STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055650	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center of Redlands	700 East Highland Avenue Redlands, CA 92374

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper care was provided to prevent a right heel pressure ulcer (an injury to the skin or underlying tissue that develop from prolonged pressure), for one of three sampled residents (Resident 1).This failure had the potential to place Resident 1, a clinically compromised resident, at risk for further skin breakdown, which could affect his health and safety. Findings:During a review of Residents 1's admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included muscle wasting and atrophy (a condition with shrinking and loss of muscle), major depressive disorder (a condition with feeling of sadness and hopelessness), fracture of unspecified part of right clavicle (broken right collarbone where the specific location of the break has not been detailed), fracture of right ilium (a break in the upper largest part of the hip bone), spinal stenosis (narrowing of the spinal canal that puts pressure on spinal cords and nerve), spastic quadriplegic cerebral palsy (affective all four limbs due to abnormal brain development or damage before, during or after birth), cervicalgia (neck pain), alcohol abuse (impaired ability to stop or control alcohol use), and hypertension (high blood pressure, polyp of colon (growth on the inner lining of the large intestine or rectum), dorsalgia (back pain).During an interview on September 25, 2025, at 12:00 PM, with the Wound Treatment Nurse (WTN), WTN stated Resident 1's admission assessment, did not include a pressure sore, injury, or wound on the right heel. WTN further stated that on June 22,2025 while WTN was doing wound care, Resident 1 started complaining of pain on right heel. WTN assessed and noted a darkened area to the right heel, measuring 5.0 cm X 5.0 cm X UTD (unstageable), 100% necrosis (death of body tissue).During an interview on September 25, 2025, at 12:45 PM, with the Physical Therapist (PT), PT stated, Resident 1 was evaluated during admission on [DATE], as totally dependent with maximum assist. Both lower extremities are impaired, and he was unable to move without assistance. PT stated, there should have been a care plan initiated for offloading both feet off the bed to prevent pressure sore on admission. During an interview on September 25, 2025, at 1:00 PM, with the Director of Nursing (DON), DON stated the pressure wound on right heel was identified and assessed on June 22, 2025. Situation, Background, Assessment and Recommendation (SBAR), Change of Condition (COC) were completed that day. Treatment was ordered by the primary physician (PP) and initiated by WTN on the same day on June 22, 20225. DON was asked if there was a care plan initiated on admission to prevent Resident 1's pressure injury by offloading both feet and a daily skin assessment. DON stated, No and was not able to provide documentation. DON further stated they implemented daily skin assessment once a shift for all residents, and care plan was initiated for Resident 1 on June 23, 2025, for offloading and bilateral boots for heel protectors.A review of the following clinical records for Resident 1 indicated:a. Braden Evaluation (a clinical tool to assess a patient's risk of developing pressure ulcers [Severe risk total score: less than 9, High risk total score: 10-12, moderate risk total score: 13-14, Mild risk: total score: 15-18]): .Braden score: 15.0.b. Situation, Background, Assessment and Recommendation (SBAR) communication record dated June 22, 2025, indicated, . complained of pain on right heel, Treatment nurse assessed area and noted darkened area to right heel 100% necrosis measuring 5.0cm X 5.0cm X UTD.c. Physical Therapy Evaluation and Plan of Treatment: May 28,2025: Musculoskeletal System Assessment- Right lower Extremities strength= Impaired, LLE: Left lower extremities = Impaired.During a review of the facility's policy and procedure (P&P), titled, Prevention of Pressure Injuries, revised April 2020, the P&P indicated, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the intervention designed to reduce or eliminate those considered modifiable. #3. Inspect the skin daily when performing or assisting with personal care or ADL.