STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055001	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redlands Healthcare Center	1620 West Fern Avenue Redlands, CA 92373

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** 50575 Based on observation, interviews, and record reviews, the facility failed to maintain infection control practices for one of thirty-nine residents (Resident 60), when Resident 60's oxygen tubing (a thin, flexible tube that delivers oxygen to a patient during oxygen therapy) it had not been changed every seven (7) days, as per facility policy. This failure placed Resident 60 at risk for developing a respiratory infection (caused by bacteria, viruses, fungi, or parasite). Findings: During a review of Resident 60's Admission Record (clinical record with demographic information), the Admission Record indicated, Resident 60 was admitted on [DATE], with the diagnoses of acute respiratory failure (a serious condition that makes it difficult to breathe on your own), pleural effusion (a collection of fluid around your lungs), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a concurrent observation and interview on February 3, 2025, at 11:02 AM, with Licensed Vocational Nurse 2 (LVN 2), in Resident 60's room, Resident 60 was laying down, asleep, and using oxygen via nasal cannula (a small, flexible tube that contains two open prongs intended to deliver oxygen into the nares). There was a wheelchair on the left side of Resident 60's room with an e-tank (a container with oxygen inside) with a bag that contained oxygen tubing dated January 23, 2025. LVN 2 stated the oxygen tubing was dated January 23, 2025, and it should have been changed. During an interview on February 6, 2025, at 9:12 AM, with the Infection Preventionist (IP), the IP stated central supply staff and the certified nursing assistants change the oxygen tubing and humidifiers every Thursday. The Infection Preventionist further stated the oxygen tubing should have been changed on January 30, 2025, and it was four days late. During an interview on February 6, 2025, at 9:45 AM, with the Director of Nursing (DON), the DON stated the oxygen tubing should have been changed. The DON further stated, We missed that one. During a review of Resident 60's, Order Summary Report dated January 1, 2025, indicated Oxygen-change nasal cannula every week and also PRN (PRN-as needed). (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility policy and procedure (P&P) titled, Prevention of Infection Respiratory Equipment, dated November 2011, the P&P indicated, Purpose . The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment among residents and staff . Infection Control Considerations Related to Oxygen Administration . 4. Change the oxygen cannula and tubing every seven (7) days, or as needed.

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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 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** 49001 Based on observation, interview, and record review, the facility failed to ensure, call light (a device that allows patients to communicate with nursing staff when they need assistance) was within reach for one of six sampled residents (Resident 51) who has hemiplegia (partial paralysis on left side of her body with left hand contracture). This failure had the potential to place Resident 51 at risk of harm, as Resident 51 experiencing an emergency or needing assistance would not be able to call for help. Findings: During a review of Resident 51's clinical record, the Admission Record (a document that gives a summary of resident information), the Admission Record indicated, Resident 51 was admitted to the facility on [DATE], with diagnoses which included, hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side (partial paralysis on left side of the body), spondylosis, lumbar region (an age-related degeneration of the vertebrae and disks of the lower back). During a concurrent observation and interview on February 03, 2025, at 11:03 AM with Resident 51, in Resident's 51 room. Resident 51 was laying on bed awake. The call light was located on the left bed rail. Resident 51 stated, the call light does not get answer unless I screamed. Resident 51 further stated, usually her roommate calls the staff for assistance, instead of her. During a second observation and interview, on February 4, 2025, at 11:05 AM with the License Vocational Nurse (LVN 1), in Resident 51's room, Resident 51 was asleep with her arms under the bed covers, the call light was not visible. LVN 1 stated the call light was under Resident 51's pillow. Resident 51 was not able to reach the call light. LVN 1 then pulled the call light under the left side of Resident 51's pillow and placed it over her chest. During concurrent interview and record review on February 4, 2025, at 4:31 PM with the Director of nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled Answering the Call Light, revised October 2010. The P&P indicated, . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The DON stated the call light was under the pillow of Resident 51 and not within easy reach. During concurrent observation and interview on February 05, 2025, at 12:23 PM, with the DON, in Resident 51's room. Resident 51 was awake laying on her left side with both arms under the bed covers. The call light was placed on her left upper arm near the shoulder. Resident 51 tried to reach the call light in her left upper arm but was unable to reach it. Resident 51 had a little movement, trying to move the bed covers. The DON assisted Resident 51 and removed the bed covers. Resident 51 could not reach the call light that was placed on her left upper arm. The DON stated, she will move Resident 51's call light to her chest area. During interview on February 5, 2025, at 12:59 PM, with the DON, The DON stated, the expectation is all call lights to be within reach of all residents.