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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555379	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asistencia Villa Rehabilitation and Care Center	1875 Barton Road 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47206 Based on observation, interview, and record review, the facility failed to follow their policy and procedure to ensure the removal of medication from the medication cart immediately upon receipt of a physician order to discontinue an order to prevent error in administration of medication for one of four sampled residents (Resident 1). This failure had the potential to place a clinically compromised Resident 1's health and safety at risk when Resident 1 was administered a medication that had already been discontinued. Findings: During a review of Resident 1 ' s admission record, the face sheet (contains demographic and medical information), indicated Resident 1 was admitted on [DATE], with a diagnosis that included polyneuropathy, unspecified (is a damage or disease affecting peripheral nerves [made of fibers that send messages from the brain and spinal cord] roughly the same areas on both sides of the body, featuring weakness, numbness, and burning, pain). During a review of the clinical record for Resident 1 the Brief Interview for Mental Status (BIMS- screening tool to identify and monitor cognitive decline), dated July 18, 2024, indicated, Resident 1 ' s score was a 11, which indicated Resident 1 had no mental impairment. During an interview with the registered nurse supervisor (RN 1) on July 25, 2025, at 12:40 PM, RN 1 stated that one of the licensed vocational nurses (LVN 1) approached and informed him on July 24, 2024, that he had given a medication to Resident 1 that had already been discontinued. When inquired about the process of discontinuing a medication, the RN 1 explained that upon receiving an order to discontinue medication, the supervisor typically instructs the charged nurses to remove it from the resident ' s medication cart and dispose of it in the pharmacy container. During an interview with the administrator (ADM 1) on July 25, 2024, at 2:05 PM, ADM 1 acknowledged that LVN 1 made a medication error by administering discontinued medication to Resident 1. When questioned about the process for discontinuing medication, the Administrator 1 stated a discontinued medication should promptly remove from the cart to prevent inadvertent medication administration. The ADM 1 mentioned that in this instance, the medication was not removed from the medication cart by the staff who received the order to discontinue it on July 22, 2024. The medication remained in the medication cart despite being discontinued, ultimately contributing to the medication error. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER: Asistencia Villa Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1875 Barton Road, 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with LVN 1 on July 30, 2024, at 2:54 PM, LVN 1 stated he administered a discontinued medication Methocarbamol (a muscle relaxant) on July 24, 2024, at 12:00 PM. When questioned how he noticed the error, LVN 1 explained he recognized it himself, and the grandson of Resident 1, also noticed the mistake and brought it to his attention. When questioned about the procedure of discontinuing medication. LVN 1 explained the initial step is to remove the medication from the medication cart. LVN 1 also acknowledged being busy at that time and failing to notice that the medication had already been discontinued, despite the medications still being in the medication cart. Furthermore, LVN 1 stated the presence of the medication in the medication cart contributed to the medication error. LVN 1 accepted responsibility for the mistake and expressed that he is accountable for it. During a review of Resident 1 ' s order summary dated July 22, 2024, at 4:13 PM, the order summary indicated that one tablet of Methocarbamol oral tablet 500 milligrams (MG-unit of measurement) was to be given by mouth three times a day for musculoskeletal pain, and this was discontinued on July 22, 2024, at 4:12 PM. Upon further review of Resident 1 ' s progress notes dated July 24, 2024, at 3:45 PM, which was created by LVN 1, the progress note indicated the medication Methocarbamol was administered despite having been discontinued on July 22, 2024. During the review of the facility- provided document titled Discontinued Medications - Disposal policy and procedure manual, dated March 2024, it was noted that the procedure states, Medication shall be removed from the medication cart immediately upon receipt of an order to discontinue in order to avoid inadvertent administration .