

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055914	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2025
NAME OF PROVIDER OR SUPPLIER Plymouth Village		STREET ADDRESS, CITY, STATE, ZIP CODE 819 Salem Drive 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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for one of seven residents (Residents 4) reviewed for dining observation when a Licensed Vocational Nurse (LVN 2) was standing over Resident 4 while feeding him lunch on June 16, 2025.</p> <p>This failure resulted in staff not maintaining Resident 4's individuality and dignity.</p> <p>Findings:</p> <p>During a review of Resident 4's admission Record (contains demographic and medical information), undated, the admission Record indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses of Hemiplegia, unspecified affecting right dominant side (weakness on one side of the body), Dysphasia (condition affecting speech) and dysphagia (difficulty swallowing).</p> <p>During an observation on June 16, 2025, at 12:24 PM, in the second dining room, LVN 2 was standing over Resident 4 while feeding him lunch.</p> <p>During an interview on June 16, 2025, at 1:00 PM, LVN 2 stated staff are expected to be seated while feeding residents.</p> <p>During a concurrent interview and record review, on June 16, 2025, at 3:14 PM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled, Assistance with Meals, revised March 2022, it indicated Dining Room Residents: . 3. Residents 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 DON stated staff should be engaging and sitting next to residents for a full meal.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe oxygen administration were provided in accordance with the physician's orders and facility policies and procedures for one of three sampled residents (Resident 12) reviewed for respiratory care when Resident 12's oxygen tubing (a device which delivers oxygen) was not labeled to indicate the date that it was changed.</p> <p>This failure had the potential for Resident 12 to be at risk of developing a respiratory infection (caused by bacteria, viruses, fungi, or parasite).</p> <p>Findings:</p> <p>During a review of Resident 12's clinical record, the admission Record (patient demographics), indicated, Resident 12 was admitted on [DATE], with diagnoses that included chronic obstructive pulmonary disease (COPD - a lung disease that makes it hard to breathe), diastolic (congestive) heart failure (a condition where the heart muscle is too stiff to relax properly, preventing the heart from filling with enough blood between beats), and atrial fibrillation (heart rhythm disorder).</p> <p>During a review of Resident 12's Physician Order, dated February 10, 2025, the Physician Order indicated, Resident 12's had an order for Oxygen Tubing and Humidifier Change when in use every night shift, every Wednesday. The Physician Order also indicated Resident 12 had an order dated March 30, 2025, for Oxygen at 2 LPM (Liters Per Minute) continuously to maintain O2 (Oxygen) sats (saturation- levels) > (greater than) 90% (percent) every shift for COPD.</p> <p>During a concurrent observation and interview on June 16, 2025, at 10:10 AM, with the Director of Staff Development (DSD), in Resident 12's room, a nasal cannula (device used to deliver supplemental oxygen to a patient through the nose) attached to an oxygen concentrator through the oxygen tubing, was found undated. The DSD stated she was not aware when the tubing was last changed. The DSD further acknowledged the oxygen tubing should have been labeled to know when to change every week.</p> <p>During a concurrent interview and record review on June 17, 2025, at 3:09 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Departmental (Respiratory Therapy)-Prevention of Infection, dated 2001, was reviewed. The P&P indicated, The purpose of this procedure is to guide prevention of infection associated with respiratory therapy task and equipment, including ventilators, among residents and staff . Infection Copntrol Considerations Related to Oxygen Administration . 7. Change the oxygen cannula and tubing every seven (7) days, or as needed. The DON stated the policy was not followed.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</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 error rate was less than five percent. There were two medication errors identified out of 27 opportunities for errors, affecting one of 13 residents (Resident 14), resulting in an overall medication error rate of 7.4 percent when Resident 14's Levothyroxine (replacement hormone for people whose thyroid gland is not working properly) and Hydrocodone-Acetaminophen (medication used to relieve severe pain) were crushed together during medication administration.</p> <p>These failures had the potential for Resident 14 to have negative health consequences and effectiveness of the medications.</p> <p>Findings:</p> <p>During a review of Resident 14's clinical records, the admission Record (contains demographic and medical information) indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included, gastro esophageal reflux (a condition where stomach acid flows back up into the esophagus), hypothyroidism (a condition when the thyroid gland doesn't make enough thyroid hormone) and pain in thoracic spine (middle section of the spine, situated between the neck and the lower back).</p> <p>During a review of Resident 14's physician's orders, dated June 6, 2025, it indicated Resident 14 had an order for Levothyroxine Sodium Oral Tablet 25 mcg (micrograms- unit of measurement) Give 1 tablet by mouth in the morning for hypothyroidism.</p> <p>During further review of Resident 14's physician's order, dated June 6, 2025, it indicated, May Crush or pull apart medication unless contraindicated- separate meds [medications]. Evaluate each medication for indications/contraindication for crushing - each must be prepared individually if more than one is to be administered.</p> <p>During review of Resident 14's physician's order, dated June 9, 2025, indicated Resident 14 had an order for Hydrocodone - Acetaminophen Tablet 5 -325mg (milligrams- unit of measurement). Give 1 tablet by mouth every 8 hours for pain management.</p> <p>During medication administration observation on June 18, 2025, at 5:48 AM, at the medication cart in front of Resident 14's room, one Licensed Vocational Nurse (LVN 3) verified the information of Resident 14 and then proceeded to take out one tablet of Levothyroxine Sodium 25 mcg and one tablet of Hydrocodone-Acetaminophen 5-325 mg. LVN 3 then combined both medications in one plastic pouch and crush both medications together. LVN 3 placed the crushed medication in a plastic medication cup and mix it with apple sauce and proceeded to give it to Resident 14 to swallow it.</p> <p>During concurrent interview and record review on June 18, 2025, at 5:51 AM, with the LVN 3, LVN 3 stated mixing all medications is okay if there is an order.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review, on June 18, 2025, at 7:00 AM, with the Director of Nursing (DON), the DON reviewed the facility's policy and procedure (P&P) titled, Administering Medications, revised April 2019. The P&P indicated, . 4. Medications are administered in a safe and timely manner, and as prescribed . 4. Medications are administered in accordance with prescriber orders, including any required time frame. The DON stated facility did not follow the policy.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</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 ensure safe, sanitary food preparation, and storage practices in the kitchen when:</p> <ol style="list-style-type: none"> 1. The main kitchen floors had accumulation of food crumbs, black stains, and dirt; the walk-in freezer had food crumbs on the floor, and the walk-in refrigerator floors had multiple cilantro leaves, cauliflower pieces, and multiple moist black and brown residue under the shelf. 2. Food equipment such as the toaster had black grime, white residue, and food crumbs; the mixer was found with multiple reddish-orange splashes on the handle. 3. The edge of the wall under the three-compartment sink had black build up and multiple white residues. <p>These failures had the potential to cause foodborne illnesses (caused by the ingestion of contaminated food or beverages) in a highly susceptible population of 44 residents who received food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on June 16, 2025, at 07:48 AM, with the Sous Chef (SC) in the main kitchen, the floors had an accumulation of food crumbs, black stains, and dirt. The walk-in freezer had food crumbs on the floor, and the walk-in refrigerator floors had multiple cilantro leaves, cauliflower pieces, and multiple moist black and brown residue under the shelf. The SC stated the floors are to be cleaned daily. <p>During an interview on June 16, 2025, at 03:25 PM, with the Director of Dining Services (DDS), the DDS stated the expectation was for kitchen floors and walk in freezers/refrigerators to be maintained clean after each shift.</p> <p>During a review of the FDA Federal Food Code, dated 2022, under 4-601.11, it indicated, .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris [scattered pieces of waste or remains] . 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.</p> <ol style="list-style-type: none"> 2. During a concurrent observation and interview on June 16, 2025, at 7:53 AM, with the SC in the main kitchen, the toaster had black grime, white residue and food crumbs inside and out. The mixer was found with multiple reddish-orange splashes on the handle. The SC stated that equipment should have been cleaned. <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 - Many</p>	<p>During a concurrent interview and record review on June 16, 2025, at 3:10 PM, with the DDS, the facility's policy and procedure (P&P) titled Sanitation and Infection Prevention/Control, revised January 2024, was reviewed. The P&P indicated Written procedures are available, detailing daily and weekly (as needed) cleaning for all areas and equipment in the department . The DDS stated the policy and procedure was not followed.</p> <p>During a concurrent interview and record review on June 16, 2025, at 3:27PM, with the DDS, the kitchen cleaning checklist titled, Station Cleaning Checklist Dishwasher (19), undated, was reviewed. The cleaning checklist indicated, Fri (Friday) - Deck brush kitchen, pull all equipment and clean under and behind . The DDS stated the checklist should have been followed.</p> <p>3. During a concurrent observation and interview on June 16, 2025, at 7:57 AM, with the SC, the edge of the wall under the three-compartment sink had black build up and multiple white residues. The SC stated it should be cleaned daily after use.</p> <p>During an interview on June 16, 2025, at 3:25 PM, with the DDS, the DDS stated the expectation was for the wall to be cleaned and free of buildup.</p> <p>During a review of the FDA Federal Food Code, dated 2022, under 4-601.11, it indicated, .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris [scattered pieces of waste or remains] .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.</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 observation, interview, and record review the facility failed to ensure the privacy of patient health records for one of six sampled residents (Resident 14) was maintained when a Licensed Vocation Nurse (LVN 3) left Resident 14's health information on the computer screen, unattended in the hallway, visible for anyone to see.</p> <p>This failure had the potential for Resident 14's private information to be disclosed without authorization which could lead to Health Insurance Portability and Accountability Act (to protect medical records and other personal information) violations.</p> <p>Findings:</p> <p>During a review of Resident 14's clinical records, the admission Record (contains demographic and medical information) indicated, Resident 14 was admitted to the facility on [DATE], with diagnoses which included, gastro esophageal reflux (a condition where stomach acid flows back up into the esophagus), hypothyroidism (a condition when the thyroid gland doesn't make enough thyroid hormone) and pain in thoracic spine (middle section of the spine, situated between the neck and the lower back.</p> <p>During a concurrent observation and interview on June 18, 2025, at 5:48 AM, with a LVN 3 at the medication cart in front of Resident 14's room, LVN 3 logged into Resident 14's electronic health records in the computer. LVN 3 proceeded to go inside the room to administer Resident 14's medication leaving the computer screen up and unattended. LVN 3 stated he realized he left Resident 14's information open on the computer when he was inside the room. LVN 3 further stated he was not supposed to keep the computer on with Resident 14's information unattended.</p> <p>During a concurrent interview and record review on June 18, 2025, at 7:00 AM, with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, HIPAA Privacy Policy, dated January 1, 2021, was reviewed. The P&P indicated, 1. Administrative, Technical and Physical Safeguards . [Name of Provider] ensures that appropriate administrative, technical , and physical safeguards are in place to (a) reasonably safeguard PHI from any intentional and unintentional use or disclosure that is in violation of the Privacy Rule; (b) ensure the confidentiality , integrity and availability of e-PHI it creates, receives, maintains or transmits; (c) protect against reasonably anticipated uses or disclosure that violate the Rules; and (d) limit incidental uses and disclosures resulting from otherwise permitted or required uses or disclosures. The DON stated the policy was not followed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained when a Laundry Staff used a dirty laundry basket (a basket for holding clothes and linen that have been washed) to transfer washed linens into the dryer machine.</p> <p>This failure had the potential to cause harm to the 44 residents residing within the facility by increasing the risk of exposure and spread of infection (the process by which an infectious agent (like a virus or bacteria) moves from one source to another, causing illness).</p> <p>Findings:</p> <p>During a concurrent observation and interview on June 18, 2025, at 12:10 PM, in the laundry room with the Infection Preventionist (IP), Laundry Supervisor (LS) and Laundry Staff (LS 1) observed a large rectangular blue plastic laundry basket with a lid covered with stained dirty white sheet located near the dryer. LS 1 stated the laundry basket is used to transfer washed linens from the washing machine to the dryer. The LS stated the white sheet on top of the laundry basket are changed every day. LS1 stated the white sheet on the laundry basket are changed once a week. LS1 proceeded to remove the white sheet from the top of the laundry basket to replace it with a clean sheet. Once LS 1 removed the dirty white sheet, the lid was observed dirty and appeared to have items inside the laundry basket. There was a black trash bag, a white trash bag, dirty socks, one individual packet of coffee creamer, a dirty mop, a blue blanket, a few dirty tissue papers and spray bottle, inside the laundry basket. The LS stated, I did not know about this. The IP stated, she had not seen this laundry basket when she was making rounds before.</p> <p>During an interview on June 18, 2025, at 12:30 PM, with the Director of Buildings and Grounds, the director of Buildings and Grounds stated he expected laundry staff to use a clean laundry basket.</p> <p>During a concurrent interview and record review on June 18, 2025, at 12:50 PM, with the Director of Nursing (DON) and IP, the facility policy and procedures (P&P) titled, Laundry and Bedding, Soiled, dated September 2022, was reviewed. The P&P indicated, Transport . 4. Linen carts are cleaned and disinfected whenever visibly soiled and according to the established schedule . 6. Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. The IP stated, Laundry staff had received education in handling and transporting linens and she was not sure why a dirty laundry basket was used. The DON acknowledged the policy and stated, the dirty laundry basket should not have been used at all. The DON stated her expectation for staff is to use clean laundry carts all the time.</p>		