

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  12/12/2025
NAME OF PROVIDER OR SUPPLIER  Asistencia Villa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1875 Barton Rd 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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure adequate supervision for one (1) of four (4) sampled residents (Resident 1), when Resident 1 left the facility without staff knowledge. Resident 1 was found five hours later in an adjacent building. This failure had the potential to result in serious injuries/accidents or death of Resident 1 due to lack of supervision. A review of Resident 1's Face Sheet (contains resident demographic), the Face Sheet indicated, Resident 1 was admitted on [DATE], with diagnoses that included spinal stenosis cervical region (the bony tunnel (spinal canal) in the neck gets too narrow squeezing the spinal cord), abnormalities of gait and mobility (your usual way of walking is off). During an interview on December 12, 2025, at 2:52 PM, with the License Vocational Nurse (LVN 1), LVN 1 stated that during the shift change, she received a communication from LVN 2 that on December 12, 2025, around 5:00 AM they could not locate Resident 1, prompting a search. LVN 1 further stated the resident was found at the adjacent facility around 11:00 AM (5 hours after) and was subsequently taken to hospital. During a telephone interview on December 12, 2025, at 3:32 PM, with LVN 2, LVN 2 reported she last saw, and briefly spoke with Resident 1 in the hallway on December 12, 2025 (day of incident) at approximately 5:00 AM. After that, LVN 2 proceeded to perform her duties. When she conducted her rounds, shortly after 5:00 AM, she noticed that Resident 1 was not in his room, prompting her to inform the supervisor. They began searching for him and attempted to call his phone, which went directly to voicemail. During an interview on December 12, 2025, at 4:00 PM, with the Administrator (Admin 1), Admin 1 stated that approximately 10 minutes after the facility reported to CDPH that Resident 1 was missing, the police contacted the facility by phone to inform them that the resident had been found at the assisted living facility adjacent to theirs. Admin 1 further stated upon their investigation, Resident 1 mentioned he went out the building to get some fresh air. During concurrent record review and telephone interview on December 17, 2025, at 10:48 AM, with Admin 1, Admin 1 indicated that Resident 1 does not have a pass or authorization to exit the facility and does not possess an order from the physician. To mitigate the risk of elopement for residents who are alert and oriented, elopement assessments are conducted, and constant supervision is ensured. The facility's Policy and Procedure titled Wandering and Elopements was examined, which states, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If a resident is missing: a. Determine if the resident is out on an authorized leave or pass; . Admin 1 affirmed that it is their policy that constant supervision is required for residents who are not authorized to leave, acknowledging that insufficient supervision have contributed to the incident.</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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