

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: 555642	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Redlands Comm Hosp D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 350 Terracina Blvd 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 observation, interview, and record review, the facility failed to maintain infection control practices when: 1. Resident 4's Enhanced Barrier Precautions (EBP-an infection control guideline that requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading infectious diseases) protocol were not followed in accordance with facility's policy and procedure (P&P). 2. One glucose monitoring (a device used to measure the amount of sugar (glucose) in the blood) device was found visibly soiled with dried white substance while docked (recharged) at the nurse's station. These failures had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi or parasite) to 7 medically compromised residents and staff in the facility. Findings: 1. During a review of Resident 4's Record of Admission (contains demographic and medical information), undated, the Record of Admission indicated Resident 4 was admitted to the facility on [DATE]. A review of the Resident 4's History and Physical (H&P-contains information of health issues), dated November 3, 2025, indicated, Resident 4 was admitted with diagnoses which include intraparenchymal hemorrhage of brain (a brain bleed that occurs within the actual brain tissue.), dysphagia (swallowing difficulties), and hypertension (when the pressure in the heart's blood vessels is too high). During an observation on December 3, 2025, at 9:10 AM, outside Resident 4's room, an EBP sign was observed posted on the door. During an observation on December 3, 2025, at 9:15 AM, inside resident 4's room, observed Registered Nurse (RN)2 administering the following medications via Gastrostomy tube (G tube- a tube inserted through the belly that brings nutrition directly to the stomach.); rosuvastatin (used to lower high cholesterol) 20 milligrams (MG-a unit of measurement), sertraline (used to treat various mental health conditions) 25 MG, lisinopril (used to treat high blood pressure)10 MG, Acetaminophen 325 MG / Hydrocodone Bitartrate 10 MG,(used to manage moderate to severe pain) to Resident 4 on EBP without wearing the required protective gown. During a follow-up concurrent observation and interview and on December 3, 2025, at 1:30 PM, with RN 2, outside Resident 4's room, EBP signed was reviewed with RN2. EBP sign says gown is be worn with resident contract. RN 2 verified and confirmed Resident 4 is on EBP precaution. RN 2 confirmed that she did not wear any protective gown during her medication administration. RN 2 acknowledged that she did not follow the facility's P&P for EBP. During a concurrent interview and record review on December 3, 2025, at 1:44 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated April 2025, was reviewed. The P&P indicated, .1. The use of gowns, gloves and masks by health care providers will be based on risk assessment criteria and the patient care activities whether or not the patient is known to be multi drug resistant organism (MDRO) colonized or infected.1. Risk assessment criteria to implement enhanced barrier precautions (EBP).a. iii. Presence of indwelling devices urinary catheter, feeding tubes.b . Patient care activities.b. viii. Device care or use (central line, urinary catheter, feeding tube and tracheotomy). The DON stated the policy was not followed and further state it is important for the P&P to be followed to prevention the spread of infectious diseases. 2. During a current observation and interview on December 3, 2025, at 6:23 AM, with RN 1, on the Transitional Care Unit (TCU) Nursing Station, a glucose monitoring was found visibly soiled with dried (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	white substance docked at the nurse's station. RN 1 acknowledged the glucose monitor was dirty with a white substance, RN 1 stated the facility's expectation is for patient care equipment to be cleaned after use on each resident. During an interview on December 3, 2025, at 7:45 AM, with the DON and Infection Control Nurse (ICN), the DON and ICN stated that the facility's P&P for patient care equipment is to be cleaned prior and immediately after use for each resident. During a concurrent interview and record review on December 3, 2025, at 12:46 PM, with the DON, the facility's P&P titled, Guidelines for Care and Cleaning of Patient Equipment, dated April 2024, was reviewed. The P&P indicated, .2. To reduce the risk of transmission of microorganisms, and the spread of infection, by effective cleaning and decontamination. A. The following equipment and items are to be wiped with hospital approved disinfectant wipes in between each patient use by the person attending the patient.17. Blood glucose monitor. The DON confirmed that the P&P was not followed and stated that adherence is critical due to the increased infection risk within the resident population.		

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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 interview and record review, the facility failed to ensure the nursing staff provided treatment appropriately for one of seven sampled resident (Resident 18) when the nursing staff did not check Resident 18's blood glucose (sugar) daily as ordered. This failure resulted in Resident 18 inadequately monitored for blood sugar, which had the potential to cause uncontrolled blood sugar and negatively affect Resident 18's health and safety. Findings: During a review of Resident 18's admission Records (contains demographic and medical information), undated, Resident 18 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of female breast (breast cancer, abnormal cells in the breast grow uncontrollably and form a tumor), metastatic cancer to the spine (cancer cells traveled from the breast and formed new tumors in spine bones), and diabetes mellitus type II (a condition where the body cannot control blood sugar). During an interview on December 1, 2025, at 10:21 AM, with Resident 18, Resident 18 stated, I am a Diabetic Type II, and I am not on insulin, but on oral medications to help with my blood sugar. During a review of Resident 18's MD [Medical Doctor] Orders, start date of November 27, 2025, the MD Orders indicated, Blood glucose monitoring every AM (morning). During a concurrent interview and record review on December 2, 2025, at 8:17 AM, with the Director of Nursing (DON), Resident 18's blood glucose lab values in her EMR (electronic medical record- a digital version of a patient's paper chart for a facility, containing their medical history, diagnoses, medications, and test results), dated from November 27, 2025, to December 1, 2025, was reviewed. The blood glucose was missing as follows: On November 30, 2025 On December 1, 2025 The DON verified and acknowledged the two missing blood glucose and stated it was important to check resident's blood glucose for patient safety and overall quality of care for residents. During a concurrent interview and record review on December 2, 2025, at 3:41 PM, with the DON, the following facility's policy and procedure (P&P) titled, Orders for Medication, Treatment and Diagnostic Testing, dated January 2025, was reviewed. The P&P indicated, To specify the conditions under which Hospital personnel may accept and carry out orders for the administration of medication, treatments, and diagnostic tests . The DON acknowledged the policy was not followed. The DON stated this policy is the only policy specific to following MD orders, and further stated the blood glucose should have been checked on the morning of November 30, 2025, and December 1, 2025, and was not.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post facility name, and the total number and the actual hours worked per shift for licensed and unlicensed staff daily. This failure resulted in residents, family, and staff being unable to see if the unit is staffed appropriately. Findings: During a concurrent observation, interview, and record review on December 3, 2025, at 5:51 AM in the Transitional Care Unit (TCU) with the Registered Nurse (RN 1), the in-unit staffing list (a posted list visible to residents, family, and staff, that outlines how many hours all patient care staff classifications are working during a given shift) was posted on a television monitor. The television did not show the facility's name, or the actual hours worked per shift for licensed and unlicensed staff. The RN 1 stated the Direct Hours Per Patient Day (DHPPD)(the average number of hours per day that nursing staff spend providing hands-on care to each resident in a facility) is not posted anywhere in the unit. During a concurrent interview and record review on December 4, 2025, at 7:50 AM, with the Director of Nursing (DON), the DON stated, The DHPPS is now posted on the unit but I only started calculating the DHPPD yesterday because I did not know we had to do it because this has never come up. The DON further stated the expectation was that the DHPPD should be posted daily so that residents, family, and staff know if the facility has appropriate staffing. During an interview on December 4, 2025, at 8:20 AM, with the DON, the DON stated, We do not have a policy for that, we just follow the regulations. The DON further stated the regulations were not followed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were properly labeled for one of three sampled residents (Resident 7) when the gastrostomy tube (G-Tube-a soft tube placed through the skin directly into the stomach) formula bottle (a bottle premixed medical nutrition formula used for tube feeding to provide calories, proteins and nutrients when a resident cannot eat by mouth is given by the stomach) was not labeled with nurse initials and the water flush bag (a water bag used to deliver scheduled water flushes through the feeding tube to maintain hydration and keep the tube clear) was not labeled with the prescribed rate as required. These failures placed Resident 7 at risk for receiving incorrect formula, improper feeding rates, or inadequate hydration, which potentially resulting in dehydration, electrolyte imbalance, aspiration (choking), and compromise nutrition. Findings: During a review of Resident 7's Patient Demographics (contains patient background), Patient Demographics indicated, Resident 7, was admitted to the facility on [DATE]. During a review of Resident 7's History & Physical Report (H&P-contains medical information), the H&P indicated, Resident 7 was admitted to the facility on [DATE], with diagnoses of gastric cancer (a type of cancer that starts in the stomach), recent gastric / intestinal perforation repair (a surgery to fix a hole or tear in the intestine so that food and fluids do not leak) and gastroesophageal reflux disease (GERD-a condition where stomach acid flows back into the throat or esophagus). Assessment Plan.Devices: PEG tube (percutaneous endoscopic gastrostomy-a soft feeding tube place through the skin into the stomach so the person can get nutrition). During a review of Resident 7's Nutrition Therapy Recommendations, dated November 21, 2025, at 1:15 PM, the Nutrition Therapy Recommendations indicated, Nutrition Related Concerns: Increase Nutrition Need, tube Feeding Type: [Brand Name], Tube Feeding Rate (mls [milliliter-unit measurement] / [per] hr [Hour]): 65 . During a review of Resident 7's Physician Order, dated November 20, 2025, the Physician Order indicated, Order, short bowel tube feeding, [Brand Name] 1 each PEG Q24 HR (every 24 hours) @ [at] 1400 [2:00 PM] (total formula ordered per 24 hours) liquid ., Dose, 65 ml/hr. During a review of Resident 7's Physician Order, dated December 2, 2025, at 9:32 AM, the Physician Order indicated, Order Free H2O (water) q4h (every 4 hours) ., Intervention Text Amount: 200 ml. During an observation on December 1, 2025, at 10:06 AM, in Resident 7's room, Resident 7 was observed lying in bed receiving continuous enteral tube feeding. Resident 7's feeding setup was reviewed, and the following were noted: a. The formula bottle was labeled with Resident 7's name, starting date and time, and the rate of formula. The nursing staff initial who started the formula was missing. b. The water flush bag was labeled with Resident 7's name, room number, and starting date and time. The prescribed water rate was missing. During an interview on December 1, 2025, at 10:10 AM, with Registered Nurse (RN 3), inside Resident 7's room, RN 3 stated the tube feeding labels must include: resident name, room number, formula type, rate, date, start time, and nurse initials. RN 3 confirmed that the formula bag was missing nurse initials, and the water flush bag was missing the prescribed rate. During an interview on December 1, 2025, at 4:05 PM, with the Clinical Nurse Educator (CNE), inside the conference room, the CNE stated that all formula bags and water flush bags must be labeled with patient information, date, time, rate, and nurse initials. During a concurrent interview and record review on December 2, 2025, at 11:11 AM, with the CNE, the facility's policy and procedure (P&P) titled, Nasal [Nose] /Oral [Mouth] Gastric tube, Insertion, Maintenance and Feeding Tube Use, dated April 2022, was reviewed. The P&P indicated, .h. Label the bag with patient information; enteral access type; and the tube feeding formula type, strength, and amount. Include the date and time and initial it. The CNE stated that the formula bag should have been initiated, and the water flush bag should have included the prescribed rate.		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure the successful electronic submission of complete and accurate direct care staffing information was transmitted to Centers for Medicare and Medicaid Service (CMS) for two quarters (May 13, 2025, and August 14, 2025). This failure resulted in the facility not being monitored for any potential staffing issues. Findings: During an interview and record review on December 3, 2025, at 8:55 AM, with the Director of Nursing (DON), the CMS Submission Report (various mandatory reports such as payroll based journal (PBJ) or staffing data based on payroll) for the 2025 quarters were reviewed. The DON stated, The PBJ is supposed to be submitted quarterly. I thought it went through, but it did not due to issues with our system, [Name of Company]. The DON further stated, The PBJ Submission on May 13, 2025, and August 14, 2025, were submitted to CMS but our [Name of Company] we used erased the information because of the wrong code so it was transmitted with no staffing information. The DON further stated, It's important that information is transmitted to show we have enough staff to care for our residents. During an interview on December 4, 2025, at 8:18 AM, with the DON, the DON stated, We do not have a policy. We just follow the regulations.		