

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: 055707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Ontario Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 maintain an effective pest control program for 55 out of 55 residents when a live roach was observed in kitchen food preparation area. This failure had the potential to contaminate food, food preparing surfaces, and equipment which will place residents at risk for food borne illness and infections. During a concurrent observation and interview on February 17, 2026, at 12:28 PM, with Dietary Supervisor (DS- a person who oversees food services in the facility), in the kitchen, a live roach was observed crawling on the wall above the kitchen sink. The DS caught the roach with a piece of aluminum foil. The DS stated she was not sure how the roach came inside the kitchen. DS further stated, it is not acceptable to have roaches inside the kitchen as it is a concern for contamination and infection. During an interview on February 18, 2026, at 3:30 PM, with the Dietician, the Dietician stated, it is important to have a pest control program inside the kitchen as there is a high risk of food contamination that could affect the health of residents. During a concurrent interview and record review on February 19, 2026, at 2:55 PM, with the Infection Preventionist (IP- an individual who is responsible for preventing infection in the facility), the facility's policy and procedure (P&P) titled, Infection Control, dated April 2025, and Pest Control, dated May 2008, were reviewed. The Infection Control P&P indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The IP stated, as there was a live roach in kitchen there is a high chance of contaminating and infecting the food. The Pest Control P&P indicated, The facility shall maintain an effective pest control program, the IP stated, policy was not followed as there was roach in the kitchen. During a concurrent interview and record review on February 20, 2026, at 2:35 PM, with Director of Nursing (DON), the facility's P&P titled, Sanitation, dated November 2022, was reviewed. The P&P indicated, Policy statement. The food service area is maintained in a clean and sanitary manner. Policy interpretation and implementation . 1. All kitchen, kitchen areas and dining area are kept clean, free from garbage and debris and protected from rodents and insects. The DON stated roaches inside the kitchen are unacceptable and she said the facility should be free of pest. The DON further stated roaches inside the kitchen pose a high risk of food contamination of food and can cause infection for residents.		

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
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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR - a screening assessment to ensure individuals who are identified to have a significant mental illness [SMI] or intellectual/developmental [I/DD] disability are appropriately placed in nursing homes for long term care) was completed accurately for one of two sampled residents (Resident 8) when PASRR screening assessment for Resident 8 did not include her diagnoses of anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), depression (a mental health condition characterized by persistent feelings of sadness, loss of interest in activities) and psychotic disorder not due to a substance or known physiological condition (severe mental illness). This failure had the potential to result in Resident 8's condition not being identified prior to admission and their needs for treatment and services not being accurately assessed, placing them at risk of inadequate care. During a review of Resident 8s admission Record (contains medical and demographic information), the admission Record indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included depression, anxiety disorder, and other psychotic disorder not due to a substance or known physiological condition. During a review of Resident 8's Preadmission Screening and Resident Review (PASRR) Level I screening (a level 1 screening includes assessment of the resident's medical diagnoses to determine if the resident has or is suspected of having a PASRR condition [i.e. SMI, or I/DD]), dated December 16, 2025, it indicated in section III for Serious Mental Illness . 9. Diagnosed Serious Mental Illness. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia/Schizoaffective Disorder, or symptoms of psychosis, delusions, and/or mood disturbance? The answer was marked NO. Further review of the PASRR indicated, Result of Level I Screening: Level I- Negative, resolution status LII (Level II -triggered when the initial Level 1 screening identifies a potential need for specialized care, meaning the individual being assessed is suspected of having SMI or I/DD) - not required. During an interview on February 19, 2026, at 2:24 PM, with Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 8's PASRR dated December 16, 2025, did not reflect Resident 8's diagnoses. The MDSC further stated the facility should have accurately screened the resident and corrected the PASRR to include the diagnoses on readmission to the facility. During a concurrent interview and record review on February 20, 2026, at 3:03 PM, with the Administrator, the facility's policy and procedure (P&P) titled, admission Criteria, revised March 2019, was reviewed. The P&P indicated, . 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASRR) process.b. if the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred o the state PASARR representative for the Level II (evaluation and determination) screening process. The DON acknowledged that based on Resident 8's admission records, the PASRR was not accurate, and that the P&P was not being followed.		

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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 interview and record review, the facility failed to maintain accurate records of controlled medications (medications that are controlled by the government because it may be abused or cause addiction) for one of two medication carts (Medication Cart Station 2) reviewed for medication storage. This failure had the potential for drug diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by an unauthorized person in a highly vulnerable population of 55 residents. During a concurrent interview and record review on February 18, 2026, at 4:15 PM, with the Administrator (Admin), the Narcotic Floor Release (NFR- narcotic records, a form used by the facility to verify counting of controlled drugs at the change of shift by oncoming and off going licensed nurses) NFR- dated February 1, 2026, through February 18, 2026, was reviewed. The NFR indicated there were eight signatures missing as follows:-February 4, 2026, oncoming day shift (7 AM to 3:00 PM)-February 5, 2026, oncoming day shift (7 AM to 3:00 PM and off going evening shift (3:00 PM to 11:00 PM)-February 11, 2026, oncoming night shift (11:00 PM to 7:00 AM)-February 13, 2026, off going night shift (11:00 PM to 7:00 AM)-February 16, 2026, oncoming evening shift (3:00 PM to 11:00 PM)-February 17, 2026, off going night shift (11:00 PM to 7:00 AM)-February 17, 2026, off going evening shift (3:00 PM to 11:00 PM)The Admin confirmed there were missing signatures for reconciling the narcotic inventory in the NFR. During an interview on February 18, 2026, at 4:20 PM, with Licensed Vocational Nurse (LVN) and Admin, LVN 1 stated, the nursing staff are responsible for signing the NFR at the start of their shift and at the end of their shift. LVN 1 stated it is important for nursing staff to fill out the NFR to verify that the narcotic count is correct and that the cart is intact. During an interview on February 18, 2026, at 4:30 PM, with LVN 2, LVN 2 stated the expectation is to fill out the NFR at the start and end of shift because it is important to hold the staff accountable and to avoid drug diversion. During a concurrent interview and record review on February 20, 2026, at 2:40 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Controlled Substances, dated November 2022, was reviewed. The P&P indicated, dispensing and Reconciling Controlled Substances. 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up. 3. Nursing staff count controlled medication inventory at the end of each shift, using records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. The DON stated the policy was not followed and should have been because the nursing staff should ensure the narcotic count is correct for drug diverging.		

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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 ensure staff followed safe infection control practices for 2 of 24 sampled residents (Residents 5 and 6) when:1. A Certified Nursing Assistant (CNA) did not use appropriate personal protective equipment (PPE- equipment used to minimize injuries and illness) while providing hygiene care to Resident 5, who was on Enhanced Barrier Precautions (EBP- health care staff wear gowns and gloves during high contact care (providing hygiene, dressing, bathing, wound care, changing linens and device care) to prevent the spread of resistant germs).2. A Certified Hospice Health Aid (CHHA) did not use appropriate PPE while changing linens for Resident 6 who was on EBP precautions.These failures had the potential to increase the risk of transmission of multidrug-resistant organisms (MDROs- germ or bacteria that are had to kill with common antibiotic) to the resident, other residents, and staff due to improper use of infection control precautions and potentially prolong resident's recovery caused my complications.1. During a Review of Resident 5's Face sheet (FS-Document containing resident demographics), the Face sheet indicated Resident 5 was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar), peripheral vascular disease (PVD- blood flow to the arms and legs is reduced because the vessels are narrow or blocked), and peripheral neuropathy (nerve damage in the hand or feet that can feel like burning, tingling, numbness).During a review of Resident 5's Orders dated April 10, 2024, the Orders indicated, May have Enhanced Barrier Precaution. Every shift for D/T [DUE TO] Diabetic Ulcer [an open wound/sore the develops on the foot of someone with diabetes].During an observation on February 18, 2026, at 10:46 AM, in room [ROOM NUMBER], CNA 2 was brushing Resident 5's hair without a gown or gloves.During an interview on February 18, 2026, at 10:58 AM, CNA 2 stated, the residents with a blue dot next to their name are on EBP. CNA 2 further stated Resident 5 is on EBP and she should have worn a gown and gloves to protect the residents from the spread of infections.A review of Resident 5's care plan (a detailed guide outlining an individual's medical, personal and social needs, as well as the support required to meet them), dated August 21, 2025, indicated, use gown and gloves during high contract resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, changing linens, device care, wound care).2. During a Review of Resident 6's Face sheet, it indicated Resident 6 was admitted to the facility on [DATE], with diagnoses that included of diabetes, hemiplegia (paralysis on one side of the body), gastrostomy (a surgically created opening into the stomach for feeding and medication), and is on hospice care (care is based on comfort for someone who is near the end of life).A review of Resident 6's Orders, dated November 16, 2025, the Orders indicated, Resident may be on Enhanced Barrier Precaution related to gastrostomy tube and colonization of MDRO VRE [VRE- vancomycin Resistant Enterococcus is a germ that has become resistant to the antibiotic [medication to heal bacterial infections] vancomycin] every shift.During an observation on February 17, 2026, at 8:50 AM, in room [ROOM NUMBER], CHHA was removing and changing linens without a gown for Resident 6. During an interview on February 17, 2026, at 8:54 AM, CHHA stated, she works for an outside hospice company and was changing Resident 6's Linens. CHHA further stated she was not sure if Resident 6 was on any type of precautions. During an interview on February 17, 2026, at 8:56 AM, with an Environment Staff Aid (EVS Aid) and CHHA, the EVS Aid 1 stated, any residents who have a blue dot next to their name are on EBP. CHHA confirmed that Resident 6 was on EBP and should have worn a gown when removing linens. CHHA stated it is important to use the proper PPE to not transmit [spread] infection from resident to resident.During a review of Resident 6's care plan dated January 27, 2026, indicated, use gown and gloves during high contract resident care activities (dressing, bathing, transfers, hygiene, toileting, brief changes, changing linens, device care, wound care).During a concurrent interview and record review on February 19, 2026, at 2:10 PM, with the Infection Preventionist (IP), Resident 5 and 6 orders were reviewed. Resident's 5 orders dated April 10, 2024, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 5 was on EBP. Resident 6's orders dated November 16, 2025, indicated Resident 6 was on EBP. The IP confirmed and verified both Resident 5 and Resident 6 were on EBP and stated, the expectation is that any staff who is providing high contact care, for a resident on EBP, should wear a gown and gloves. The IP added, it is important to wear appropriate PPE because it is an extra layer of precautions to protect the residents from us and to prevent the spread of MDRO. During a concurrent interview and record review on February 20, 2026, at 2:34 PM, with the Director of Nursing (DON), the facility's Policy and Procedures (P&P) titled Enhanced Barrier Precautions, dated April 2024 was reviewed. The P&P indicated, .a. gloves and gown are applied prior to performing the high contact resident care activity. The DON stated that the policy was not followed and should have been for Resident 5 and Resident 6. The DON stated it is important to follow the policy to prevent because the staff should not cross contamination and reduce the spread of infections from one resident to another.		

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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 ensure 11 of 25 resident's rooms (1, 2, 3, 4, 6, 7, 8, 9, 11, 14, and 21) had the required 80 square feet (Sq Ft - unit of measurement) of space for each resident. This failure had the potential to negatively impact resident comfort, dignity, and safety by limiting adequate space for movement, equipment placement and staff assistance of 26 residents who reside in those 11 rooms. Findings: During an interview with the administrator (Admin) on February 17, 2026, at 10:59 AM the admin stated that the facility had 11 rooms (room [ROOM NUMBER], 2, 3, 4, 6, 7, 8, 9, 11, 14, and 21) that were smaller than the required 80 Sq feet. The Admin stated the facility had previously submitted a room waiver for all 11 rooms and that there are not any issues with care in relation to the size of the rooms. During a concurrent observation and interview on February 17, 2026, at 4:00 PM with the Maintenance Supervisor (MS), during an environmental tour of rooms 1, 2, 3, 4, 6, 7, 8, 9, 11, 14, and 21, The following measurements were noted as follows:- room [ROOM NUMBER] had two residents (Resident 22 and 34) and measured 77.91 square feet (Sq Ft. -unit of measurement) for each resident.- room [ROOM NUMBER] had two residents (Resident 58 and 25) and measured 78.14 Sq Ft. for each resident. - room [ROOM NUMBER] had two residents (Resident 8 and 10) and measured 76.59 Sq Ft. for each resident.- room [ROOM NUMBER] had two residents (Resident 7 and 53) and measured 76.73 Sq Ft. for each resident.- room [ROOM NUMBER] had two residents (Resident 14 and 45) and measured 77.78 Sq Ft. for each resident.- room [ROOM NUMBER] had two residents (Resident 37 and 40) and measured 78.37 Sq Ft. for each resident.- room [ROOM NUMBER] had two residents (Resident 21 and 52) and measured 77.91 Sq Ft. for each resident.- room [ROOM NUMBER] had four residents (Resident 17, 39, 54, and 55) and measured 70.95 Sq Ft. for each resident.- room [ROOM NUMBER] had three residents (Resident 3, 11 and 51) and measured 76.66 Sq Ft. for each resident.- room [ROOM NUMBER] had three residents (Resident 15, 28, and 64) and measured 77.54 Sq Ft. for each resident.- room [ROOM NUMBER] had two residents (Resident 12 and 33) and measured 70.06 Sq Ft. for each resident. The MS verified that all 11 rooms (room [ROOM NUMBER], 2, 3, 4, 6, 7, 8, 9, 11, 14 and 21) did not have the required 80 Sq Ft of space for each resident. During an interview on February 18, 2026, 2:57 PM with Certified Nurse Assistant (CNA) CNA 1, stated the size of all rooms in the facility are wheelchair accessible and have sufficient space to provide care. During an interview on February 20, 2026, at 2:50 PM with the Admin, the Admin stated there have been no issues with care in relation to the rooms that are less than 80 Sq Ft.		