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	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asistencia Villa Rehabilitation and Care Center	1875 Barton Road Redlands, CA 92373

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on the observation, interview and record review, the facility failed to ensure a Significant Change of Status Assessments (SCSA) of the Minimum Data Set (MDS-a computerized assessment instrument) was completed within 14 days for one resident (Resident 36) when Resident 36 had a significant change in the nutrition route from enteral (nutrition delivered directly to the stomach or intestines) to oral (nutrition taken by mouth) after gastric tube (g-tube is a small tube that is placed through the skin into the stomach, used to give food, water, or medicine to people who can't eat by mouth) removal and a changed in the level of eating assistance. This failure resulted in Resident 36's care plan not being updated and revised to reflect his current status, which had the potential to delay the implementation of care and support needs. Findings: During a review of Resident 36's Admission Record (a document that contains demographic and clinical data), indicated, Resident 36 was admitted to the facility on [DATE], with diagnoses which included acute kidney failure (a condition where the kidneys suddenly stop working properly) and metabolic encephalopathy (a brain problem caused by issues with how the body uses food and energy). During an observation on October 14, 2024, at 12:25 PM, Activity Director (AD) serve and set up Resident 36's lunch tray in the dining room, Resident 36 began to eat his lunch independently. He continued to eat independently throughout his meal. During a record review on October 14, 2024, at 2:00 PM, with Director of Nursing (DON), the DON reviewed Resident 36's physician order dated July 10, 2024, which indicated . Order Summary: Regular diet. Pureed texture (smooth soft consistency, like pudding) , Regular/Thin consistency, large portion . During a concurrent interview and record review, October 17, 2024, at 2:20 PM, with the DON and MDS nurse, the DON and the MDS nurse reviewed Resident 36's clinical record dated July 26, 2024, which indicated, .Summarize your observations, evaluation, and recommendations: resident noted to have g-tube removed able to tolerate PO [by mouth] diet . Recommendation of Primary Clinician(s): [name of the Nurse Practitioner] in facility to remove G-Tube . The MDS nurse stated she did not know Resident 36's g- tube was removed on July 26, 2024. (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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, October 17, 2024, at 2:40 PM, with the DON and MDS nurse, the DON and the MDS nurse reviewed Resident 36's clinical record of MDS assessments. The assessments indicated the following levels of eating assistance for Resident 36: a. July 18, 2024, MDS Quarterly assessment , indicated, Partial/moderate assistance [helper does less than half the effort] b. April 19, 2024, MDS Quarterly assessment , indicated, Not attempted . c. January 23, 2024, MDS Quarterly assessment , indicated, Not attempted . d. October 25, 2023, MDS Admission assessment, indicated, Not applicable. The DON and MDS nurse stated Resident 36's level of assistance changed from dependent gastric tube feeding to oral partial/moderate assistance for eating. A review of the MDS assessments for Resident 36 revealed the last assessment completed was a quarterly assessment completed July 18, 2024. No other MDS assessments had been completed since July 18, 2024, the DON and MDS nurse confirmed that no additional MDS assessments had been completed since July 18, 2024. The MDS nurse stated that she missed completing the SCSA for Resident 36, which should have been completed by August 10, 2024. (It has been 68 days since the SCSA was due, and it has not been completed to reflect Resident 36's current status). A review of the facility policy and procedure titled Change in Resident's Condition or Status revised January 2024, indicated . 2. A significant change of condition is major decline or improvement in resident status that: a. will not normally resolve itself without intervention . b. impacts more than one area of the resident's health status; c. requires interdisciplinary review and/or revision to the care plan; . 9. If a significant change in resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA [is a federal law that establishes regulations for nursing facilities] regulations governing resident assessments and as outlined in the MDS RAI [Resident Assessment Instrument. It's a tool used in nursing homes to assess residents' health and needs] Instruction Manual . A review of the RAI manual revised October 2023, indicated . The SCSA is a comprehensive assessment for a resident . It can be performed at any time after the completion of an Admission assessment .The MDS completion date (item Z0500B) must be no later than 14 days from the ARD [(Assessment Reference Date) is the last day of this observation period] (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on interview and record review, the facility failed to ensure Minimum Data Set (MDS- a computerized assessment instrument) Assessments were completed accurately to reflect the resident's status, care, and services for one of two sampled residents (Resident 68) reviewed for restraints (tools used to keep a patient safe by limiting their movement. They can be things like special belts, mittens, or straps that prevent a person from hurting themselves or others, or from pulling out important medical equipment). This failure had the potential to cause inaccuracy in identifying Resident 68's care and support needs. Findings: During a review of Resident 68's Admission Record (a document that contains demographic and clinical data), the Admission Record indicated, Resident 68 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (a brain problem caused by issues with how the body uses food and energy) and attention of tracheostomy (tube helps people breathe when they can't breathe normally through their mouth or nose). During an observation on October 14, 2024, at 2:30PM, in room [ROOM NUMBER], Resident 68 was wearing mittens (in a medical care setting, a type of cloth glove that covers the hands to limit movement and prevent self-harm or pulling out medical devices) on both hands and an abdominal binder (a stretchy piece of fabric that wraps around the stomach) on his abdomen. During a concurrent observation and interview on October 17, 2024, at 12:30 PM, with a License Vocational Nurse 1 (LVN 1), in room [ROOM NUMBER], Resident 68 was wearing mittens on both hands and an abdominal binder on his abdomen. LVN 1 stated the mittens were used to prevent Resident 68 from pulling out his tracheostomy, and the abdominal binder was used to block him [Resident 68] from pulling on his gastric tube (g-tube is a small tube that is placed through the skin into the stomach, used to give food, water, or medicine to people who can't eat by mouth). During a concurrent interview and record review, on October 17, 2024, at 3:00 PM, with the Director of Nursing (DON) and Minimum Data Set Nurse (MDS Nurse), the DON and MDS Nurse reviewed Resident 68's physician orders. The order dated August 8, 2024, indicated, May have abdominal binder due to pulling at G-tube, and the order dated August 23, 2024, indicated, May have bilateral mittens as needed due to pulling at medical equipment. The DON and MDS Nurse confirmed the orders. The MDS Nurse stated she was aware of Resident 68 uses both mittens and an abdominal binder. During a further record review and interview on October 17, 2024, at 3:10 PM with the DON and MDS Nurse, the DON and MDS Nurse reviewed Resident 68's Quarterly MDS assessment dated [DATE], the assessments under Section P titled Restraints and Alarms, indicated Resident 68 did not use physical restraints. The DON and MDS Nurse confirmed Trunk restraint [a device or strap that secures a person's torso (their trunk, which includes the chest and abdomen) to a bed or chair] and Limb restraint [using straps or devices to secure a person's arms or legs] were not coded for Resident 68's Quarterly MDS Assessments. The MDS nurse stated it should have been coded. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on October 17, 2024, at 3:40 PM, with the DON and MDS Nurse, the DON and MDS Nurse reviewed the facility policy and procedures (P&P) titled Certifying Accuracy of the Resident Assessment, revised January 2024. The P&P indicated . 3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. The DON and MDS Nurse stated that the facility did not follow the policy. During a review of CMS (The Centers for Medicare & Medicaid Services) RAI manual (Resident Assessment Instrument, this manual provides guidelines and definitions for completing MDS assessment) dated October 2023, it indicated .The RAI process .require that (1) the assessment accurately reflects the resident's status . When the use of physical restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues . Steps for Assessment 1. Review the resident's medical record (e. g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period. 2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations. 3. Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44841 Based on the observation, interview and record review, the facility failed to store all drugs and biological in accordance with currently accepted professional principles and the facility's policies and procedures when one of four medication carts (200's hall medication cart) reviewed for medication storage found to be unsanitary on October 16, 2024. This failure had the potential increase the risk of infection to a resident's receiving medications with unwanted chemical reactions and decreased efficacy. Findings: During an observation on October 16, 2024, at 10:50 AM with License Vocational Nurse 2 (LVN 2), LVN 2 inspected the contents of the 200's hall medication cart. The left bottom drawer, was noted with yellow moist build up. LVN 2 stated the drawer contains the as needed over the counter medications and acknowledged there was a yellow build up on the paper towel used to wipe inside of the 200's hall medication cart left bottom drawer. During a concurrent observation and interview on October 16, 2024, at 11:10 AM with Infection Control Preventionist (ICP) nurse. The ICP nurse inspected the 200's hall medication cart and acknowledged there was a yellow build up on the paper towel used to wipe inside of the 200's hall medication cart left bottom drawer. The ICP nurse stated all medication carts should have been clean to maintain the efficacy of the medications and prevent contamination, (when something harmful, like dirt, germs, or chemicals, mixes with something clean or safe, making it unsafe to use). During an interview and concurrent record review on October 16, 2024, at 4:10 PM with the Director of Nurses (DON), the DON reviewed the facility's policy and procedure (P&P) titled, Storage of Medications, effective date January 2024, which indicated, Policy heading . The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Policy Interpretation and Implementation . 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. The DON stated the policy was not followed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50295 Based on observations, interviews, and record review, the facility failed to maintain a sanitary kitchen when: 1. There was a cabinet that stored a juice dispenser, the door to the cabinet had a sticky residue. Inside the cabinet there was a red juice spill. The cabinet under the steam table had food crumbs and trash. There was food residue around the floor sink under the steam table. This had the potential to attract pests and for microorganisms' growth. 2. The industrial mixer was stored with white food residue on the mixer. This had the potential to contaminate food being mixed in the mixer. 3. The ice machine had some brown build-up in the area where ice is formed. This had the potential to contaminate the ice. The facility failures had the potential to attract pests and cause foodborne illness to a population of 59 residents eating facility prepared meals. Findings: 1. During an observation on October 14, 2024, at 08:02 AM, on the stainless-steel counter there was a juice dispenser and below there was a cabinet. The handle to open the cabinet had a sticky residue. When the cabinet door was removed, there was a red juice spill. During an observation on October 14, 2024, at 08:13 AM, below the steam table there was a compartment which was opened and noted to have a large piece of foil with crumbs and other pieces of debris/nonfood items. During an observation on October 14, 2024, at 08:14 AM, there were crumbs and some food residue around one of the floor sinks (drains) under the steam table. During an interview on October 14, 2024, at 08:09 AM, with [NAME] 1, she stated that the area with the juice spill and the sticky residue on the handle of the cabinet should be kept clean. During an interview on, October 16, 2024, at 3:00 PM, with the Registered Dietitian Nutritionist (RDN 1) and Registered Dietitian Nutritionist (RDN 2), RDN 2 stated it was her expectation that the cabinet with the sticky residue be cleaned and cleaned frequently to avoid any issues. In addition, RDN 2, stated the area below the steam tables should be cleaned and maintained clean. During an interview on October 16, 2024, at 03:10 PM, with RDN 2, RDN 2 stated it was her expectation that the area below the steam tables be cleaned and that the domes be placed in their proper location. Finally, regarding the crumbs and food residue found around the floor sink under the steam table, RDN 2 stated it should be kept clean. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure titled, Sanitization, dated January 2024, indicated, The food service area is maintained in a clean and sanitary manner. 1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. During a review of the FDA Federal Food Code, dated 2022, 4-602.13 indicated, NonFOOD - CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. In addition, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 2. During an observation on October 14, 2024, at 08:30 AM, the industrial mixer was stored with a black plastic bag covering it. When the bag was removed the exterior of the mixer had some white food material splashes. During an interview on October 16, 2024, at 3: 08 PM, with RDN 1 and RDN 2, RDN 2 stated that the mixer should be cleaned thoroughly before putting the bag over it. During a review of the facility's policy and procedure titled, Sanitization, dated January 2024, the P&P statement indicated, The food service areas is maintained in a clean and sanitary manner. During a review of the FDA Federal Food Code, dated 2022, 4-602.13 indicated, NonFOOD -CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. In addition, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. 3. During an observation on October 14, 2024, at 10:24 AM in the kitchen, in the ice maker part of the ice machine there was a spot of brown buildup. During a concurrent observation and interview on October 14, 2024, at 10:26 AM, with the facility Maintenance Director (MD 1), in the kitchen, the tray below the ice maker part of the ice machine had a spot of brown buildup. The maintenance director stated that this area should be kept clean. During an interview on, October 16, 2024, at 3:00 PM, with Registered Dietitian Nutritionist (RDN 2), RDN 2 stated that it was her expectation that the ice machine be kept clean. During record review of the facility's policy and procedure titled, Ice Machines and Ice Storage Chests, dated January 2024, the policy and procedure indicated, Ice machines and storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the FDA Federal Food Code, dated 4-602.11 indicated, (4) In Equipment such as ice bins and BEVERAGE dispensing nozzles and enclosed components of EQUIPMENT such as ice makers, cooking oil storage tanks and distribution lines, BEVERAGE and syrup dispensing lines or tubes, coffee bean grinders, and water vending EQUIPMENT: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. In addition, ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on interviews and record reviews, the facility failed to implement its policy and procedure on antibiotic stewardship (a set of practices aimed at ensuring the safe and effective use of antibiotics [medications used to treat infections]) for one of fourteen sampled residents (Resident 47) reviewed for antibiotic used, when the Infection Control Preventionist (ICP) nurse did not accurately assess and collect data to indicate the rationale and common clinical conditions necessary to ensure the appropriate use of antibiotic therapy for Resident 47. This failure had the potential to placed Resident 47 at risk for adverse events, including the development of anti-biotic resistant organisms, from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 47's Admission Record (a document that contains demographic and clinical data), the Admission Record indicated, Resident 47 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (a brain problem caused by issues with how the body uses food and energy) and ventilator (a machine that helps someone breathe when they can't do it on their own) associated pneumonia (a type of lung infection that can happen to people who are on a ventilator). During a record review on October 15, 2024, at 3:00 PM of Resident 47s physician's order dated September 28, 2024, the physician's order indicated, . Merrem Intravenous [a powerful antibiotic given through an intravenous (IV - a method of delivering fluids, medications, or nutrients directly into a person's bloodstream) to help treat serious bacterial infections]. Solution 1 gram [gr - unit of measure] intravenously three times a day for Sepsis (serious condition caused by an infection that can lead to organ failure) until 10/09/2024 [October 9, 2024] and Zyvox Intravenous [a strong antibiotic administered through an IV to treat serious bacterial infections] Solution 600 mg [mg - milligram is unit of measure] intravenously every 12 hours for Sepsis until 10/09/2024 [October 9, 2024]. During a concurrent interview and record review on October 16, 2024, at 9:45 AM with the ICP nurse, the ICP nurse reviewed form titled Surveillance Data Collection Form (a form used to monitor and collect data to understand and ensure the residents received the appropriate antibiotic), indicated as follows: a. Resident name: [Resident 47 name] . Loeb's minimum criteria for initiating antibiotics [was not filled to indicated criteria data] . treatment. Antibiotic treatment : Merrem . Date started: 9/28/24 [September 28, 2024]. Diagnosis: [left blank]. Drug/dosage/route: Merrem IV 1 gr tid [three times a day] x 10 days for Sepsis. Culture: [left blank]. Type: [left blank] . isolation/precaution: yes. Type: c. auris [candida auris is a type of fungus that can cause serious infections] Loeb's criteria [ ] met. [ ] Does not meet. [left blank]. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident name: [Resident 47 name] . Loeb's minimum criteria for initiating antibiotics [was not filled to indicated criteria data] . treatment. Antibiotic treatment : Zyvox IV . Date started: 9/28/24 [September 28, 2024]. Diagnosis: [left blank]. Drug/dosage/route: Zyvox IV Q [every] 12 x 10 days. Culture: [left blank]. Type: [left blank] . isolation/precaution: [left blank]. Type: [left blank] Loeb's criteria [ ] met. [ ] Does not meet. [left blank]. The ICP nurse stated the facility used the Loeb Criteria (a criteria helps staff determine whether a patient has a true infection that needs treatment or if the symptoms are due to something else to be able to provide the best treatment) to monitor outcomes of true infection (means that the criteria indicate a real infection) versus untrue infection (patients might show some of these signs but don't actually have an infection) to ensure the appropriate use of antibiotic therapy. During a concurrent interview and record review on October 16, 2024, at 10:05 AM, with the Director of Nursing (DON) and the ICP nurse, the DON and ICP nurse reviewed Resident 47's clinical records of infection notes dated September 30, 2024, the notes indicated, Patient on medication Merrem IV 1gm tid due to sepsis and Zyvox 600mg IV due to sepsis well tolerated and no ase [adverse side effect] noted. No additional infection notes have been documented since September 30, 2024, to indicate whether the usage of the two antibiotics was for a true infection or an untrue infection. The ICP nurse stated that she should have been conducting an analysis (looking for trends, spikes, or unusual patterns in the data) and reviewing the Loeb Criteria to confirm whether Resident 47 has a true infection, ensuring the appropriate use of antibiotic therapy. During an interview and concurrent record review on October 16, 2024, at 10:15 AM with the DON and ICP nurse, the DON and ICP nurse reviewed the facility's policy and procedure (P&P) titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016. The P&P indicated, Policy Statement . Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship . Policy Interpretation and Implementation 1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. 2. The IP, or designee, will review antibiotic utilization as part of antibiotic stewardship program and a. Therapy may require further review and possible changes if: (1) the organism is not susceptible to antibiotic chosen; (2) the organism is susceptible to narrower spectrum antibiotic; (3) therapy was ordered for prolonged surgical prophylaxis; or (4) therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The DON and the ICP nurse stated the facility did not follow the policy.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 44841 Based on observation, interview, and record review, the facility failed to implement their infection control program to help prevent the spread of COVID-19 (Corona Virus Disease, a highly infectious disease caused by the SARS-CoV-2 virus) when the facility did not have any tracking and documentation of staff COVID-19 vaccination status. This failure had the potential to cause harm to the 95 residents residing within the facility by causing cross contamination of the environment and increasing the risk of exposure and spread of the COVID-19 virus. Findings: During a concurrent interview and record review on October 17, 2024, at 9:40 AM, with the Infection Control Preventionist (ICP) nurse, the ICP nurse was asked to review the staff COVID-19 vaccination status. The ICP nurse was not able to provide a document that indicated a tracking system of staff members and their COVID-19 vaccination status. The ICP nurse stated she was unaware of her responsibility to maintain a system for documenting staff COVID-19 vaccination. The ICP nurse further stated she realized this duty only after reading the facility's Policy and Procedure on COVID-19 Vaccination for Staff, which she provided to the surveyor. During an interview on October 17, 2024, at 9:55 AM, with the Director of Nursing (DON), the DON stated the ICP nurse did not have any tracking and documentation of staff COVID-19 vaccination status. Furthermore, the DON emphasized that this documentation should have been consistently maintained and regularly updated to helps the facility implement targeted infection control measures to protect residents and staff. (continued on next page)

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	10/17/2024

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview and record review, on October 17, 2024, at 10:10 AM, with the DON and ICP nurse the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Vaccination of Staff, revised January 2024, was reviewed. The P&P indicated . Policy Statement . It is the policy of this facility to offer current COVID-19 vaccination to all healthcare providers and all residents . Policy Interpretation and Implementation . Tracking, Documentation and Reporting 1. The infection preventionist maintains a tracking worksheet of staff members and their vaccination status. 2. The tracking worksheet provides the most current vaccination status of all staff who provide any care, treatment, or other services for the facility and/or its residents. The worksheet includes: a. staff name (and/or employee ID); b. initial start of employment or service; c. termination of employment or service (if applicable); d. job title or role; e. assigned work area; f. a brief description of how they interact with residents; g. vaccination status: (1) the specific vaccine received; (2) dates of each dose; (3) date of the next scheduled dose (for a multi-dose vaccine); and (4) any booster doses (date and specific type of vaccine); 3. The facility maintains documentation related to staff COVID-19 vaccination that includes, at a minimum, the following (as applicable): a. That staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine, b. That staff were provided education regarding the benefits and potential risks associated with COVID- 19 vaccine; c. A copy of the informed consent; and d. Verification of vaccination or documentation of exemption/delay. The DON stated the facility did not follow the policy.

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 50295 Based on observations, interviews, and record review, the facility failed to ensure their equipment was maintained in safe operating condition when: The countertop water dispenser was found leaking and collecting standing water in the drain. This facility's failure to ensure a safe, operating equipment has the potential to increase risk of resident harm and attract pests due to the standing water which can affect the population of 59 residents who receive food from the kitchen. Findings: During an observation on October 14, 2024, at 08:04 AM, there was a leaking water dispenser on the countertop, with sitting water in the drain underneath the cover. During an interview on October 14, 2024, at 08:09 AM, with [NAME] 1, she stated they do not use it and it that it looks like it is leaking and needs to be fixed. During an interview on, October 16, 2024, at 3:10 PM, with Registered Dietitian Nutritionist (RDN 1), and Registered Dietitian Nutritionist (RDN 2), RDN 2 stated that it was her expectation that the water dispenser should be fixed as soon as possible. During a review of the facility's policy and procedure titled, Maintenance Service, dated January 2024, the policy and procedure statement indicated, Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During further review of the FDA Federal Food Code, dated 2022, under Section: Equipment, 4-501.11 titled, Good Repair and Proper Adjustment, indicated, EQUIPMENT shall be maintained in a state of repair and condition Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk.