STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055707	A. BUILDING _____ B. WING _____	**10/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ONTARIO HEALTHCARE CENTER	**1661 SOUTH EUCLID AVENUE 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 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 interview and record review, the facility failed to ensure comprehensive infection surveillance for COVID-19 (Disease caused by the [DIAGNOSES REDACTED]-CoV-2 virus, a highly contagious and potential fatal respiratory infection) in the facility, when two out of three sampled residents (Residents 1 & 2) were not being screened at least daily for COVID-19 symptoms. This failure could have resulted in resident harm for all residents in the facility, as the lack of daily documented infection surveillance of COVID-19 has the potential to allow undetected COVID-19 outbreaks to occur in the facility, and can unnecessarily delay containment efforts towards protecting unaffected residents in the facility from COVID-19 exposure. Findings: During a review of the facility's resident census, and the list of residents designated as Persons Under Investigation (PUI - designated for residents who are suspected of having been exposed and/or being positive for COVID-19) in the facility, dated September 9, 2020, Resident 1 and Resident 2 were not designated as PUI residents, and were located within the facility's Green Zone (an area of the facility where residents are not suspected of being exposed and/or infected with COVID-19, and are cohorted together in the facility, away from affected residents). During an interview on September 10, 2020, at 1:20 p.m., with the DON, the DON stated only the residents in the facility's Yellow Zone (an area of the facility where residents suspected of being exposed and/or infected with COVID-19 are cohorted together in the facility, away from unaffected residents) are receiving daily COVID-19 symptom screening. During a concurrent interview and record review, on September 10, 2020, at 1:20 p.m., with the Director of Nursing (DON), the facility's Mitigation Plan, and the health records for Resident 1 & Resident 2 were reviewed. The Mitigation Plan was reviewed by the DON, and she stated all residents are to be screened for COVID-19, as indicated in the Mitigation Plan. The health records for Residents 1 & 2 were reviewed by the DON, and she stated there was no documentation that indicated Residents 1 & 2 were being screened for COVID-19 symptoms. During a concurrent interview and record review, on September 10, 2020, at 1:35 p.m., with the DON, the care plan for Resident 1 (undated) was reviewed. The care plan indicated a Focus for Resident 1 included, Risk for transmissible respiratory disease such as COVID-19 due to exposure to person positive for COVID-19. The care plan indicated Interventions included, . Monitor for signs and symptoms of respiratory illness such as cough, shortness of breath, sore throat and fever every shift . The DON stated the care plan for Resident 1 was not followed, as the COVID-19 symptom screening was not being documented in Resident 1's health record. During a review of the care plan for Resident 2, (undated) on September 10, 2020, the care plan did not include any Focus, nor Interventions towards COVID-19 sign and symptom monitoring. During a review of the facility's Mitigation Plan, the 1. Testing & Cohorting section (undated) of the Mitigation Plan indicated, . All residents are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks at a minimum of two times per day and documented in the clinical record .

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

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.