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	04/23/2026

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

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu for 70 of 71 residents when residents were served one (1) ounce of strawberry topping instead of two (2) ounces for Regular and Small portions and four (4) ounces for Large portions as indicated on the menu, during breakfast on April 22, 2026.This failure had the potential to result in lower caloric content of meals served and contribute to a decline in nutritional status and undesirable weight loss when recipes are not followed for 70 medically compromised residents.During tray line (when cook serves food on plates for each resident according to the menu) observation on April 22, 2026, at 07:03 AM, in the kitchen, the cook served strawberry topping using a 1-ounce purple-handle scoop to all 70 Residents, instead of #16 scoop and #8 scoop as indicated on the facility approved menu.During a review of the facility document titled, Spring Cycle Menu, dated April 22, 2026, the Spring Cycle Menu indicated, strawberry topping #16 scoop (1/4 cup = 2 ounces) for all diets Regular and Small portions and #8 (1/2 cup - 4 ounces) for all diets Large portions.A review of the facility's census list dated April 22, 2026, indicated there were 70 Residents in the facility. One resident was listed as NPO (nothing by mouth), 43 residents were to receive Regular, 2 received Small Portions, and 2 residents with Large Portions.During an interview with the Dietary Supervisor (DS) on April 22, 2026, at 9:33 AM, the DS stated the purple handle scoop measured 1 ounce, the #16 scoop measured 1/4 cup - equivalent to 2 ounces and the #8 scoop measured 1/2 cup - equivalent to 4 ounces.DS stated #16 scoop (2 ounces) should have been used for all diets for regular and small portions and #8 scoop (4 ounces) should have been used for all large portions. The DS acknowledged that the wrong scoop was used during breakfast on April 22, 2026, resulting in serving less amount of strawberry topping to 70 residents in-house.During an interview with the cook on April 23, 2026, at 8:45 AM, the cook stated he grabbed the wrong scoop and served the strawberry topping not according to the recipe. The cook acknowledged he served the wrong amount of strawberry topping to 70 in-house resident and stated the recipe and the Spring Cycle Menu should be followed.During an interview with the Registered Dietician Nutritionist (RDN) on April 23, 2026, at 8:56 AM, the RDN stated the recipe, and the Spring Cycle Menu should be followed.During a review on April 23, 2026, at 8:51 AM, of the facility's undated policies and procedures (P&P) titled, 7.1 Food Preparation, the P&P indicated: Policy: Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. Procedure: 2. Recipes are specific as to portion yield, method of preparation, amounts of ingredients, and time and temperature guide. The undated P&P titled Recommended Dietary Allowances stated Policy: Food & Nutrition Services shall provide food of the quality and quantity to meet each resident's needs in accordance with their physician's orders and to meet the Recommended Daily Dietary Allowances (RDA'S. Procedure: 1. The prepared menu will have a nutritional analysis, which is the foundation of meal planning, to assure that the nutritional needs of the residents are in accordance with the physician order and the Recommended Dietary Allowances. 2. The menus will be reviewed and approved by the Facility Registered Dietitian.During a concurrent interview with the DS and facility's P&P review on April 23, 2026, at 8:58 AM, the above P&Ps were reviewed by DS. The DS acknowledged the P&Ps were not followed when the cook used the wrong scoop size to serve strawberry topping to 70 in-house residents on April 22, 2026, during breakfast.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 maintain infection control practices when:1) A Certified Nursing Assistant (CNA3) did not performing hand hygiene when providing care between Resident 93 and Resident 89.2) Treatment Nurse 1 (TN 1) did not wear a gown while applying a wound dressing to a skin tear (a wound where the top layer of skin gets torn away from the layer right beneath it.) on Resident 47's hand while Resident 47 was on enhanced barrier precautions (EBP - a set of infection control practices focused on using personal protective equipment (PPE) like gowns and gloves during specific high-contact resident care activities for residents at increased risk of acquiring infection).These failures resulted in increased risk for the cross contamination (the spread of microorganisms from one surface to another) of infectious microorganisms within the environment and amongst a vulnerable population of 70 residents who lived in the facility.1) During a review of Resident 93's admission Record (contains medical and demographic information), the admission Record indicated Resident 93 was admitted to the facility on [DATE], with the diagnoses which included type two diabetes mellitus (difficulty in blood sugar control), hypertension (HTN-high blood pressure), hyperlipidemia (there are too many fatty substances (lipids)in the blood) and presence of right artificial knee joint (a medical device designed to replace a missing knee joint). During a review of Resident 89's admission Record the admission Record indicated Resident 89 was admitted to the facility on [DATE], with diagnoses which included pulmonary embolism (a serious, sudden blockage in one of the lung's arteries, usually caused by a blood clot), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) and alcohol cirrhosis of the liver with ascites (scarred liver tissue, causes the liver to harden and fail,). During an observation on April 20, 2026, at 3:10 PM, in the hallway of unit 2 outside room [ROOM NUMBER], CNA 3 was observed entering room [ROOM NUMBER] and obtained a blood pressure reading for Resident 93. Then CNA 3 proceeded to obtain a blood pressure reading for Resident 89 in the same room without performing hand hygiene. After completing Resident 93 and Resident 89's care, CNA 3 exited room [ROOM NUMBER] without performing hand hygiene. CNA 3 then entered room [ROOM NUMBER] without performing hand hygiene. During an interview on April 20, 2026, at 3:19 PM, with CNA 3, in the hallway of unit two, CNA 3 acknowledged she did not perform hand hygiene between Resident 93 and Resident 89's care. CNA 3 stated that hand hygiene should be performed before and after each resident contact and between resident care. CNA 3 acknowledged that this was not done and should have to prevent possible cross contamination. During a concurrent interview and record review on April 21, 2026, at 3:35 PM, with the Director of Staff Development/ Infection Preventionist (DSD/IP), the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated October 2023, was reviewed. The P&P indicated, . Purpose: This facility considers hand hygiene the primary means to preventing the spread of Healthcare—associated infections. Indications for hand hygiene.1. Hand hygiene is indicated.a. Immediately before touching a resident.d. After touching a resident.e. After touching the resident environment. The DSD/IP stated the policy was not followed and it is the expectation of the facility for staff to perform hand hygiene before and after resident contact to hep prevention the spread of infection. During a concurrent interview and record review on April 21, 2026, at 4:16 PM, with the Director of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nursing (DON), the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated October 2023, was reviewed. The P&P indicated, .Purpose: This facility considers hand hygiene the primary means to preventing the spread of Healthcare—associated infections. Indications for hand hygiene.1. Hand hygiene is indicated.a. Immediately before touching a resident.d. After touching a resident.e. After touching the resident environment. The DON stated the policy was not followed. 2) During a review of Resident 47's admission Record, (contains medical and demographic information), the admission Record indicated, Resident 47 was admitted to the facility on [DATE], with diagnoses which included acute osteomyelitis, right ankle and foot (a sudden severe infection of the bones in the right ankle or foot), type 2 diabetes mellitus (high blood sugar) with foot ulcer (open sores), and congestive heart failure (a condition in which the heart cannot pump blood efficiently to meet the body's needs). During a review of Resident 47's physician's orders, an order dated April 19, 2026, indicated, Enhanced barrier precautions during high-contact resident care activities secondary to wounds. Every shift. During a concurrent observation and interview on April 20, 2026, at 10:47 AM, Resident 47's room had a sign outside the door which indicated enhanced barrier precautions the 6 Moments of EBP, the sign further indicated the EBP precautions pertained to the resident in Bed B which was Resident 47. The sign indicated the following instances for when wearing a gown and gloves were required as PPE: morning & evening care, toileting & changing incontinence briefs, caring for devices & giving medical treatments, wound care, mobility assistance & preparing to leave room, changing linen. TN 1 stated she needed to place a new wound dressing (bandage) on Resident 47's hand because the resident had a skin tear. She proceeded to enter the room and provided wound care to Resident 47 without wearing a gown. During a concurrent observation and interview on April 20, 2026, at 10:53 AM, with TN 1, upon TN 1 exiting Resident 47's room, TN 1 stated Resident 47 recently had a blood draw (a procedure in which a healthcare professional uses a sterile needle to puncture a vein to collect blood for laboratory testing) and had a bandage applied to the puncture site, but when he went to remove the dressing, it caused a skin tear to his hand. TN 1 further stated Resident 47 was on enhanced barrier precautions because of a recent amputation to his right foot which was considered a wound. TN 1 stated for a resident on enhanced barrier precautions, staff were supposed to put on a gown and gloves during wound care, but she only needed to wear it if she was providing care directly to the resident's foot wound. TN 1 stated Resident 47 was on enhanced barrier precautions because of the wound on his foot and not because of the wound on his hand and therefore, she did not need to wear a gown while changing the dressing on his hand. TN 1 observed the sign outside resident 47's doorway and acknowledged the enhanced barrier precautions sign indicated to wear a gown and gloves during wound care, but TN 1 stated again that it did not apply to the wound on his hand and she only needed to wear a gown with gloves when she provided care for his foot wound. During a concurrent observation and interview on April 20, 2026, at 11:02 AM, with Resident 47, Resident 47 had a two-inch gauze dressing taped to his hand which had red liquid which resembled blood that had absorbed through all layers of the dressing. Resident 47 stated he had recurring infections with his foot and was on antibiotics. Resident 47 further stated part of his foot was removed and he had a large wound dressing on it. Resident 47 stated he had blood drawn on his hand and went to remove the dressing which caused a skin tear. Resident 47 stated TN 1 had just come in and applied a new dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on April 23, 2026, at 2:17 PM, with the facility's Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated enhanced barrier precautions was a set of precautions in place for any residents who had a port of entry for infection such as dialysis access devices, gastric tubes, or wounds. The DSD/IP further stated staff caring for anyone on enhanced barrier precautions during the 6 moments of care including wound care, were supposed to wear a gown and gloves. The DSD/IP stated if the resident was on enhanced barrier precautions, staff were supposed to wear a gown and gloves when performing wound care for any wound in which there was open skin including applying a bandage to a skin tear on a residents' hand. The DSD/IP stated it was important to ensure the resident is not exposed to any type of infectious MDRO from staff. During an interview on April 23, 2026, at 2:25 PM, with the Director of Nursing (DON), the DON stated staff were supposed to wear a gown and gloves during any high contact care activity for a resident on enhanced barrier precautions. The DON further stated high contact care included caring for any open skin wound which required a dressing which included a skin tear that required a bandage. During a review of Resident 47's care plan (an individualized plan for the medical care of a resident) titled, Surgical incision. dated April 16, 2026, the care plan indicated, .Resident has a surgical incision and is at risk for infection.Interventions.Utilize enhanced barrier precautions (EBP) during high-contact resident care activities. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated March 2024, the P&P indicated, Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .h. wound care (any skin opening requiring a dressing).

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of six sampled Residents (Resident 7) was provided care in a manner that maintained dignity during meal assistance when Certified Nursing Assistant (CNA 1) was standing while assisting Resident 7 to eat. This failure had the potential to negatively impact Resident 7's dignity and psychosocial well-being by failing to provide a respectful, person-centered approach to Resident 7 dining experience.A review of Resident 7's admission Record, (contains demographic and medical information), indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and schizophrenia (a mental illness that can affect thoughts, mood, and behavior).During an observation on April 20, 2026, at 1:04 PM, in Resident 7's Room, Resident 7 was lying in bed while CNA 1 was standing next to Resident's 7 bed, while providing feeding assistance during lunch.During an interview on April 20, 2026, at 1:16 PM, with CNA 1, outside resident 7' room, CNA 1 stated she was standing because Resident 7 was not positioned well in bed and it was uncomfortable to sit in chair next to the bed. CNA 1 acknowledged that Resident 7 should have been repositioned and further stated she had not been trained or educated that standing over a resident's during feeding was inappropriate.During a concurrent interview and record review on April 1, 2026, at 4:20 PM, with the Director of Nursing (DON), an Inservice Training Record title Properly Feeding a Resident During Meal Time, dated April 14, 2026, was reviewed. The Inservice Training Record indicated, staff were educated on the following: positioning, hand hygiene, safe feeding techniques and sitting beside the resident. The Inservice Training Record indicated, CNA 1 signature is documented on sign in sheet of the training. The DON stated, CNAs are educated on maintaining residents' dignity during meals which includes not standing over resident while feeding them. During a concurrent interview and record review, on April 22, 2026, at 3:40 PM, with the Administrator and the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Assistance with Meals , dated March 2022, was reviewed. The P&P indicated, Residents Requiring Full Assistance 2.Resident who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example a. not standing over residents while assisting them with meals. The Administrator and the DON stated the facility's policy was not 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure controlled substances (medications that are controlled by the government because it may be abused or cause addiction) were accurately accounted for and documented for one of one sampled residents (Resident 30), when Resident 30's Controlled Drug Receipt/Record/Disposition Form (CDR - document used to record the administration or destruction of a controlled drug for tracking purposes) for Oxycodone's (a pain medication) 5 mg (milligram- unit of measurement) count was found inaccurate.This failure had the potential to result in inaccurate count of narcotic drugs and drug diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff in a highly vulnerable population of 70 residents.During a review of Resident 30's clinical records, the admission Record, indicated Resident 30 was admitted on [DATE], with diagnoses which included, fracture of right tibia (a crack in the large bone on the front of your lower right leg), cirrhosis of liver (the severe and permanent scarring of the liver), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) .During a review of Resident 30's Order Summary, dated April 22, 2026, indicated, oxycodone HCl (hydrochloride) (medication used to treat moderate to severe pain) oral tablets 5 mg, give 2 tablets by mouth every four hours as needed for severe hip pain.During a concurrent observation, interview, and record review on April 22, 2026, at 7:05 AM, Licensed Vocational Nurse (LVN 3) and LVN4 were observed at Unit 1 medication cart completing the controlled substance count. During this process, a narcotic count discrepancy was identified for Resident 30. A review of the Controlled Drug Record (CDR) for oxycodone HCl by LVN 3 indicated, that 59 tablets of oxycodone 5 mg were available. LVN 4 proceeded to count the contents of Resident 30's bubble pack (a secure, organized packaging system where pills are sealed in individual, clear plastic bubbles or blisters on a card, usually arranged by date and time of day) and stated 57 tablets were remaining, resulting in a discrepancy of two (2) oxycodone 5 mg tablets. LVN3 stated Resident 30 had been administered oxycodone 10 mg at approximately 6:30 AM. However, concurrent review of the electronic medical record (EMR), including the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), with LVN3 and LVN 4, revealed no documentation for the administration of oxycodone 10 mg for that time. Further record review of the CDR and EMR confirmed that two (2) oxycodone 5 mg tablets were unaccounted for and not documented as administered.During a concurrent interview and record review on April 22, 2026, at 7:13 AM, with the Director of Nursing (DON), at unit 1 medication cart, Review of resident 30's oxycodone HCl 5 mg tablet CDR was reviewed, CDR reflects 59 tablets available, while the physical count reflects 57 tablets available. The DON acknowledged the discrepancy of two (2) oxycodone 5 mg tablets and stated that facility process requires controlled substances to be documented at the time of removal and administration on both the CDR and the EMR/MAR. The DON further acknowledged that this process was not followed and that the lack of documentation was not consistent with facility expectations.During a follow up interview on April 22, 2026, at 7:25 AM, with DON and LVN5, in conference room, LVN5 acknowledged administering oxycodone 10 mg to Resident 30 for LVN3 but stated he/she?? did not document the medication at the time of removal or administration. LVN5 reported writing the information down with the intent to provide it to LVN3 but he/she?? did not complete the required documentation. LVN5 acknowledged she did not follow facility process for controlled substance administration and documentation, which requires immediate and concurrent documentation. The DON further acknowledged that this process was not followed.During a concurrent interview and record review, on April 23, 2026, at 9:28 AM, with the [NAME] and Director of Staff Development (DSD)/Infection preventionist (IP), in the DSD/IP's office, the facility's policy and procedure (P&P) titled, Medication Administration, dated April 2019, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was reviewed. The P&P indicated, .Purpose; Medications are administered in a safe and timely manner, and as prescribed .22. The individual administering the medication initials the resident MAR on the appropriate line after giving each medication and before administering the next.23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record .a. The date and time the medication was administered.b. The dosage .c. The route of administration.d. The injection site if applicable .e. Any complications or symptoms for which the drug was administered.f. Any results achieved and when those results were observed; and.g. The signature and title of the person administering the drug. The DSD/IP stated the licensed nurse is expected to document medication administration concurrent with administering the medication. The [NAME] and DSD/IP further stated the facility's policy was not followed.During a record review of the facility's policy and procedure (P&P) titled, Controlled Substances, dated November 2022, was reviewed. The P&P indicated, .Purpose: The facility complies with all laws regulations and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as schedule II-V of the comprehensive drug abuse prevention and Control Act of 1976) . Dispensing and reconciling controlled substances.1. Controlled substances inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss slash diversion and detection slash follow up.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the kitchen stove was maintained in a clean and sanitary condition, when the six (6)-burner stove had accumulation of dirt and food residue.This failure had the potential to lead to the growth of harmful microorganisms, including bacteria, viruses, and fungi, and cause food-borne illness to 70 residents served by the kitchen.During an observation on April 20, 2026, at 8:35 AM, in the kitchen, the 6ˆburner commercial stove had substantial accumulations of burnt grease and food debris on both the burner grate and surrounding surfaces.During a concurrent interview and record review with the Dietary Supervisor (DS) on April 20, 2026, at 8:37 AM, the kitchen document titled, Cleaning log, undated, was reviewed. The log indicated, Convention Ovens Deep Clean. When: Fridays. Description: Wash/Clean/Sanitize. The log was left blank for Sunday to Saturday. The DS stated the stove is typically cleaned at the end of each day. The DS further stated that the stove, flat top griddles, and surrounding surfaces were cleaned three days prior, according to the cleaning schedule. The DS acknowledged that food frequently spills onto the stove during cooking and emphasized that these spills should be wiped up immediately to prevent the build-up of burnt food particles and grease. The DS was unable to provide an explanation for the significant accumulation of burnt grease and food debris observed on the burner crate and adjacent surfaces.During an interview conducted with Dietary Aide 1 (DA1) on April 20, 2026, at 8:45 AM, DA1 reported that all kitchen equipment, including the stove, is wiped clean daily at the end of each day prior to closing. Additionally, DA1 confirmed that a deep cleaning of the equipment is performed weekly, in accordance with the Cleaning Log.During a concurrent interview and record review on April 23, 2026, at 8:58 AM, with the DS, the facility's undated Policy and Procedure (P&P) titled, Ranges and Ovens, was reviewed. The P&P states, Ranges - Cleaning Procedure: 1. Open top gas range and grill. When top grids are completely cool, remove grills from the range. Immerse grills in a solution of water and grease solvent to soak. 2. Boil grates and burners in salt/soda or other grease solvent/water solution. Clean clogged burners posts with a stiff wire brush. 3. Back apron of the range and other range surfaces should be washed with a hot detergent solution following manufacturer's instructions to remove grease. Rinse and dry with a clean cloth. 4. Range drip pans must be emptied and washed on a routinely scheduled basis. 5. Grills must be cleaned after each use. Allow sufficient time for grills to cool before cleaning. Do not use caustic or acid solutions on grills as they are used will eventually cause sticking and rusting. The DS acknowledged the facility's P&P was not followed when the 6-burner commercial stove was found with significant accumulations of burnt built up grease and food debris on the burner crate and surrounding surfaces.During a concurrent Interview and record review with the DS on April 23, 2026, at 9:01 AM, with the DS, the facility's undated P&P titled Sanitation, was reviewed. The P&P stated, Policy: The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving, and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order. Procedure: 1. The FNS director is responsible for instructing employees in the fundamentals of sanitation in food service and for training employees to use appropriate techniques . 4. The FNS director is responsible for instructing food and nutrition services personnel in the use of equipment. Each employee shall know how to operate and clean all equipment in his specific work area . 9. The FNS Director will write the cleaning schedule in which he designates by job title and or employee who is to do the cleaning task . All the utensils, counters, shelves, an equipment shall be kept clean, maintain in good repair . 16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over stove, which will be cleaned by the maintenance staff. The DS acknowledged the facility's P&P was not followed.During an interview with the Administrator (Admin) on April 23, 2026, at 3:57 PM, the Admin stated that all kitchen equipment is expected to be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintained in sanitary conditions.Record review of the FDA Federal Food Code, dated 2022, 4-601.11 indicates, (C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. in addition, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted.Record review of the FDA Federal Food Code, dated 2022, 1-2010 (A)(B) indicates [Equipment] means an article that is used in the operation of a FOOD ESTABLISHMENT such as a freezer, grinder, hood, ice maker, MEAT block, mixer, oven, reach-in refrigerator, scale, sink, slicer, stove, table, TEMPERATURE MEASURING DEVICE for ambient air, VENDING MACHINE, or WAREWASHING machine.

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	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redlands Healthcare Center	1620 W Fern Ave 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 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** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that allows patients to communicate with nursing staff when they need assistance) was within resident's reach for two of three sampled residents (Resident 55 and 7) when,Resident 55's call light was on the floor between bed 1 and bed 2, unreachable by the resident.Resident 7's call light was observed on the floor next to the resident's bed and out of resident's reach.These failures had the potential to result in Resident 55 and 7's needs not being addressed, placing both residents at risk for injury.1.During a review of Resident 55's clinical record, the admission Record (list of diagnoses and demographic information), the admission Record indicated, Resident 55 was admitted to the facility on [DATE], with diagnoses which included history of falling, acquired absence of right hand, dementia (a decline in brain function that is severe enough to interfere with daily life, characterized by memory loss, confusion, and personality changes), cognitive communication deficit (an impairment in communication skills) and acute respiratory failure with hypoxia (low blood oxygen levels). During an observation on April 20, 2026, at 10:50 AM, in Resident 55's room, Resident 55 was lying in bed in his room, awake and covered with a light blanket. Resident 55's call light was on the floor between bed 1 and bed 2, unreachable by the resident. During an interview with Resident 55 on April 20, 2026, at 10:51 AM, Resident 55 stated that he was unable to reach and locate the call light. During a concurrent observation and interview on April 20, 2026, at 10:52 AM, in Resident 55's room with Licensed Vocational Nurse 2 (LVN2), LVN2 confirmed Resident 55's call light was on the floor between beds, away from the resident. LVN2 stated that the call light must consistently be positioned within the residents' immediate reach to ensure that the resident can promptly request assistance whenever necessary, which is critical for their safety and well-being. LVN2 further added that the call light should never be placed on the floor or in any location where it is inaccessible to the resident. During an interview on April 21, 2026, at 11:22 AM with the Director of Nursing (DON), the DON stated that call lights are expected to be within immediate reach of each resident so they can call for assistance when needed. During a concurrent record review and interview with the Administrator (Admin) on April 23, 2026, at 3:55 PM, the facility's Policy and Procedure (P&P) titled Answering the Call Light revised October 2010, was reviewed. The P&P stated, Purpose - The purpose of this procedure is to respond to the resident's requests and needs. General guidelines: . 4. Be sure that the call light is always plugged in; 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of resident. The Admin stated that staff must follow facility's Policy and Procedure and acknowledged the P&P was not followed when Resident 55's call light was found on the floor between beds and unreachable by the resident. 2. A review of Resident 7's admission Record, (contains demographic and medical information), indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which included dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and , schizophrenia (a mental illness that can affect thoughts, mood, and behavior). (continued on next page)

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	04/23/2026

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

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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	During an observation on April 20, 2026, at 8:30 AM, in Resident 7's room, the call light was observed hanging from the bed and resting on the floor, out of reach of the resident. Resident 7 was awake, agitated and confused at time of observation. An interview was attempted with Resident 7, however, due to Resident 7's confusion and agitation, the resident was unable to effectively communicate. During an observation and interview with Licensed Vocational Nurse 1 (LVN 1) on April 20, 2026, at 8:53 AM, in Resident 7's room, LVN 1 observed Resident 7's call light hanging from the bed and resting on the floor and acknowledged the call light was on the floor and not within reach for resident. LVN 1 stated the call light should be within Resident 7's reach and it's important for the resident (Resident 7) to be able to request care. LVN 1 further stated Resident 7 had decreased ability to effectively communicate his needs. During concurrent interview and record review on April 21, 2026, at 3:45 PM, with the Administrator (Admin) and with the Director of Nursing (DON), in the DON office, the facility policy and procedure (P&P) titled Answering the Call Light, revised October 2010 was reviewed. The P&P indicated, Purpose – The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines . 4. Be sure that the call light is plugged in at all times.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 ADON stated the call light should be within resident's reach at all times. The Administrator and the DON both acknowledged the P&P was no followed.