

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 12/18/2025
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to establish and maintain effective infection prevention and control practices for nine of ten sampled residents (Residents 2, 11, 33, 36, 59, 79, 81, 97, and 103) when: 1. For Resident (81), the oxygen tubing (a flexible plastic tube to deliver oxygen from the oxygen concentrator to the resident) was resting on top of the oxygen concentrator (a medical device that pulls in room air and concentrates oxygen to supplemental oxygen to the resident), open to air and not stored inside a respiratory equipment bag, on December 15, 2025. 2. Two urinary catheter bags (a medical bag used for collecting urine) were touching the floor for Residents 2 and 59 on December 15, 2025. 3. One Certified Nursing Assistant 3 (CNA 3) did not wear a gown while performing high contact resident care activities (transferring, dressing, and assisting with toileting) for Resident 11 who was on enhanced barrier precautions (infection control measures used in healthcare settings to prevent the spread of multidrug-resistant organisms) 4. One Licensed Vocational Nurse 4 (LVN 4) did not sanitize and disinfect the glucometer (device used to check blood sugar) between uses on five residents (Residents 33, 36, 79, 97, and 103) on December 17, 2025. These failures had the potential to result in cross-contamination (when germs are spread from one person, surface, or object to another, making it easier for infections to spread) and infection due to improper storage of respiratory equipment, failure to follow enhanced barrier precautions, improper placement of urinary drainage systems, and failure to disinfect shared medical equipment between residents. 1. During a review of Resident 81's Administration Record (Contains demographic and medical information), it indicated Resident 81 was admitted to the facility on [DATE], with the diagnoses that included acute respiratory failure (when lungs suddenly cannot get enough oxygen in to the body) respiratory failure with hypoxia (when the lungs cannot give the body enough oxygen to breath Properly), chronic obstructive pulmonary disease (a long term lung disease that makes it had to breath because the airway are damage or blocked). During a concurrent observation and interview with CNA 1 on December 15, 2025, at 10:40 AM, in Resident 81's room, an oxygen concentrator was observed positioned in the middle of the room. The oxygen tubing was observed coiled and resting on top of the oxygen concentrator open to air and not stored inside a respiratory equipment bag. At the time of the observation, the tubing was not connected to the resident. CNA 1 stated the oxygen equipment belongs to Resident 81 and the oxygen tubing should be stored inside a respiratory equipment bag when not in use for infection control purposes. CNA 1 further stated leaving the tubing open to air could result in contamination. During a review of Resident 81's Physician Orders, dated November 25, 2025, it indicated Resident 81 had an order for Oxygen at 2 L per min via n/c (oxygen delivered through a nose tube at a steady flow of 2 liters per every minute), every shift. During a concurrent interview and record review on December 18, 2025, at 4:26 PM, with the Director of Nursing (DON), the facility's policy and procedure titled Departmental (Respiratory &ndash; (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Therapy) - Prevention of infection, revised September 2025, was reviewed. The Policy indicated, Purpose. the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment., Infection Control Considerations Related to Oxygen Administration., 6. Keep the oxygen cannula and tubing used PRN (as needed) in a plastic bag when not in use. The DON confirmed that staff did not followed the policy. 2a. During a review of Resident 2's clinical records, the admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease, stage 5 (condition where damaged kidneys lose their ability to filter waste and urine), other neuromuscular dysfunction of bladder (condition affecting the bladder due to inactivity of the brain), and surgical amputation of left leg (removal of damaged body part). During a concurrent observation and interview, on December 15, 2025, at 11:08 AM, with the Registered Nurse (RN 1), in Resident 2's room. Resident 2 was lying in his bed. His urinary catheter bag was hanging off the bed frame on the resident's right side of the bed resting on the floor. The RN 1 stated it is not supposed to be on the floor for infection control purposes. 2b. During a review of Resident 59's clinical records, the admission Record, indicated Resident 59 was admitted to the facility on [DATE], with diagnoses that included obstructive and reflux uropathy (a blockage that causes the urine to flow backward), neuromuscular dysfunction of bladder (a condition affecting the bladder due to inactivity of the brain), and cystitis, unspecified without hematuria (an inflammation of the bladder). During a concurrent observation and interview, on December 15, 2025, at 11:10 AM, with the RN 1, in Resident 59's room. Resident 59 was lying in his bed. His urinary catheter bag was hanging off the bed frame on the resident's right side of the bed resting on the floor. The RN 1 stated it is not supposed to be on the floor for infection control purposes. During a concurrent interview and record review with the Case Manager/Infection Prevention Nurse (CM/IPN) on December 17, 2025, at 2:40 PM, the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised September 2025, was reviewed. The P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection control. 2. Be sure the catheter tubing and drainage bag are kept off the floor. The CM/IPN stated the P&P was not followed and should have been to prevent bacteria from re-entering the urinary bag. 3. During a review of Resident 11's admission Record, it indicated Resident 11 was admitted to the facility on [DATE], with diagnoses which included fracture of lateral malleolus of left fibula (a type of ankle fracture), hypothyroidism (also called underactive thyroid, is when the thyroid gland does not make enough hormones), and abnormalities of gait (walking) and mobility. During an observation on December 16, 2025, at 9:29 AM, outside Resident 11's room, there was a sign posted outside the residents doorway which indicated, Enhanced Barrier Precautions. gown and gloves must be used during high contact resident care activities. dressing. transferring. or assisting with toileting.[room and bed number of Resident 11]. CNA 3 was then observed to enter Resident 11's room without wearing a gown and assisted Resident 11 by dressing the resident, emptying Resident 11's urinal drainage bag (a bag which is attached to a urinary catheter and contains and holds urine) and dumped the urine into the toilet, and assisting the resident to transfer from the bed to a wheelchair. CNA 3 never wore a gown during her interaction with the resident. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on December 16, 2025, at 9:41 AM, CNA 3 exited Resident 11's room and stated she had just assisted Resident 11 by emptying the resident's urine drainage bag, put on the residents' pants, shoes and bra, and then transferred the resident to a wheelchair. CNA 3 stated she was not aware Resident 11 was on enhanced barrier precautions because she did not see the sign posted outside the resident's doorway. CNA 3 then observed the sign Enhanced Barrier Precautions posted outside the resident's door and acknowledged the sign indicated the room and bed of Resident 11. During a review of Resident 11's physician's orders, an order dated November 10, 2025, indicated, Foley Catheter [a flexible tube inserted through the urethra into the bladder to drain urine] . RT [related to] urinary retention [the inability to completely empty the bladder of urine]. During a review of Resident 11's physician's orders, an order dated November 11, 2025, indicated, Enhanced Barrier Precautions: Foley. During a review of Resident 11's care plan (an individualized plan for the medical care of a resident) titled, The resident has Indwelling catheter d/t [due to] urinary retention, had a listed goal which indicated, The resident will show no s/sx [signs and symptoms] of urinary infection. The care plan included the following interventions, .monitor/record/report to MD for s/sx [signs and symptoms] UTI [Urinary Tract Infection]. During an interview on December 18, 2025, at 10:23 AM, with the Director of Nursing (DON), the DON stated Enhanced Barrier Precautions were developed to help protect the residents by preventing the spread of infection. The DON further stated staff assisting residents on enhanced barrier precautions were supposed to wear a gown and gloves during transferring, changing, and assisting with toileting or other high contact care activities. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, (undated), the P&P indicated, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing.c. transferring.f. changing briefs or assisting with toileting.g. device care or use (central line, urinary catheter.5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. 6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.10. Signs are posted on the door or wall outside the resident room indicating the type of precautions and PPE [personal protective equipment like gloves, gowns etc.] . 4. During medication administration observation on December 17, 2025, at 5:47 AM, in station 1, with Licensed Vocational Nurse 4 (LVN 4), LVN 4 was observed at Station 1 preparing to perform blood sugar level (BSL) checks. LVN 4 entered Resident 33's room and performed a BSL check using a shared glucometer. Upon completion, LVN 4 did not clean or disinfect the glucometer. LVN 4 immediately proceeded to Resident 103's room and utilized the same glucometer to perform a BSL check. LVN 4 continued to perform BSL checks for Resident 79, 97, and 36 using the same device. During the entire sequence, LVN 4 failed to sanitize or disinfect the glucometer between residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on December 17, 2025, at 7:06 AM with LVN 4, LVN 4 acknowledged and stated she did not sanitize glucometer after use for Resident's 33, 103, 79, 97, and 36. LVN 1 further stated the glucometer should have been sanitized after each use. During a concurrent interview and record review with the Case Manager/Infection Prevention Nurse (CM/IPN), on December 17, 2025, at 2:36 PM, the facility's policy and procedure (P&P) titled Cleaning and Disinfection of Resident-Care Items and Equipment revised September 2025, was reviewed. The P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogen standard. 5. Reusable items are cleaned and disinfected or sterilized between residents (e.g., stethoscopes, durable medical equipment. The CM/IPN stated the P&P was not followed and should have been to prevent blood-borne pathogen through contamination (spread of infection).		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the call light system (a communication device linking patients/residents to staff, allowing them to request assistance via a button or pull cord, alerting a central station for timely help) and shower equipment were maintained in safe and working condition for resident use when:1. One wall mounted call light located in one of two facility showers, did not have a pull cord accessible for resident use.This failure resulted in the inability for residents or staff to have a call light readily available in the shower to summon staff assistance in case of an emergency.2. One of two shower beds (used by residents for bathing and for transport to and from their room) had two non-functioning side rails due to missing locking pins. The absence of the pins rendered the side rails unsecured and unable to be locked in an upright position.This failure resulted in increased risk of residents' injury due to the inability for staff to properly use the shower bedside rails during bathing and transportation in order to help prevent falls and potential injury.1. During an observation on December 16, 2025, at 12:05 PM, in one of two facility shower rooms (Shower room A), there were two separate shower stalls. One of the two shower stalls had a call light on the wall but could not be activated because there was no pull cord connected to it and there was no button to press or activate.During a concurrent observation and interview on December 16, 2025, at 12:10 PM, with the Facility Maintenance Director (FMD), the FMD stated residents, and staff were supposed to be able to call for assistance by using a pull cord to activate the call system. The FMD further stated the call system was supposed to be available for every shower and toilet area. The FMD acknowledged one of two shower stalls did not have a pull cord and there was no way to manually activate the call system without a pull cord. The FMD stated he did not know why there was no pull cord and that he had not been made previously aware the pull cord was missing.During an interview on December 17, 2025, at 2:12 PM, with the Administrator (ADMIN), the ADMIN stated every shower and every restroom in the facility should have a pull cord to activate the call system.During an interview on December 18, 2025, at 10:27 AM, with the Director of Nursing (DON), the DON stated the pull cords for the call system should present on all call lights and in operating condition. The DON further stated it was important to ensure the call light system was maintained properly to ensure residents can get help if they fall and to ensure the residents can get ahold of staff in a timely manner, if needed.During a review of the facility's policy and procedure (P&P) titled, Nurse's Call System, (undated), the P&P indicated, It is the policy of this facility to maintain building systems in good working order, inspecting them at intervals which comply with state, federal and company standards as to repair as necessary. 2. Replace immediately defective light bulbs or buzzers and chords.3. Check to see that call systems in toilets, bathrooms and shower are properly grounded and working.2. During an interview on December 16, 2025, at 10:01 AM, with Resident 62, Resident 62 stated the facility had a shower bed which had non-functioning side rails and that it had been that way for a couple months.During a concurrent observation and interview on December 18, 2025, at 2:25 PM, inside Resident 56's room, CNA 3 was in Resident 56's room with the shower bed and had just finished transporting Resident 56 from the shower room to the residents' room and assisted with transferring the resident to her bed. The shower bed which was used to shower Resident 56 and transport her back to her room, had two side rails which were down and were unable to be kept in an upright position because there was a missing pin on each side of the bed which was used to keep the bed rails up. CNA 3 stated she just finished showering Resident 56 and brought her back to her bed in the shower bed. CNA 3 stated the siderails usually swing upward and then a pin is placed in a hole on both sides of the bed to hold up the siderails but both pins were missing and were supposed to be attached to the bed. CNA 3 stated she did not use the bed rails and instead transferred the resident in the shower bed with the side rails down since there were no pins to keep the side rails up. CNA 3 stated sometimes if she needs the side rails to stay up, she will find a plastic spoon and stick the handle of the spoon in the pin hole on each side of the bed to keep the side (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	rail upright.During a concurrent observation and interview on December 18, 2025, at 2:27 PM, CNA 4, CNA 4 was assisting to remove the shower bed from Resident 56's room and stated the shower bed had not had pins to keep the side rails up for approximately one month. CNA 4 stated she sometimes would jam a spoon handle in the hole to keep the side rails up. CNA 4 stated she was not sure if the maintenance department was aware of the issue or not.During an interview on December 18, 2025, at 2:57 PM, with the Facility Maintenance Director (FMD), the FMD stated he was made aware a few days ago that the pins were missing for the side rails on the shower bed. The FMD further stated he had not fixed the bed yet because he was waiting to see where he could find the correct pin size for the side rails. The FMD stated he was now going to install temporary pins on the bed which could be used to keep the side rails up.During an interview on December 18, 2025, at 4:45 PM, with the Director of Nursing (DON), the DON stated the side rails for the shower bed were supposed to be up anytime any resident was being transported in the shower bed due to safety concerns. The DON further stated he was not aware one of the shower beds did not have the required pins to keep the side rails functional.During a review of the facility's policy and procedure (P&P) titled, Safety and Supervision of Residents, (undated), the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes.and a facility-wide commitment to safety at all levels of the organization. 4. Employees shall be trained and inserviced on potential accident hazards and how to identify and report accident hazards, and try to prevent avoidable accidents.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure medication storage was secured and IV (intravenous, a small tube that gives fluids into a vein) fluid was properly labeled when: 1. An IV fluid bag for Resident (63) was observed without a documented date, time, medication name, rate, or staff initials on the label. 2. One of two treatment carts (Cart in 400 hall - a mobile cabinet on wheels, used all the bandages, syringes, meds, etc. needed to treat patients right at their bedside) was found unlocked and unattended by staff. 3. One of 15 medication carts (Station 1's medication cart - a cart used by licensed nurses to transport medication to resident rooms) was found unlocked and unattended by a licensed nurse. These failures had the potential to be accessed and dispensed by an unauthorized person, and placing the health of 93 residents at risk for harm. 1. During a review of Resident 63's admission Record (contains demographic and medical information), the admission Record indicated Resident 63 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus with diabetic chronic kidney disease (a condition where the body does not use insulin well, causing high blood sugar overtime that damages the kidneys and makes them work less effectively), dehydration (when the body does not have enough fluids, making it hard for organs to work properly) and Alzheimer's disease (a brain disease that slowly affects memory and the ability to do daily activities). During an observation on December 15, 2025, at 11:56 AM, inside Resident 63's room, Resident 63 was lying in bed with his eyes closed. On his right side, there was an IV (intravenous, a small tube that gives fluids into a vein) infusion actively running. The IV fluid was 0.9% Normal Saline (salt water that helps keep the body hydrated) was hanging on an IV pole, (a tall stand that holds the IV bag above the patient) and infusing at a rate of 100 ml (milliliter, unit to measure liquids) per hour. The IV bag displayed an orange-colored label indicating an amount of 100 cc (cubic centimeter, a small unit used to measure liquid); however, the label did not include the medication name, infusion rate, date, time, expiration date, or staff initials. A 300 mL reminder marking (a line on the bag used to track how much fluid has been given) was visible on the IV bag. During a concurrent observation and interview on December 15, 2025, at 12:06 PM, inside Resident 63's room, with Registered Nurse (RN 1), RN 1 stated that a temporary pharmacy label is sometimes used for a new order of IV fluids. RN 1 confirmed that the IV bag did not include the medication name, infusion rate, date, time, expiration date, or staff initials at the time it was hung. RN 1 further stated the nurse who hung the IV should have included all required labeling information, as this information is important for safe medication administration. During a review of Resident 63's Physician Orders, dated December 15, 2025, the Physician Orders indicated, Sodium Chlorine intravenous Solution 0.9 % (Sodium Chloride) Use 100 ml/hr (100 milliliters each hour, intravenously every shift for hydration (having enough water in the body) until December 16, 2025, at 23:59 (11:59 PM) x 48 hrs. (for a total duration of forty-eight hours). During a concurrent interview and record review on December 18, 2025, at 4:25 PM, with the Director of Nursing, (DON), the facility's policy and procedure (P&P) titled, INFUSION THERAPY PRODUCT LABELS, dated January 2025, was reviewed. The P&P indicated, Infusion therapy products shall be labeled in accordance with facility requirements and applicable state and federal laws. The Label shall include sufficient additional information as required to assure safe and efficient administration (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to residents., b. An auxiliary label shall be affixed to each infusion therapy product container, which provided for information about its administration to be completed., IV solution / additives administration, Resident, Rm (room), Infusion Rate, Time started a.m., p.m.; started by, date, medication(s) added, by (nurse), date, time a.m., p.m. The DON stated that the IV bag labeling did not meet policy requirements and confirmed that the policy was not followed by staff. 2. During an observation on December 17, 2025, at 5:20 AM, one of two facility treatment carts (the cart in the 400 hall) was observed to have five drawers which contained multiple supplies and medications used for wound treatment. The cart was left unlocked and unattended by staff and each of the five drawers could easily be opened. During a concurrent observation and interview on December 17, 2025, at 5:30 AM, with Registered Nurse 2 (RN 2), RN 2 stated all treatment carts were supposed to be locked when not in use. RN 2 observed the treatment cart in hallway 400 and acknowledged it was unlocked, and stated the last assigned individual should have the keys and ensure the cart is locked when not in use. RN 2 further stated sometimes staff would leave the treatment cart unlocked because nurse's unintentionally take home the keys , preventing access to medications and supplies RN 2 stated the last nurse assigned to the treatment cart worked yesterday during the morning shift. During an interview on December 18, 2025, at 10:28 AM, with the Director of Nursing (DON), the DON stated all medication and treatment carts were supposed to be locked when not in use and the carts should not be left unlocked. The DON further stated it was important to ensure the carts were locked for safety of the residents because there were medications in the carts. During a review of the facility policy and procedure (P&P) titled, Storage of Medications, dated January 2025, the policy indicated, Medications and biologicals shall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.b. Only licensed nurses.and those lawfully authorized to administer medications shall be allowed access to medications. Medication rooms, carts, and medication supplies shall be locked or attended by persons with authorized access. 3. During a concurrent observation and interview on December 17, 2025, at 2:36 PM, with a Licensed Vocational Nurse 1 (LVN 1), one medication cart was found unlocked and unattended in station 1 hallway. LVN 1 verified the medication cart was unlocked and stated, the expectations are to keep medication carts locked to keep the residents from opening it. During a concurrent interview and record review on December 18, 2025, at 4:46 PM, with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Pharmaceutical Services Policy and Procedure Manual-Storage of medications, dated January 2025, was reviewed. The P&P indicated, Medications and biologicals shall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The DON stated, the policy was not followed and should have been, for medication safety.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR - a screening assessment to ensure individuals who are identified to have a significant mental illness (SMI), intellectual or developmental disability (I/DD)) are not inappropriately placed in nursing homes for long term care) were completed accurately for two of two sampled residents (Resident 7 and 36) when: 1. PASRR screening assessment for Resident 7 did not include his diagnosis of cerebral palsy (disorders affecting movement, posture, and muscle coordination, caused by damage to the developing brain). 2. PASRR screening assessment for Resident 36 did not include her diagnoses of generalized anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), bipolar disorder (a mental health condition causing extreme mood swings, from manic highs [high energy, irritability] to depressive lows [sadness, hopelessness, low energy], affecting energy, sleep, focus, and daily functioning) and major depressive disorder (a mental health condition characterized by persistent feelings of sadness, loss of interest in activities, and a diminished ability to function in daily life). These failures had the potential to result in Resident 7 and 36's condition not being identified prior to admission and their needs for treatment and services not being accurately assessed, placing them at risk of inadequate care. Findings: 1. During a review of Resident 7's admission Record (contains medical and demographic information), the admission Record indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which include major depressive disorder, anxiety disorder, Post Traumatic Stress Disorder (PTSD - a mental health condition triggered by experiencing or witnessing a terrifying, shocking, or dangerous event) and Cerebral Palsy. During a review of Resident 7's Preadmission Screening and Resident Review (PASRR) Level I screening (a level 1 screening includes assessment of the resident's medical diagnoses to determine if the resident has or is suspected of having a PASRR condition [i.e. SMI, or I/DD]), dated July 14, 2023, indicated in section II for Intellectual or Developmental Disability(ID) / (DD) or Related Conditions (RC) . 4. The individual has or is suspected of having a primary diagnosis of ID/DD/RC include . cerebral palsy., marked NO. Further review of the PASRR indicated, Result of Level I Screening: Level I- Positive, resolution status [NAME]- Submitted (submitted for level 2 assessment [level 2 assessment is done when the resident is positive for possible SMI and/or I/DD]). During an interview on December 17, 2025, at 9:44 AM, with Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 7's PASRR dated July 14, 2023, did not reflect Resident 7's existing diagnosis of cerebral palsy. The MDSC further stated the facility should have accurately screened the resident and corrected the PASRR to include the diagnosis on admission to the facility. The MDSC acknowledged that the facility did not accurately screen or correct the PASRR for Resident 7. During a concurrent interview and record review on December 17, 2025, at 2:56 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Charting and Documentation, dated July 2017, was reviewed. The P&P indicated, . Documentation in the medical record will be objective. complete, and accurate. The DON acknowledge that based on Resident 7's admission records, the PASRR was not accurate, and that the P&P was not being followed. The DON further states, it was important to have accurate documentation, ensuring the residents were provided with the services they needed, and to prevent harm. 2. During a review of Resident 36's admission Record, it indicated Resident 36 was admitted on [DATE], with diagnoses that included major depressive disorder, bipolar disorder, and generalized anxiety. During a review of Resident 36's Preadmission Screening and Resident Review (PASRR) Level I screening, dated October 6, 2025, the PASRR Level 1 screening indicated in section III for Serious Mental Illness. 9. Diagnosed Serious Mental Illness. Does the individual have a serious diagnoses mental disorder such as. Depressive Disorder, Anxiety Disorder. symptoms of Psychosis, Delusions, and/or Mood Disturbance? This question was marked NO. Further review of the PASRR (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated a resolution status LII- Not Required (Level 2 assessment is not required). During an interview on December 17, 2025, at 9:02 AM, with Minimum Data Set Coordinator (MDSC), the MDSC stated Resident 36's PASRR dated October 6, 2025, did not accurately reflect Resident 36's existing diagnoses of anxiety, depression, and bipolar disorder. The MDSC further stated the facility should have accurately screened the resident and corrected the PASRR to include her diagnoses on admission to the facility. The MDSC acknowledged that the facility did not accurately screen or correct the PASRR for Resident 36. During a concurrent interview and record review on December 17, 2025, at 2:58 PM, with the Director of Nursing (DON), facility's policy and procedure (P&P) titled, Charting and Documentation, dated July 2017 was reviewed. The P&P indicated, . Documentation in the medical record will be objective, complete, and accurate. The DON acknowledge that based on Resident 36's admission record, the PASRR was not accurate, and that the P&P was not being followed. The DON further states, the importance of accurate documentation in PASRR was to ensure the residents are getting the individualized care and services they require.		

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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** Based on observation, interview, and record review, the facility failed to ensure one of twenty-seven (27) sampled residents (Resident 10) received medications as ordered by the physician, and the facility did not inform the physician of the missed medication doses when: a. Resident 10's anticoagulant Heparin (a blood thinner medication used to prevent the formation and growth of blood clots) was not administered on November 28, 2025, for 9:00 AM and 9:00 PM dose. Additionally, on November 29, 2025, she was not given her 9:00 AM dose (total of three missed doses). There was no documented evidence indicating the physician was notified of the missed doses. b. Resident 10's antibiotic Keflex (a medication used to treat a bacterial infection) was not administered on November 29, 2025, for 6:00 AM dose and 12:00 PM dose (total of two missed doses). There was no documented evidence indicating the physician was notified of the missed doses. These failures had the potential for Resident 10 to experience subtherapeutic (less than optimal) benefits from her medications and for increased risk for worsening infection and/or the development of blood clots. Additionally, by not informing the physician of missed doses, the physician was not provided with an opportunity to consider the potential medical impact on the patient and consider if additional orders were necessary. A review of Resident 10's admission Record (contains medical and demographic information), indicated Resident 10 was admitted to the facility on [DATE], with diagnoses which included thrombocytosis (a disorder in which your body produces too many platelets which can cause blood clots or bleeding problems), Guillain-Barre Syndrome (a condition in which the body's immune system attacks the nerves), and hereditary motor and sensory neuropathy (an inherited disorder that progressively damages the nerves, causing muscle weakness and sensory loss). During and interview on December 16, 2025, at 8:58 AM, Resident 10 stated she was receiving Heparin and Keflex a few weeks ago but was not provided a few doses of each medication because the facility did not have the medications available. Resident 10 further stated the Keflex medication was to treat an infection on her scalp. a. During a review of Resident 10's physician's orders, an order dated June 28, 2025, indicated, Heparin Sodium.injection 5000 unit/ml [units per milliliter] inject 0.5 milliliter subcutaneously [beneath the skin] every 12 hours for DVT [deep vein thrombosis - a condition where a blood clot forms in a deep vein] prophylactic [prevention]. During a review of Resident 10's Medication Administration Record (MAR - document used to record the administration of medications to the resident), dated November 1, 2025, through November 30, 2025, the MAR indicated Resident 10 did not receive her 9:00 AM and 9:00 PM doses of Heparin on November 28, 2025. Additionally, the MAR indicated Resident 10 did not receive her 9:00 AM heparin dose on November 29, 2025. During a review of Resident 10's progress notes, a progress note dated November 28, 2025, at 9:35 AM, indicated, Heparin Sodium.injection solution 5000 unit/ml inject 0.5 milliliter subcutaneously every 12 hours for DVT prophylactic.medication not here. Will cont [continue] to f/u [follow up] with pharm [pharmacy]. During a review of Resident 10's care plan (an individualized plan for the medical care of a resident) titled, [name of Resident 10] is on anticoagulant therapy Heparin Sodium injection. dated April 25, 2025, the care plan interventions indicated, Administer anticoagulant medications as ordered by physician. b. During a review of Resident 10's physician's orders, an order dated November 27, 2025, indicated, Keflex oral capsule give 500 mg [milligrams - unit of measure] by mouth every 6 hours for scalp cellulitis [inflammatory disease of the scalp] for 7 days. During a review of Resident 10's MAR, Dated November 1, 2025, through November 30, 2025, the MAR indicated Resident 10 did not receive her 6:00 AM and 12:00 PM doses of Keflex on November 29, 2025. During a review of Resident 10's progress notes, a progress note dated November 29, 2025, at 5:44 AM, indicated, Keflex oral capsule give 500 mg by mouth every 6 hours for scalp cellulitis for 7 days. Waiting for pharmacy to deliver. Org [original] order on the 27th [of November], sent reorder the 29th, e-kit [an emergency kit with a supply of medications] has none available. During a review of Resident 10's care plan titled, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Red raised bump on scalp, dated November 27, 2025, the care plan interventions indicated, give medication as ordered. During a concurrent interview and record review on December 18, 2025, at 10:46 AM, with the Director of Nursing (DON), the DON stated when medications are not administered to a resident as ordered by the physician, the physician needs to be notified. The DON further stated physician notification of missed medication doses should be documented in the resident's progress notes. Resident 10's MAR dated November 1, 2025, through November 30, 2025, was reviewed. The DON acknowledged Resident 10 had three missed doses of heparin and two missed doses of Keflex in November 2025 and there was no documented evidence in Resident 10's Electronic Health Record (EHR) regarding physician notification of the missed doses. The DON stated it was important for the resident to receive the entire course of antibiotics (Keflex) to ensure the infection did not get worse and there should be no laps in antibiotic administration. During a continued interview on December 18, 2025, at 4:46 PM, with the DON, the DON stated medications can be brought in by the pharmacy immediately when requested for cases of emergencies or for antibiotics like Keflex. The DON stated the facility should have had the medications Keflex and heparin available for Resident 10 as ordered by the physician. The DON further stated the pharmacy should have been contacted by staff to provide a STAT (immediate) order of the medications for Resident 10. During a concurrent interview and record review on December 18, 2025, at 4:57 PM, with the facility's Consultant Pharmacist (CP), the CP reviewed Resident 10's electronic health record and stated regarding Resident 10's Keflex, the facility staff did not send the Keflex order to the pharmacy for filling until November 29, 2025 (two days after it was ordered by the physician). The CP further stated staff must have been taking the first few doses of the Keflex from the facility's E-kit (emergency kit) and did not send the order to the pharmacy until two days later which is why the medication was not available for a few doses. The CP stated, in regard to the Heparin, the facility received a 30-day supply of the medication on November 3, 2025, and they should have had enough medication to last through December 3, 2025. The CP further stated the facility should have had both Keflex and Heparin available for Resident 10 as ordered by the physician. During a review of the facility's policy and procedure P&P titled, Ordering and Receiving Medications from [name of pharmacy], dated January 2025, the P&P indicated, Medications and related products shall be ordered and received from [name of pharmacy] on a timely basis.b. New medications, except for emergency or stat medications, are ordered as follows: 1) if needed before the next regular delivery, the facility shall phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request within 4 hours. 2) Anti-infectives and drugs used to treat severe pain, nausea, agitation, diarrhea, or other severe discomfort that are not ordered stat shall be available and administered within 4 hours of the time ordered. 3) The emergency kit shall be used when the resident needs a medication prior to pharmacy delivery.C. Stat and emergency medications are ordered as follows: 1) During regular pharmacy hours, the emergency or stat order shall be phoned or faxed to the pharmacy. Such medications shall be delivered and administered within 4 hour. If available, the initial dose shall be obtained from the emergency kit, when necessary.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three residents (Resident 10) investigated for urinary catheter (a medical device that drains urine from the bladder) received services for the care and maintenance of her catheter when Resident 10's urinary bag (a bag attached to the catheter that collects urine) was found in Resident 10's wheelchair and was not placed lower than her bladder to allow proper flow of urine from the bladder. This failure had the potential for Resident 10 to experience a backflow of urine from the urine drainage bag into the bladder, or for the urine flow to be obstructed which can lead to pooling of urine and urinary infections. A review of Resident 10's admission Record (contains medical and demographic information), the admission Record indicated Resident 10 was admitted to the facility on [DATE], with diagnoses which included retention of urine (a condition in which you are unable to empty all the urine from your bladder), multiple fractures of the ribs, abnormalities of gait (walking) and mobility, and Dementia (a decline in mental ability which interferes with daily life, affecting memory, thinking, language, judgement, and behavior). During a concurrent observation and interview on December 15, 2025, at 10:45 AM, in Resident 10's room, Resident 10 was sitting in her wheelchair next to her bed and had her foley catheter drainage bag next to her, in the wheelchair. There were approximately 300 milliliters (mls- unit of measure) of urine in the drainage bag. Resident 10 stated she returned from the rehab gym 40 minutes ago and was brought to her room by a staff member, in her wheelchair. Resident 10 further stated the rehab staff member left the urine drainage bag in her wheelchair. During a concurrent interview and record review on December 15, 2025, at 10:54 AM, with Licensed Vocational Nurse 5 (LVN 5), LVN 5 observed Resident 10 in her wheelchair and acknowledged Resident 10's foley catheter drainage bag was next to her in the wheelchair. LVN 5 stated there was approximately 300 mls of urine in the drainage bag and stated the bag was supposed to be below the level of the bladder but it was not. LVN 5 further stated it was important to have the drainage bag lower than the bladder to ensure urine could not backflow into the bladder. During an interview on December 15, 2025, at 10:59 AM, with Certified Occupational Therapy Assistant 1 (COTA 1), COTA 1 stated she was the staff member who brought Resident 10 back to her room in her wheelchair after Resident 10's rehab session in the facility gym approximately 45 minutes prior. COTA 1 stated Resident 10's foley drainage bag should be lower than the resident's bladder and she (COTA 1) thought she had placed Resident 10's foley drainage bag lower. During an interview on December 18, 2025, at 10:20 AM, with the Director of Nursing (DON), the DON stated it was the staff's responsibility to make sure the foley drainage bag was placed at a level below the bladder to prevent the backflow of urine and to prevent urinary tract infections. During a review of Resident 10's History and Physical progress note (H&P), titled, admission Summary, dated November 24, 2025, the H&P indicated Resident 10 was admitted to the facility after experiencing a fall downstairs, and sustaining multiple bone fractures. The H&P also indicated, She also developed urinary retention and was not able to void on her own, so foley was re-inserted. She was sent to SNF [Skilled Nursing Facility] for PT/OT [physical therapy/occupational therapy]. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated September 2025, the P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. 3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure careplan (a structured and individualized approach that helps clinicians provide effective care for patients) was initiated to address weight loss for one of six Residents (Resident 63) reviewed for nutrition / hydration. This failure had the potential to placed Resident 63 at risk for malnutrition and dehydration. During a review of Resident 63's admission Record (Contains demographic and medical information), it indicated Resident 63 was admitted to the facility on [DATE], with the diagnoses which included type 2 diabetes mellitus with diabetic chronic kidney disease (a condition where the body does not use insulin well, causing high blood sugar overtime that damages the kidneys and makes them work less effectively), dehydration (when body does not have enough fluids, making it hard to organs to work properly), and Alzheimer's disease (a brain disease that slowly affects memory, think and the ability do daily activities). During an observation on December 17, 2025, at 12:02 PM, inside Resident 63's room. Resident 63 was laying in bed, facing the door, covered with a blanket. The resident was awake and able to respond by nodding his head Yes or No. When asked if he was eating his meals, the resident nodded his head no. When asked if he liked the food provided, Resident 63 again nodded his head no, when asked if he would like to eat something else the resident nodded his head no and closed his eyes. During a concurrent observation and interview on December 17, 2025, at 12:30 PM with Certified Nursing Assistant, CNA 2, CNA 2 was assisting Resident 63 with his lunch meal. CNA 2 stated Resident 63 requires assistance with meals and was able to consume about 50% of his breakfast but refused to eat lunch. CNA 2 further stated that when residents do not eat their meals, staff offer alternative food items, and notify the licensed nurses' residents of meal poor meal intake or meal refusal. The LVN came to the resident's room and offered fruit and milk, however the resident continued to refused. During a concurrent interview and record review of Resident 63's monthly weights, on December 18, 2025, at 4:38 PM with the director of Nursing (DON), the following was reviewed: i. October 6, 2025, Resident 63 weight 130 pounds (-11 pounds loss over approximately 6 weeks; approximately 7.8% weight loss.) ii. November 2, 2025, Resident 63's weight 130 pounds. iii. December 1, 2025, Resident 63's weight 120 pounds (-10 pounds loss over approximately 8 weeks; approximately 7.7% weight loss.) DON stated Resident 63 should have weekly weights, but the staff did not do it. DON further confirmed no care plan addressing Resident 63's his total weight loss. During a review of Resident 63's Physician Order, it indicated, CCHO Diet (a carbohydrate-controlled diet used to help manage blood sugar levels) soft and bite-sized - Level 6 texture (soft foods that require some chewing but can be easily broken apart with a fork), Thin/Regular - Level 0 consistency (the liquids flows exactly like water), Daily Snacks, Nepro or Equivalent (a nutritional supplement drink designed to provide extra calories and protein) Daily. Order dated December 10, 2025. During a review of Resident 63's Change in Condition Evaluation, dated November 13, 2025, it indicated, 1. The change in condition, symptoms or signs I am calling about is/are. 30. Weight loss, 2. This started on: November 13, 2025., 4. Summarize your observations, evaluations and recommendations: pt. (patient) lost weight of 12 LBS (pounds) in 3 months. No RD recommendation noted at this time. During a concurrent interview and record review on December 18, 2025, at 1:14 PM, with the Registered Dietitian (RD), the RD reviewed the nutritional record for Resident 63. RD stated Resident 63's weight decreased from 130 pounds on October 6, 2025, to 120 pounds on December 1, 2025, representing a 10-pound weight loss in approximately one month. RD further stated nursing staff reported the resident exhibited behavioral issues, including spitting out food and medications, contributing to poor oral intake. RD stated appetite stimulants were not recommended because Resident 63 refuses and spits out medications and the dietary interventions in place included liberalizing food choices, offering preferred food and snacks and continuing with supplements. During a concurrent interview and record review on December 18, 2025, at 4:42 PM with Director of Nursing (DON) the facility's policy and (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure (P&P) titled, Weight Assessment and Intervention, dated March 2022, was reviewed. The P&P indicated, Resident weights are monitored for undesirable or unintended weight loss or gain. Care Planning. 1. Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. 2. Individualized care plans shall address the extent possible: a. The identified causes of weight loss; b. goals and benchmarks for improvement and c. time frame and parameters for monitoring and reassessment. DON confirmed should have had weekly weights for Resident 63 weight loss and that a care plan addressing his weight loss should be in place. The DON further confirmed that a care plan addressing the resident's weight loss was not located in Resident 63's clinical records, for review.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications for two of 26 residents (Resident 19 and 103) observed for medication pass were administered according to the facility's policy & procedure, and maintain accurate records of controlled medications (medications that are controlled by the government because it may be abused or cause addiction) when: 1. Resident 19 had an order to received Levothyroxine (medication to treat hypothyroidism - low levels of thyroid hormone) and was not available for administration. This failure had the potential to increase Resident 19's symptoms of hypothyroidism and can cause long - term health complications. 2. Resident 103 did not receive Sevelamer Carbonate (a medication used to control high phosphorus levels in patients with kidney disease) 800 mg (milligram - unit of measure) oral tablet with meals as ordered by the physician. This failure had the potential for Resident 103 to have increased levels of phosphorus in the blood, which could negatively affect Resident 103's health and safety. 3. For one of four medication carts (Medication Cart Station 1), the Controlled/Narcotic Emergency Kit Shift to Shift Check for Licensed Nurses (a narcotic log used by the facility to verify counting of controlled medications at the change of shift by incoming and outgoing licensed nurses), had a missing signature for December 17, 2025. These failures and had the potential for drug diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff in a highly vulnerable population of 93 residents and for Resident 19 and 103 to not be administered prescribed medication and increased the resident's risk for adverse reactions and side effects. During a record review of Resident 19's admission Record (Contains demographic and medical information), it indicated Resident 19 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (a condition where the brain does not work normally, type 2 diabetes mellitus with complications (a long term conditions where the body has trouble controlling blood sugar levels) and hypertensive heart disease with heart failure (heart disease caused by long term high blood pressure that makes the heart weak and not pump well). During a medication administration pass observation for Resident 19 on December 17, 2025, at 6:50 AM a.m., with Licensed Vocational Nurse (LVN 3), the LVN 3 reviewed the medication card for Resident 19 and was unable to locate the prescribed dose of Levothyroxine Sodium Oral Table, 175 mcg (micrograms, a unit used to measure very small amount of medication), oral tablet, which was scheduled to be administered during the morning. The medication was not available and was not administered as ordered. During a record review for Resident 19's Physician Orders, it indicated, Levothyroxine Sodium Oral Tablet: (Levothyroxine Sodium) give 175 mcg by mouth in the morning at 6:30 AM, for hypothyroidism (A medical condition where the thyroid gland does not make enough thyroid [small gland in the neck] hormone and can affects the energy level and heart rate). During an interview on December 17, 2025, at 7:32 AM with LVN 3, the LVN 3 stated when a medication is not available, she notified the Registered Nurse (RN) supervisor, the RN supervisor checks for available emergency or cycle medications and notified the physician regarding the medication unavailability. The LVN further stated that Levothyroxine is scheduled to be administered early in the morning and must be given on an empty stomach to properly regulate the resident's thyroid levels. LVN 3 confirmed that Levothyroxine 175 mcg was not available at the time of the scheduled dose and therefore was not administered as ordered for Resident 19. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on December 18, 2025, at 4:36 PM, with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Ordering and receiving medications from (name of the pharmacy) Inc, dated January 2025, was reviewed. The P&P indicated, . Medications and related products shall be ordered and received from (name of the pharmacy), Inc on a timely basis., Procedures, . d. Refills of medications should be called to the pharmacy 3 to 4 days in advance of need to assure an adequate supply is on hand. The DON stated that nursing staff are responsible for ensuring prescribed medication is available for administration and confirmed that for Resident 19, the facility's policy and procedure was not followed by the staff. 2. During a review of Resident 103's clinical records, the admission Record indicated Resident 103 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease, abnormal posture, and dependence on renal dialysis. During a concurrent medication administration observation and interview on December 17, 2025, at 6:31 AM, with a Licensed Vocation Nurse 4 (LVN 4) in Resident 103's room, LVN 4 was preparing to administer morning medications to Resident 103. LVN 4 pulled out a bottle with the label Sevelamer Carbonate 800mg- *give with meals* and administered to Resident 103, without meals. LVN 4 stated breakfast is served between 7:00 AM- 7:30 AM. LVN further stated Resident 103 would like to take the medication with meals, however because of time conflict, she is unable to take it with meals. During a follow-up interview on December 17, 2025, at 7:07 AM, with LVN 4, LVN 4 acknowledged the medication should have been given with meals. During a review of Resident 103's physicians orders, it indicated Sevelamer Carbonate Oral Tablet 800 M, give 4 tablets by mouth three times a day for hyperphosphatemia, take it with meals- start date: December 4, 2025. During a concurrent interview and record review on December 18, 2025, at 4:47 PM, with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled Medication Administration-General Guidelines, dated January 2025, was reviewed. The P&P indicated, Medication shall be administered in accordance with good nursing principles and practices and only by persons legally authorized to do so.Administration. J. Medications shall be administered in accordance with written orders of the attending physician. The DON stated the medical should have been given as ordered. 3. During a concurrent interview and record review on December 17, 2025, at 2:39 PM, with Licensed Vocational Nurse 1 (LVN 1), in Station 1 hallway, the Medication Cart's Controlled/Narcotic Emergency Kit Shift to Shift Check for Licensed Nurses (a narcotic log used by the facility to verify counting of controlled medications at the change of shift by incoming and outgoing licensed nurses), dated December 1, 2025, through December 17, 2025, was reviewed. The narcotic log indicated there was a missing signature on December 17, 2025, for the outgoing nurse (7:00 PM to 7:00 AM). LVN 1 confirmed the missing signature and stated the expectation is for the narcotic log to be counted by two nursing staff and signed every shift change. During a concurrent interview and record review on December 18, 2025, at 4:44 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Pharmaceutical Services Policy and Procedure Manual- Controlled Medication Storage dated January 2025. The P&P indicated, .d. At each shift change, a physical inventory of all controlled medications shall be conducted by two licensed nurse and is documented on the controlled substances accountability record. The DON stated the policy was not followed.		

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NAME OF PROVIDER OR SUPPLIER Asistencia Villa Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1875 Barton Rd Redlands, CA 92373	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **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 observed out of 26 opportunities for errors, affecting two of 13 observed residents (Residents 19 and 103), resulting in an overall medication error rate of 7.69 percent when: 1. Resident 19 had an order to receive Levothyroxine (medication to treat hypothyroidism - low levels of thyroid hormone) and was not available for administration. This failure had the potential to increase Resident 19's symptoms of hypothyroidism and can cause long - term health complications. 2. Resident 103 did not receive Sevelamer Carbonate (a medication used to control high phosphorus levels in patients with kidney disease) 800 mg (milligram - unit of measure) oral tablet with meals as ordered by the physician. This failure had the potential for Resident 103 to have increased levels of phosphorus in the blood, which could negatively affect Resident 103's health and safety. These failures had the potential for Resident 19 and 103 not to be administered the prescribed medication and increased the resident's risk for adverse reactions and side effects. 1. During a record review of Resident 19's admission Record (Contains demographic and medical information), it indicated Resident 19 was admitted to the facility on [DATE], with diagnoses that included metabolic encephalopathy (a condition where the brain does not work normally, type 2 diabetes mellitus with complications (a long term conditions where the body has trouble controlling blood sugar levels) and hypertensive heart disease with heart failure (heart disease caused by long term high blood pressure that makes the heart weak and not pump well). During a medication administration pass observation for Resident 19 on December 17, 2025, at 6:50 AM a.m., with Licensed Vocational Nurse (LVN 3), the LVN 3 reviewed the medication card for Resident 19 and was unable to locate the prescribed dose of Levothyroxine Sodium Oral Table, 175 mcg (micrograms, a unit used to measure very small amount of medication), oral tablet. which was scheduled to be administered during the morning. The medication was not available at the time of the scheduled administration and was not administered as ordered. During a record review for Resident 19's Physician Orders, it indicated, Levothyroxine Sodium Oral Tablet: (Levothyroxine Sodium) give 175 mcg by mouth in the morning at 6:30 AM, for hypothyroidism (A medical condition where the thyroid gland does not make enough thyroid [small gland in the neck] hormone and can affects the energy level and heart rate). During an interview on December 17, 2025, at 7:32 AM with LVN 3, the LVN 3 stated when a medication is not available, she notified the Registered Nurse (RN) supervisor, the RN supervisor checks for available emergency or cycle medications and notified the physician regarding the medication unavailability. The LVN further stated that Levothyroxine is scheduled to be administered early in the morning and must be given on an empty stomach to properly regulate the resident's thyroid levels. The LVN 3, confirmed that Levothyroxine 175 mcg was not available at the time of the scheduled dose and therefore was not administered as ordered for Resident 19. During a concurrent interview and record review on December 18, 2025, at 4:36 PM, with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Ordering and receiving medications from (name of the pharmacy) Inc, dated January 2025, was reviewed. The P&P indicated, . Medications and related products shall be ordered and received from (name of the pharmacy), Inc on a timely basis., Procedures, . d. Refills of medications should be called to the pharmacy 3 to 4 days in advance of need to assure an adequate supply is on hand. The DON stated that nursing staff are responsible for ensuring prescribed medication is available for administration and confirmed that for (continued on next page)		

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 19, the facility's policy and procedure was not followed by the staff. 2. During a review of Resident 103's clinical records, the admission Record indicated Resident 103 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease, abnormal posture, and dependence on renal dialysis. During a concurrent medication administration observation and interview on December 17, 2025, at 6:31 AM, with a Licensed Vocation Nurse 4 (LVN 4) in Resident 103's room, LVN 4 was preparing to administer morning medications to Resident 103. LVN 4 pulled out a bottle with the label Sevelamer Carbonate 800mg- *give with meals* and administered to Resident 103, without meals. LVN 4 stated breakfast is served between 7:00 AM- 7:30 AM. LVN further stated patient wants to take the medication with meals, however because of time conflict, she is unable to take it with meals. During a follow-up interview on December 17, 2025, at 7:07 AM, with LVN 4, LVN 4 acknowledged the medication should have been given with meals. During a review of Resident 103's physicians orders, it indicated Sevelamer Carbonate Oral Tablet 800 M, give 4 tablets by mouth three times a day for hyperphosphatemia, take it with meals- start date: December 4, 2025. During a concurrent interview and record review on December 18, 2025, at 4:47 PM, with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled Medication Administration-General Guidelines, dated January 2025, was reviewed. The P&P indicated, Medication shall be administered in accordance with good nursing principles and practices and only by persons legally authorized to do so. Administration. J. Medications shall be administered in accordance with written orders of the attending physician. The DON stated the medical should have been given as ordered.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure utensils used for eating were kept in a clean and sanitary condition during lunch on December 15, 2025, when Resident 62 received a built up spoon (a type of adaptive utensil with an enlarged handle, designed to help individuals with a weak or limited grip) which had water pooled in its handle. When Resident 62 picked up the spoon and attempted to eat her food, the water spilled out of the handle and onto her food. This failure had the potential to cause food-borne illness as a result of contamination of food served to Resident 62 by water from an unknown source which had pooled in the handle of the spoon. During a concurrent observation and interview on December 15, 2025, at 12:38 PM, in the facility's dining room, Resident 62 was eating a sandwich for lunch. Resident 62 stated she was eating a sandwich for lunch because she received a tray of food but when she went to use her built up spoon to eat, the spoon was missing a cap on the end of the handle and water spilled out of the handle directly onto her food. Resident 62 further stated there had been at least 5 previous occasions when she received a built-up spoon with her meals and the spoon was missing the cap at the end of the handle and water spilled onto her food when she attempted to use it. Resident 62 stated today she was provided with a sandwich after the water spilled onto her food. During an interview on December 15, 2025, at 12:44 PM, in the facility's dining room, Resident 52 (who was sitting next to Resident 62) stated he too required a built up spoon and on numerous occasions, had received a built up spoon without an end cap on the handle and subsequently water which had pooled in the handle spilled onto his food when he went to use the spoon. Resident 52 further stated, it seemed like for every meal, either him or Resident 62 received the spoon without an end cap and water is almost always pooled in its handle. During a concurrent observation and interview on December 15, 2025, at 12:50 PM, in the facility's dining room, a Certified Nursing Assistant 5 (CNA 5) stated Resident 62 was eating a sandwich instead of the regular meal because the resident received a spoon that had no cap on its handle and water from the spoon spilled onto her food. CNA 5 showed Resident 62's tray and built-up spoon which had been provided to Resident 62. The spoon on Resident 62's tray had a large hollow handle and was missing an endcap on the rear of the handle which left an opening into the handle approximately the size of a quarter. CNA 5 further stated she provided Resident 62 with the sandwich after the water fell on the resident's food. During an interview on December 18, 2025, at 10:22 AM, with the Director of Nursing (DON), the DON stated adaptive devices which were not in good repair should be disposed of and not provided to residents. The DON further stated he was made aware that water pooled inside of the handle of a spoon which had no cap and spilled onto a resident's food. The DON further stated it was unknown where the water originated from and that it could have been from the dishwasher and would potentially contaminate any food it came into contact with. The DON stated the spoon should have been either repaired or discarded and not provided to Resident 62. During an interview on December 18, 2025, at 1:50 PM, with the facility's Registered Dietician (RD), the RD stated facility staff should ensure adaptive devices are safe for the resident to use and that water should not be able to pool in the handle of a spoon and if it did, the spoon should be cleaned prior to being given to a resident. The RD further stated if an adaptive device was broken or needed to be repaired, it should not be given to a resident for use. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, (undated), the P&P indicated, .1. Adaptive devices (special eating equipment utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. During a review of the facility's P&P titled, Food and Nutrition Services, (undated), the P&P indicated, .6. Nursing staff will ensure that assistive devices are available to residents as needed, and in good working order. During a review of the facility's P&P titled, Sanitation, dated 2023, the P&P indicated, The Food and Nutrition Services Department shall have equipment of the type and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in the amount necessary for the proper preparation, serving, and storing of food.All equipment shall be maintained as necessary and kept in working order.11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas.		