 AM, with [NAME] 1, one produce storage box that contained whole heads of lettuce was found inside a six-door refrigerator. The bottom of the box had visible dirt and debris. [NAME] 1 confirmed the box had not been cleaned, and stated it should have been washed prior to use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review, on June 4, 2025, at 8:41 AM, with the DSS and the Assistant Administrator, the facility's P&P titled P-DS49 Sanitation of Reach in Refrigerator dated July 13, 2023, was reviewed. The P&P indicated, . 2. Weekly tasks f. Scrub the interior and exterior of the refrigerator using hot detergent solution and brush or clean cloth. Pay special attention to shelf guides, gaskets, the door frame and hinge areas. g. Rinse and sanitize the interior and exterior. The DSS acknowledged the policy was not followed, and further stated the storage containers were expected to be clean. 3. During a concurrent observation and interview, on June 2, 2025, at 8:24 AM, with [NAME] 1, an opened box, containing Fully Cooked Boneless Pork Ribs which an open date of May 9, 2025, and a used by date of August 9, 2025, was found inside the freezer. The internal plastic liner was not sealed, and the pork ribs had freezer burn. [NAME] 1 acknowledged the finding, and stated the bag should have been sealed properly after opening to prevent contamination and freezer burn. During an interview on June 2, 2025, at 9:39 AM, with the DSS, the DSS stated the opened box and unsealed bag were not safe for residents due to risk of bacterial growth and ice formation. During a concurrent interview and record review, on June 4, 2025, at 8:43 AM, with the DSS and the Assistant Administrator, the facility's policy and procedure (P&P) titled P-DS52 Food Storage and Handling dated June 4, 2024, was reviewed. The P&P indicated, . 2. Frozen Meat, Poultry and food c. Store items promptly at 0°F or below. Foods should be labeled, date and in their original containers if designed for freezing. Foods to be froze should be stored in airtight . The DSS stated that policy was not followed. The DSS further stated the liner inside the box should have been resealed airtight after opening to prevent freezer burn and exposure to air. The DSS explained that leaving that liner open increased the risk of ice buildup, loss of taste, and bacteria growth. 4. During a concurrent observation and interview, on June 2, 2025, at 8:30 AM, with the DSS, inside the dry storage room, a 12-quart plastic clear container labeled Noodles Pasta was found with a prep date of May 23, 2025. It did not have Use by date. The DSS stated the label was incomplete. The DSS further stated food items must include both prep and use by dates to ensure safe consumption. During a concurrent interview and record review, on June 4, 2025, at 8:45 AM, with the DSS and the Assistant Administrator, the facility's policy and procedure (P&P) titled P-D552 Food Storage and Handling dated June 4, 2024, was reviewed. The P&P indicated, .13. Dry Storage Area .h. label and date all storage products. The DSS stated the policy was not followed. The DSS further stated that all dry goods should have both a prep date and use by date clearly labeled to ensure safe consumption and proper inventory rotation.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and maintain an effective infection prevention and control program (proper methods used to stop the spread of germs and protect residents, staff and visitors from getting sick) for one of three residents reviewed for infection control (Resident 17) when Resident 17's suction tubing (flexible tube, used to remove bodily fluids and debris from one's airway or surgical site) was left open to air and without a dated label. This failure had the potential to result in cross-contamination (germs or bacteria from one dirty surface or item get spread to something clean, which can make people sick) causing preventable infection to Resident 17. Findings: During a review of Resident17's admission Record (contains demographic and medical information), it indicated Resident 17 was admitted to the facility on [DATE], with diagnoses of dementia (a condition that affects the brain and causes problems with memory, thinking and understanding), congestive heart failure (the heart is weak and doesn't pump blood well, which can cause trouble breathing and body swelling) and gastrostomy status (has a feeding tube in their belly to help them eat when they can't eat by mouth.) During a review of Resident's 17 Physician Orders, dated December 27, 2024, it indicated Enteral Feeding (giving food or liquid nutrition through a tube that goes into the stomach or intestines because the person can't eat by mouth) Order every shift oral care - use swab (a small soft stick used clean a part of the body, like inside the mouth) / suction (a way to gently suck out things like saliva (spit) or mucus from the mouth using a tube) as appropriate. During an observation on June 2, 2025, at 10:15 AM, inside Resident's 17 room, Resident 17 was lying in bed, with head of the bed elevated. A portable suction machine (a small machine that helps remove spit or mucus from someone's mouth using a plastic tube) was on the bedside table, next to the resident. The suction machine was plugged into an electrical outlet, and connected to a suction tubing (a rigid plastic tube used to suction saliva or mucus). The Yankauer tip showed signs of prior use, such as dried residue on the tip. It was uncovered, and resting directly on the bedside table surface. The tubing was not bagged, capped or stored in a clean, sanitary manner and was exposed to open air and surrounding environmental contaminants. There was no date, or label visible on the tubing or canister (a clear container that hold the spit or mucus that the suction machine collects) to indicate when it was last used or when it was last replaced. During an interview on June 2, 2025, at 10:18 AM, inside Resident's 17 room, with Licensed Vocational Nurse (LVN 1), LVN 1 acknowledged the Yankauer had already been used for suctioning and stated, After use, it should be placed inside a plastic bag to prevent contamination. LVN 1 further stated she was not familiar with the facility's policy on how often Yankauer suction tubing should be changed or replaced. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on June 5, 2025, at 11:32 AM, with Director of Nursing, (DON), the DON stated the Yankauer suction tip was single use and must be discarded after each use. The DON acknowledged that the Yankauer found on Resident 17's bedside table had already been used for suctioning and was not stored properly. The DON stated staff were trained to discard used Yankauer tips immediately and confirmed that both the suction canister and tubing should be labeled with the date of when it was last replaced. The DON further stated license nurses are assigned every Sunday to check all suction machines and tubing to ensure proper cleaning, storage and labeling are in place. During a concurrent interview and record review on June 5, 2025, at 11:42 AM, with the DON, the DON reviewed the facility's policy and procedure titled Cleaning & Disinfection of Resident Care Equipment, dated January 1, 2012, which indicated Critical and semi-critical items are sterilized/disinfected in a processing location and stored appropriately until use. The DON stated the policy was not followed by staff.

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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 nine of 19 resident rooms (Rooms 26, 27, 28, 29, 30, 31, 32, 33, and 34) when Rooms 26, 27, 28, 29, 30, 31, 32, 33, and 34 measured less than 80 square feet per resident. This failure had the potential for the residents housed in Rooms 26, 27, 28, 29, 30, 31, 32, 33, and 34 to not have the ability to move about freely if the square footage limited their personal space. Findings: During a concurrent interview and record review, with the Assistant Administrator (Assist Admin), on June 2, 2025, at 8:56 AM, the Assist Admin reviewed the Entrance Conference Checklist and stated the facility had room waivers for Rooms 26, 27, 28, 29, 30, 31, 32, 33, and 34 which had less than the required square footage of livable space (less than 80 square feet). During an environmental tour with the Maintenance Supervisor (MS) and the Assist Admin, on June 4, 2025, at 3:36 PM, Rooms 26, 27, 28, 29, 30, 31, 32, 33, and 34 were inspected. The residents' rooms and their measurements of livable space were noted as follows: 1. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 2. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 3. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 4. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 5. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 6. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 7. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 8. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) 9. room [ROOM NUMBER] (three beds) measured: 231 sq. ft. [square feet] (77 sq. ft. per resident) During a follow up interview with the Assist Admin, on June 4, 2025, at 3:55 PM, the Assist Admin confirmed the measurements of the nine resident rooms and stated Rooms 26, 27, 28, 29, 30, 31, 32, 33, and 34 did not meet the 80 square feet per resident. The rooms were not crowded and did not impose any safety hazards to the residents. There were no complaints of space or room issues from the residents occupying these rooms. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	The survey team recommends the approval of the room waiver request for the rooms listed in this deficiency.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was accessible for three of three residents reviewed for environment (Residents 36, 54, and 159) when Residents 36, 54, and 159's call lights were found inaccessible to the three residents. This failure had the potential to result in leaving Residents 36, 54, 159 unable to use the call light system to call for any assistance the residents may require. Findings: 1. During a review of Resident 36's admission Record (contains demographic and medical information), it indicated Resident 36 was admitted to the facility on [DATE], with diagnoses of dementia (progressive loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life), dysphagia (difficulty swallowing), and type 2 diabetes mellitus (high blood sugar levels due to the body's resistance to insulin). During a concurrent observation and interview on June 2, 2025, at 4:00 PM, in Resident 36's room, Resident 36 was lying in bed, watching television. Resident 36's call light was wrapped around the side of the bed rail, almost touching the floor. Resident 36 attempted to reach for the call light but was unable to reach it. Resident 36 stated I couldn't reach for it. During a concurrent observation and interview on June 2, 2025, at 4:02 PM, with Licensed Vocational Nurse (LVN 1), in Resident 36's room, LVN 1 inspected the call light and stated it was not accessible to Resident 36. 2. During a review of Resident 54's admission Record, it indicated Resident 54 was admitted to the facility on [DATE], with diagnoses of abnormalities of gait and mobility (difficulty to move around without assistance from staff), cognitive communication deficit (difficulty processing, understanding or expressing communication), and history of falling. During an observation on June 2, 2025, at 9:39 AM, inside Resident 54's room, Resident 54 was lying in bed, watching television. Resident 54's call light was resting on top of the headwall light fixture, above the bed. It was not within Resident 54's reach. During an interview on June 2, 2025, at 9:48 AM, with Resident 54, Resident 54 stated he did not know where the call light was. . During a concurrent observation and interview on June 2, 2025, at 9:50 AM, with Certified Nursing Assistant (CNA 1), CNA 1 confirmed the call light was found not within Resident 54's reach. CNA 1 stated the call light should always be within resident's reach. 3. During a review of Resident 159's, admission Record, it indicated Resident 159 was admitted to the facility on [DATE]. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 159's, Physician History and Physical (H&P) dated May 31, 2025, it indicated Resident 159 had history of right femoral neck fracture (a break in the neck of the thigh bone on the right side, near the hip joint.) During an observation on June 2, 2025, at 10:02 AM, inside Resident 159's room, Resident 159's call light was found under Resident 159's bed and was not within Resident 159's reach. During an interview on June 2, 2025, at 10:05 AM, with Resident 159, Resident 159 stated I don't know where my call light is. During a concurrent observation and interview, on June 2, 2025, at 10:09 AM, with LVN 2, LVN 2 confirmed the location of the call light and acknowledged that it was not within Resident 159's reach. LVN 2 stated It is important to make sure the call light is within the resident's reach in case Resident 159 needs help. During a concurrent interview and record review on June 5, 2025, at 11:42 AM, with the Director of Nursing (DON) and the Assistant Administrator (Assist Admin), the facility's policy and procedure (P&P) titled NP29 Communication - Call System, dated October 9, 2024, was reviewed. The P&P indicated, The facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting / bathing facilities. The DON stated the policy was not followed. The DON and Assist Admin acknowledged that having the call light out of reach increases the risk for falls or unmet care needs.