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	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asistencia Villa Healthcare 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure blood pressure medication was not administered in duplicated dose for one of three sampled residents (Resident 1). This failure had the potential for Resident 1 to receive an excessive dosage of the medication which could jeopardize her health and safety. Findings: During a review of Resident 1's admission record (information about the patient's personal details, reason for admission, and medical history), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included cardiac arrest (the heart suddenly and unexpectedly stops pumping blood to the brain and other vital organs). During a review of the facility provided document titled Progress Notes, for Resident 1, dated May 24, 2025, at 2:18 AM, the Progress Notes indicated an entry from Licensed Vocational Nurse (LVN 1) stating: Double dose given, MD [Doctor of Medicine] notified, and receive the order for continually monitor for Hypotensive [low blood pressure]. During a review of the physician's order for Resident 1, dated April 28, 2025, the physician's order indicated Metoprolol Tartrate Oral Tablet 100 mg (Metoprolol Tartrate) Give 100 mg via G-Tube [Gastrostomy tube - is a tube inserted into the stomach, providing a pathway for nutrition, fluids, and medications.) every 12 hours for HTN [hypertension-high blood pressure] Hold for SBP [systolic blood pressure- is the top number in a blood pressure reading, representing the pressure in arteries when the heart beats]. During a telephone interview on June 23, 2025, at 12:39 PM, LVN 1 stated Resident 1 was given Metoprolol (medication to lower blood pressure) twice - first by him and then by another Licensed Vocational Nurse (LVN 2). LVN 1 stated he initially administered the medication at approximately 8:00 PM but was interrupted by another resident before he could document it. Upon returning to document the medication, he found that LVN 2 had already recorded the administration, as he saw LVN 2 had just left the room. When LVN 1 questioned LVN 2 about this, LVN 2 admitted to giving the medication as well, mistakenly thinking that Resident 1 was assigned to him. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LVN 2 on July 1, 2025, at 7:25 AM, LVN 2 stated he had been assigned to care for Resident 1 for the two nights leading up to the incident. LVN 2 stated he did not check their assignment before administering medications. He further stated LVN 1 approached him that night claiming he also gave the same medication to Resident 1. The doctor was called, and Resident 1 was monitored and remained stable. Additionally, LVN 2 confirmed the Metoprolol was in a bubble pack (type of packaging) in his cart, and noted there was also the same medication, intended for Resident 1, in LVN 1's cart. However, they did not know how this situation occurred. During a review of the Medication Administration Record (MAR), dated May 2025, for Resident 1, the MAR indicated that Resident 1 received Metoprolol Tartrate 100 mg on May 23, 2025, at 9:00 PM signed by LVN 2. MAR did not 3indicate that the administration of the same medication, which is Metoprolol Tartrate 100 mg, which LVN 1 reported administering approximately thirty (30) minutes earlier on May 23, 2025, after LVN 2 accidentally administer the same medication was documented. During a concurrent interview and record review on June 23, 2025, at 1:56 PM, with the Administrator (Admin), the facility's policy and procedure (P&P) titled, Documentation of Administration of Medication, dated November 2022 was reviewed. The P&P indicated, .Administration of medication is documented immediately after it is given . The Admin stated that policy was not followed. During a concurrent interview and record review on June 23, 2025, at 2:02 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Documentation of Administration of Medication, dated November 2022 was reviewed. The P&P indicated, .Administration of medication is documented immediately after it is given . The DON stated the staff must verify the orders and adhere to the five rights of medication administration. Additionally, proper documentation is required. When asked whether this P&P was followed, the DON stated, It was not followed.