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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555108 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/19/2025 |
| NAME OF PROVIDER OR SUPPLIER Inland Christian Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 1950 S. Mountain 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the quarterly Resident Assessment Instrument/Minimum Data Set (RAI/MDS- a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS] every 3 months or quarterly) was completed in accordance with federal submission timeframes, for two of two sampled residents (Resident 4 and 46) when:</p> <ol style="list-style-type: none"> 1. Resident 4's Annual Comprehensive Assessment RAI/MDS assessment was completed on June 18, 2025. (146 days late). 2. Resident 46's quarterly RAI/MDS assessment was not completed on June 18, 2025. (122 days late) <p>These failures had the potential to result in a delay in determining the resources necessary to competently care for the Resident 4 and 46 during the day-to-day operations and emergencies.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 4's History and Physical (H&P -contains resident's medical history, physical examination and reason for admission to the facility), dated June 19, 2025, the H&P indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (a group of lung disease that blocks airflow and make it difficult to breathe), heart failure (when the heart does not pump enough blood), mild cognitive impairment (a brain condition that causes noticeable but mild memory and thinking problems), and acute on chronic respiratory failure (a condition where a patient with pre-existing problems experiences a sudden worsening of their respiratory functions). <p>During an interview on June 19, 2025, at 10:57 AM, with the Director of Nursing (DON), the DON stated one of her duties is to make sure the resident's MDS is completed on time. The DON further stated the expectation for the quarterly/ annual comprehensive assessment is that it must be completed within 92 days from the prior quarterly assessment.</p> <p>During a concurrent interview and record review on June 19, 2025, at 11:05 AM, with the DON, Resident 4's quarterly MDS assessment data, dated January 23, 2025, was reviewed. The DON stated the last quarterly assessment was completed on January 23, 2025. The DON further stated the facility did not complete the annual comprehensive assessment that was due on April 26, 2025 (92 days late). The annual comprehensive assessment was completed on June 18, 20025, (146 days late).</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. During a review of Resident 46's H&P dated June 19, 2025, the H&P, indicated, Resident 46 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (high blood sugar), chronic kidney disease (when the kidneys do not work properly), hypertension (a condition where the heart is working harder to pump blood), and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin. A protein found in red blood cells, to carry oxygen all through the body).</p> <p>During an interview on June 19, 2025, at 10:57 AM, with the Director of Nursing (DON), the DON stated one of her duties is to make sure the resident's MDS is completed on time. The DON further stated the expectation for the quarterly assessment is that it must be completed within 92 days from the prior quarterly assessment.</p> <p>During a concurrent interview and record review on June 19, 2025, at 11:05 AM, with the DON, Resident 46's quarterly MDS assessment data, dated February 16, 2025, was reviewed. The DON stated the last quarterly assessment was completed on February 16, 2025. The DON further stated the facility did not complete the quarterly assessment that was due on May 19, 2025 (92 days late) and was submitted on June 18, 2025 (122 days late).</p> <p>During a concurrent interview and record review on June 19, 2025, at 11:19 AM, with the DON, the facility's P&P titled, Resident Assessments dated 2001, was reviewed.</p> <p>The P&P indicated, .1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments-conducted for all residents in the facility: (1) admission Assessment (Comprehensive); (2) Quarterly Assessment; (3) Annual Assessment (Comprehensive); and P&P titled, Quarterly Assessments, dated 2001, was also reviewed. The P&P indicated, .1. The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that is completed at least every 92 days following the previous OBRA assessment of any type. A. The ARD will not be more than 92 days after the ARD of the most recent OBRA assessment of any type</p> <p>The DON stated the P&P was not followed and should have because it provides accurate reimbursement for the facility and care planning for the residents.</p> | | |

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| <p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the quarterly (every 3 months) Resident Assessment Instrument/Minimum Data Set (RAI/MDS- a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS]) was transmitted (submitted) to CMS in accordance with federal submission timeframes, for two of two sampled residents (Resident 4 and 46) reviewed for resident assessment when:</p> <ol style="list-style-type: none"> 1. Resident 4's comprehensive RAI/MDS assessment was completed on June 18, 2025 (146 days late) 2. Resident 46's quarterly MDS assessment was completed on June 18, 2025 (122 days late). <p>These failures resulted in inadequate monitoring of Residents 4 and 46 progress or decline and the lack of Residents 4 and 46 specific information to CMS for payment and quality measure monitoring.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a review of Resident 4's History and Physical (H&P -contains resident's medical history, physical examination and reason for admission to the facility), dated June 19, 2025, the H&P indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (a group of lung disease that blocks airflow and make it difficult to breathe), heart failure (when the heart does not pump enough blood) , mild cognitive impairment (a brain condition that causes noticeable but mild memory and thinking problems), and acute on chronic respiratory failure (a condition where a patient with pre-existing problems experiences a sudden worsening of their respiratory functions). <p>During an interview on June 19, 2025, at 10:57 AM, with the Director of Nursing (DON), the DON stated one of her duties is to make sure the resident's MDS is completed on time. The DON further stated the expectation for the quarterly/ annual comprehensive assessment is that it must be completed within 92 days from the prior quarterly assessment.</p> <p>During a concurrent interview and record review on June 19, 2025, at 11:05 AM, with the DON, Resident 4's quarterly MDS assessment data, dated January 23, 2025, was reviewed. The DON stated the last quarterly assessment was completed on January 23, 2025. The DON further stated the facility did not complete the annual comprehensive assessment that was due on April 26, 2025 (92 days late). The annual comprehensive assessment was completed on June 18, 20025 (146 days late).</p> <ol style="list-style-type: none"> 2. During a review of Resident 46's H&P dated June 19, 2025, the H&P, indicated, Resident 46 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (high blood sugar), chronic kidney disease, hypertension (a condition where the heart is working harder to pump blood), and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin. A protein found in red blood cells, to carry oxygen all through the body). <p>(continued on next page)</p> | | |

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| <p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on June 19, 2025, at 10:57 AM, with the Director of Nursing (DON), the DON stated one of her duties is to make sure the resident's MDS is completed on time. The DON further stated the expectation for the quarterly assessment is that it must be completed within 92 days from the prior quarterly assessment.</p> <p>During a concurrent interview and record review on June 19, 2025, at 11:05 AM, with the DON, Resident 46's quarterly MDS assessment data, dated February 16, 2025, was reviewed. The DON stated the last quarterly assessment was completed on February 16, 2025. The DON further stated the facility did not complete the quarterly assessment that was due on May 19, 2025 (92 days late) and was submitted on June 18, 2025 (122 days late).</p> <p>During a concurrent interview and record review on June 19, 2025, at 11:19 AM, with the DON, the facility's P&P titled, Resident Assessments, dated 2001, was reviewed. The P&P indicated, .1. The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments-conducted for all residents in the facility: (1) admission Assessment (Comprehensive); (2) Quarterly Assessment; (3) Annual Assessment (Comprehensive); and P&P titled, Quarterly Assessments, dated 2001, was also reviewed. The P&P indicated, .1. The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that is completed at least every 92 days following the previous OBRA assessment of any type. A. The ARD will not be more than 92 days after the ARD of the most recent OBRA assessment of any type .</p> <p>The DON stated the P&P was not followed and should have because it provides accurate reimbursement for the facility and care planning for the residents.</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication was properly stored when:</p> <ol style="list-style-type: none"> For one of five sampled residents (Resident 41), barrier cream was found open and not in a sanitary manner on the night table next to the Resident 41's bed. <p>This failure had the potential to cause contamination to the barrier cream and lead to skin infection.</p> <ol style="list-style-type: none"> One of one treatment cart was found to have 5 expired packets of hydrogel statures gauze (a wound dressing consisting of gauze that has been infused with a hydrogel, a gel-like substance that is primarily composed of water). <p>This failure had the potential to cause worsening of the wound, delayed wound healing and can lead to wound infections.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a review of Resident 41's face sheet (FS- a document with resident demographics, brief medical history, and emergency contacts), the FS indicated, Resident 41 was admitted on [DATE] with diagnosis of multi-system degeneration of the autonomic nervous system (MSA- a condition that affects the nervous system which control involuntary functions like blood pressure, digestion, and breathing.), Neuromuscular dysfunction of bladder (a condition where the nerves and muscles that control the bladders function are impaired leading to problems with storage or emptying if urine), and muscle weakness. <p>During a review of Resident 41's orders, updated on June 18, 2025, it indicates, MASD [Moisture-associated skin damage- skin inflammation cause by prolonged exposure to moisture] to Right Buttock; cleanse with NS [Normal Saline-a solution of water and salt], pat dry, apply xeroform [a type of wound dressing, that is petrolatum -based gauze], add barrier cream to periwound [the area of skin surrounding a wound] and cover with super absorbent dressing every day shift for 14 days. And MASD to left Buttock; cleanse with NS pat dry, apply xeroform, add barrier cream to periwound and cover with super absorbent dressing every day shift for 14 days.</p> <p>During an observation on June 16, 2025, at 10:20 AM on the bedside table, there was a medication cup full of white cream, next to it were opened packets of Zinc Oxide barrier cream (Topical cream that created a protective layer on skin's surface).</p> <p>During an interview with Licensed Vocation Nurse 2 (LVN 2) on June 16, 2025, at 10:27 AM, LVN 2 stated, the medication cup had barrier cream, and it was most likely left like that by the treatment nurse.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview with Licensed Vocational Nurse 3 (LVN 3) on June 16, 2025, at 10:50 AM, LVN 3 stated it was not left in there by her and whoever left that medication cup with barrier cream should have tossed it because they are not supposed to leave the medication cups with barrier cream at bedside.</p> <p>During an interview with Infection Preventionist (IP) on June 16, 2025, at 11:20 AM, the IP stated it is not acceptable to leave a medication cup at the resident's bedside regardless of what is in it, and it should have been tossed.</p> <p>During a concurrent interview and record review on June 18, 2025, at 12:37 PM, with the Director of Nursing (DON) of the facility's Policy and Procedure (P&P) titled, Medication Labeling and Storage dated February 2023 was reviewed.</p> <p>The P&P indicated, The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>The DON stated that the barrier cream being left on the bedside table it not considered sanitary, and the P&P was not followed. The DON further stated it is important to get new barrier cream out of the bottle to not have contaminated barrier cream.</p> <p>2. During an observation with on June 17, 2025, at 12:07 PM, in the treatment cart in front of the nurse's station, five hydrogel saturated gauze were found with expiration date of May 16, 2025.</p> <p>During a concurrent observation and interview with LVN 3 on June 17, 2025, at 12:10 PM, LVN 3 stated, that the hydrogels expired in May 2025, and verified it had been 32 days of it being expired.</p> <p>During a concurrent interview and record review with the DON, on June 18, 2025, at 12:39 PM, of the facility's P&P titled, medication storage in the facility dated June 2016 was reviewed. The P&P indicated, G. All expired medications will be removed from the active supply and destroyed in the facility .</p> <p>The DON stated that the P&P was not followed, and it should have. The DON stated it is important to not have expired medications to get all of the potency of the medications.</p> <p>During an interview on June 19, 2025, at 11:11 AM, with LVN 3, stated that it is her responsibility to check the treatment cart every Friday and make sure all expirations are ok. LVN 3 further stated, there should have not been any expired medications/ supplies in the treatment cart.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to follow proper sanitation and food handling practices when:</p> <ol style="list-style-type: none"> Two food items (BBQ sauce and Shredded Parmesan Cheese) were found in the refrigerator unlabeled and undated. One food item (A tray of tomatoes) was found in the refrigerator beyond its expiration date on the label. The cooling logs for May and June 2025 indicated improper cooling practices and techniques. <p>These failures had the potential to cause significant health risks for all 54 vulnerable residents who reside in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> During the initial kitchen tour on June 16, 2025, at 8:56 AM all refrigerators and freezers in the kitchen were inspected. The following were found: Two food items were found in the refrigerator unlabeled and undated. Specifically, there was a 1-gallon bottle of [name of brand] Tangy Gold BBQ sauce, which was 1/4 full, and a bag of [name of brand] Shredded Parmesan Cheese, both without labels and dates indicating when they were placed in the refrigerator. One food item, a tray of tomatoes, was found in the refrigerator beyond its expiration date. The tray contained two whole tomatoes and one-half tomato, covered with plastic wrap, labeled must be used by 06/15/2025 at 8 AM. These tomatoes should have been discarded on June 15, 2025, at 8 AM according to the label instructions, but they were still present in the refrigerator the following day. <p>During an interview with the Director of Kitchen (DOK) on June 17, 2025, at 3:35 PM, the DOK stated that the BBQ sauce and the shredded Parmesan cheese should have been labeled and dated when placed in the refrigerator. The DOK also acknowledged that the tomatoes were expired and should have been discarded as per the labeling instructions. The DOK was unsure as of why these items were not properly managed.</p> <p>During a concurrent interview with the DOK and record review on June 17, 2025, at 3:40 PM, the facility's Policy and Procedure (P&P) titled, FOOD AND SUPPLY STORAGE, revised January 2025, was reviewed.</p> <p>The P&P indicated, All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Most, but not all, products contain an expiration date. The words sell-by, best-by, enjoy-by or use-by should precede the date. The sell-by date is the last date that food can be sold or consumed . foods past the use-by, sell-by, best-by, or enjoy-by date should be discarded . discard food past the use-by or expiration date.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>The DOK acknowledged that the facility's P&P was not followed and emphasized the importance of labeling and dating all food items before placing them in storage or refrigeration and discarding expired items immediately.</p> <p>3. During a review of facility's cooling logs on June 19, 2025, at 1:43 PM, the cooling logs indicated the following:</p> <p>05/07/2025 - Chicken was placed in the refrigerator at 1:30 PM at 170 F (Fahrenheit-a unit of measurement for cold and heat). Temp rechecked at 3:39 PM was 78.3 F. Temp rechecked at 5:00 PM was 37 F.</p> <p>05/09/2025 - Chicken was placed in the refrigerator at 8:30 AM at 150 F. Temp rechecked at 10:40 AM was 80 F. Temp rechecked at 12:30 PM was 40 F.</p> <p>05/11/2025 - Chicken was placed in the refrigerator at 1:30 PM at 170 F. Temp rechecked at 2:30 PM was 120 F. Temp rechecked at 4:30 PM was 39 F.</p> <p>05/14/2025 - Chicken was placed in the refrigerator at 3:00 PM at 160 F. Temp rechecked at 5:00 PM was 80 F. Temp rechecked at 7:00 PM was 37 F.</p> <p>05/16/2025 - Chicken was placed in the refrigerator at 12:00 PM at 160 F. Temp rechecked at 1:00 PM was 90 F. Temp rechecked at 4:00 PM was 40 F.</p> <p>05/22/2025 - Chicken was placed in the refrigerator at 1:00 PM at 170 F. Temp rechecked at 3:00 PM was 90 F. Temp rechecked at 5:00 PM was 38 F.</p> <p>06/02/2025 - Pork was placed in the refrigerator at 1:27 PM at 141 F. Temp rechecked at 2:15 PM was 110 F. Temp rechecked at 3:00 PM was 40 F.</p> <p>06/11/2025 - Corn was placed in the refrigerator at 1:22 PM at 141 F. Temp rechecked at 2:15 PM was 112 F. Temp rechecked at 3:00 PM was 36 F.</p> <p>06/17/2025 - Chicken was placed in the refrigerator at 10:00 AM at 170 F. Temp rechecked at 11:30 AM was 110 F. Temp rechecked at 1:00 PM was 37 F.</p> <p>On June 19, 2025, at 2:05 PM during a concurrent Interview with DOK and record review, the cooling logs and the facility's Policy and Procedure (P&P) #B007 revised January 2025, titled, FOOD AND HANDLING GUIDELINES, were reviewed.</p> <p>During the review of the facility's Cooling Logs dated May 2025 and June 2025 with the DOK, several entries showing temperatures still above 70&deg;F after the two-hour mark, while others show temperature checks performed too early (before the two-hour point) were identified.</p> <p>The P&P indicated, COOLING .Food shall be cooled from 135 F to 70 F as measured at its center within two hours and from 70 'F to 41 'F within an additional four hours for a total cooling time of six hours or less . Foods that have not cooled to 70&deg;F within 2 hours of being placed in the cooling equipment: reheat once to 165 F and re-cool. If food was not below 70&deg;F at 2 hours, and it was reheated, discard if not below 70 F at 2 hours when cooling for the second time. Food that is not below 41 F at 6 hours must be discarded.</p> <p>(continued on next page)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During the interview, the DOK acknowledges her oversight in monitoring the cooling process properly and explains that she believed cooling food faster was better and acknowledges that she checked the food temperature before the two-hour mark, therefore obtaining inaccurate temperature readings. The DOK stated the documentation must show the temperature reading precisely at the two-hour mark and six-hour mark to demonstrate P&P compliance.</p> <p>The DOK confirmed the facility's P&P was not followed.</p> | | |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Physician Orders Life Sustaining Form (POLST-medical orders that communicates to healthcare facilities and providers a patient's wishes for end-of-life interventions) was appropriately completed for one of five sampled residents (Resident 37) reviewed for Advance Directives (legal document that allows you to spell out your decision about end-of-life care) when the facility had Resident 37 with a BIMS (brief interview for mental status indicating decision making capacities in which a score of 13-15 has no significant decisions making impairment, a score of 8-12 has moderate decisions making impairment, a score of 0-7 has severe decisions making impairment) of 00 sign the POLST instead of the legally recognized decisionmaker.</p> <p>This failure had potential to cause emotional distress to Resident 37 and the Resident 37's family for not respecting their wishes to treatment.</p> <p>Findings:</p> <p>During a review of Resident 37's face sheet (FS- a document with resident demographics, brief medical history, and emergency contacts), the FS indicated, Resident 37 was admitted on [DATE] with diagnosis of dementia (a mental ability that interfere with daily life such as memory loss, impaired thinking and changes in behavior), Diabetes Type 2 (a condition where the body is not producing enough insulin to keep blood glucose in normal level), and dysphagia (difficulty swallowing).</p> <p>During a review of the Resident 37's POLST dated May 12, 2025, the POLST indicated, that it was discussed with the legally recognized decisionmaker, but it was signed by Resident 37.</p> <p>During a review of the Minimum Data Set (MDS-a standardized, comprehensive assessment that collects information about a resident's functional, medical, psychosocial, and cognitive status.) dated March 9, 2025, section C which include BIMS indicated Resident 37's BIMS score was 00.</p> <p>During a concurrent interview and record review on June 17, 2025, at 8:56 AM with the Director of Nursing (DON) the POLST for Resident 37 was reviewed. The POLST indicated, that it was signed by Resident 37. The DON stated that the POLST should have been signed by the legally recognized decisionmaker and not the resident.</p> <p>During an interview with Social Services Director (SS), on June 17, 2025, at 9:33 AM, the SS stated it is important to have the legally recognized decisionmaker because they want to be sure to follow the family wishes.</p> <p>During a concurrent interview and record review with the DON of the facility's Policy and Procedure (P&P) titled Physician Orders for Life Sustaining Treatment POLST dated November 2017, was reviewed.</p> <p>The P&P indicated, .The form is to be signed by the resident with capacity, or the resident representative when resident lacks capacity .</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555108 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 06/19/2025 |
| NAME OF PROVIDER OR SUPPLIER Inland Christian Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 1950 S. Mountain 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. | | | |
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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The DON stated that a resident with a BIMS score of 0 does not have the capacity to sign documents and that the POLST should have been signed by the legally recognized decisionmaker. The DON further stated that the policy was not followed and should have been in order to know the family's wishes in case of an emergency.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that proper and safe infection control policies were followed for one of 15 sampled resident (Resident 2) when in Resident 2's room, a yankauer (a rigid, hollow medical instrument used for suctioning fluids, secretions, and debris from the mouth and throat) was left uncovered and exposed. Further observation in Resident 2' room, the yankauer and suction canister was found not dated.</p> <p>These failures had the potential to result in cross-contamination (transfer of harmful bacteria) which can lead to infection.</p> <p>FINDINGS:</p> <p>A review of Resident 2's admission Record, ((contains demographic and medical information), indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included Dementia (decline in mental ability severe enough to interfere with daily life), acute respiratory failure with hypoxia (a severe condition where the lungs cannot provide enough oxygen to the body), and hemiplegia (a condition characterized by paralysis of one side of the body, affecting the face, arm, and leg).</p> <p>During an observation on June 16, 2025, at 10:39 AM, in Resident 2's room, yankauer was found laying on top of suction machine uncovered and exposed to air. Further observation, the yankauer and suction canister was found not dated</p> <p>.</p> <p>During a concurrent observation and interview on June 16, 2025, at 10:44 AM, in Resident 2's room with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated she is not familiar with how often yankauer and suction canister needs to be changed but she believes it should be every four to five days.</p> <p>During an interview on June 17, 2025, at 8:52 AM, with Infection Preventionist Nurse (IP), IP stated that yankauer should be changed every seven days, yankauer should be covered, and should be labeled. The IP further stated that, infection control practices was not followed, and her expectation is that all staff should be able to identify breaches in infection control.</p> <p>During an interview on June 18, 2025, at 12:48 PM with the Director of Nursing (DON), the DON stated the yankauer needs to be changed every time that it is used and should not be left open to air due to infection control.</p> <p>A policy and procedure (P&P) was requested, the facility was unable to provide a P&P regarding infection control practices with yankauer.</p> |

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| <p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of five sampled residents (Resident 37) received the influenza (also known as the flu, which is a contagious respiratory illness caused by influenza viruses) vaccination even though the flu vaccine was requested on November 14, 2024.</p> <p>This failure had the potential for Resident 37 to have an increase the risk of illness, higher risk of complications, and it may contribute to spreading the virus to others.</p> <p>Findings:</p> <p>During a review of Resident 37's face sheet (FS- a document with resident demographics, brief medical history, and emergency contacts), the FS indicated, Resident 37 was admitted on [DATE] with diagnosis of dementia (a mental ability that interfere with daily life such as memory loss, impaired thinking and changes in behavior), Diabetes Type 2 (a condition where the body is not producing enough insulin to keep blood glucose in normal level), and dysphagia (difficulty swallowing).</p> <p>During a review of the immunization dashboard, there was no documented evidence resident 37 received the influenza vaccine in 2024.</p> <p>During a concurrent interview and record review with the Infection preventionist (IP) on June 19, 2025, at 9:02 AM, the vaccine consent form dated November 14, 2024, was reviewed.</p> <p>The vaccine consent form indicated, I hereby request that the influenza vaccine be given per facility policy and CDC [Center for Disease Control and Prevention] guidelines. The IP stated that the facility should have followed up with the influenza vaccination since the Resident 37 agreed to it.</p> <p>During a review of the CDC influenza (flu) Vaccine dated January 31, 2025, the influenza Vaccine indicates, everyone 6 months and older should get a flu vaccine every season .</p> <p>During a concurrent interview and record review with the Director of Nursing (DON) on June 19, 2025, at 1:36 PM the facility's Policy and Procedure (P&P) titled Influenza Vaccine dated March 2022 was reviewed.</p> <p>The P&P indicated, Administration of the influenza vaccine will be made in accordance with current Centers for Disease Control and Prevention (CDC recommendations at the time of vaccination.</p> <p>The DON stated the policy was not followed and should have been because the residents are in a high risk environment making them a higher risk for complications.</p> | | |

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| <p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Keep all essential equipment working safely.</p> <p>Based on observation, interview, and record review, the facility failed to maintain essential equipment in the kitchen free of accumulation of dirt, food residue, and other debris, when on June 16, 2025, at 9 AM during the initial kitchen tour, the 4-burner stove, the flat top griddle, and the grill were found to be in unsanitary conditions.</p> <p>These failures had the potential to lead to the growth of harmful microorganisms, such as bacteria, viruses, and fungi, which could result in foodborne illnesses for all 54 residents who reside in the facility.</p> <p>Findings:</p> <p>During the initial kitchen tour on June 16, 2025, at 9 AM the kitchen was inspected, and the following were found:</p> <p>(1) The 4-burner stove was found to have buildup oil, burnt food particles and grime on, around, and underneath the burners.</p> <p>(2) The flat top griddle was observed with visible layers of grease stains and dark discoloration across the cooking surface.</p> <p>(3) The grill has old burnt food particles sticking to the grill.</p> <p>During an interview with the Director of Kitchen (DOK) on June 16, 2025, at 10:10 AM, the DOK stated that the stove, flat top griddles, and grill had been cleaned four days ago. She highlighted that during cooking, food often spills over onto the stove and should ideally be wiped down immediately to prevent the accumulation of burnt food particles and grease. According to the DOK and the facility's Master Weekly Cleaning log, a thorough deep cleaning of the stove is scheduled for every Friday.</p> <p>During a concurrent interview and record review on June 18, 2025, at 10:52 AM, the facility's Policy and Procedure (P&P) #F013, titled Cleaning of Food and Non-Food Contact Surfaces, revised in January 2025, was reviewed.</p> <p>The P&P indicated, The food contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Non-food contact surfaces of equipment shall be cleaned as often as necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris.</p> <p>The Director of Kitchen (DOK) acknowledged that the P&P #F013 mandates that food contact surfaces of all cooking equipment must be free of encrusted grease deposits and other accumulated soil, while non-food contact surfaces must be cleaned regularly to prevent the build-up of dust, dirt, food particles, and other debris.</p> <p>The DOK admitted that the P&P #F013 was not followed and that the failure to adhere to the policy resulted in the unsanitary conditions observed during the inspection.</p> |