STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055707	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ontario Healthcare Center	1661 S Euclid Ave Ontario, CA 91762

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and address early signs of pressure injury (localized damage to the skin and underlying soft tissue typically occurs over bony prominences like the tailbone, heels, and hips caused by prolonged or intense pressure) development for one (1) of three (3) sampled residents (Resident 1).This failure placed Resident 1 at risk for worsening skin breakdown, pain, infection, delayed treatment, and other complications related to pressure injury.Findings: A review of Resident 1's face sheet (contains demographic and medical information), it indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus type 1(a condition where the body can't make insulin anymore. Insulin is the hormone that helps move sugar from the blood into the body's cell of energy), difficulty in walking, and muscle weakness. A review of Resident 1's Braden Scale (evidence-based assessment tool used by healthcare professionals to evaluate a patient's risk of developing pressure injury) indicated a score of 11 (a total score of 12 or less represent HIGH RISK). A review of Resident 1's weekly skin/wound assessment dated [DATE], April 10, 2026, and April 17, 2026, indicated Resident 1 was identified with Moisture-Associated Skin Damage (MASD- skin irritation and breakdown caused by prolonged exposure to moisture, such as urine, stool, sweat, or wound drainage) on the sacral (inverted triangle-shaped bone located between your hip bones) and coccyx (tailbone) area. A review of Resident 1's clinical record indicated there was no weekly skin/wound assessment conducted on April 24, 2026. A review of Resident 1's weekly skin/wound assessment dated [DATE], indicated Resident 1's sacral/coccyx MASD has progressed to pressure injury Stage 3 (a deep, crater-like wound that goes completely through the top and middle layers of skin. The damage has reached the fatty layer beneath the skin) measuring 2.5 cm long x 3 cm wide x 0.3 cm deep. 80% granules (80% healthy red tissue) and 20% slough with moderate serosanguinous (20% medium amount of drainage from the wound that contained both clear fluid and small amount of blood). During a concurrent interview and record review on May 19, 2026, at 2:35 PM, with the Wound Care Nurse (WCN 1), the WCN 1 reviewed Resident 1's weekly wound assessments, stated there was no documentation showing the wound progressed from Stage 1 (the earliest clinical sign of tissue damage where the skin is not open or broken, but looks red or discolored, may feel warm and tern, and does not briefly turn white when you press on it) or Stage 2 (a shallow, open sore or a fluid filled blister) before it was identified as Stage 3. WCN 1 acknowledged she did not complete a wound assessment between April 17, 2026, and April 30, 2026, and stated this was unacceptable because the required assessment and progress note were not completed. WCN 1 further stated that if the pressure ulcer had been identified earlier, interventions could have been started to prevent the wound from progressing to Stage 3. During an interview on May 19, 2026, at 3:47 PM, with the Administrator (Admin), Admin acknowledged the early changes in Resident 1's skin condition were not identified which resulted in the resident's MASD progressing to pressure injury Stage 3. During concurrent telephone interview and record review on May 21, 2026, at 9:32 AM, with the Admin, the Admin reviewed and acknowledged the facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, dated 2001, which indicated, Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable.

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