STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055565	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterman Canyon Post Acute	1850 N. Waterman Ave. San Bernardino, CA 92404

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) was treated with respect and dignity when a Certified Nursing Assistant (CNA 1) used profanity (language that is rude, offensive, or vulgar, often involving swear words, or disrespectful terms) with Resident 3 during an activity program on November 12, 2024. This failure compromised Resident 3 ' s dignity and violated his right to respect, which had the potential for Resident 3 to experience psychosocial harm (mental harm and suffering). Findings: A review of Resident 3's Admission Record (a document containing clinical and demographic data), indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of chronic obstructive pulmonary disease (group of lung conditions that causes breathing difficulties) and hypertension (blood pressure that is higher than normal) A review of Resident 3 ' s for titled History and Physical dated August 12, 2024, indicated . This resident [Resident 3] has the capacity to understand and make decisions . During concurrent observation and interview on November 22, 2024, at 3:00 PM, with Resident 3, Resident 3 was sitting in his wheelchair and participating in the activity program. Resident 3 stated that he recalled attending an activity program in the Gallery Room on November 12, 2024, around 9:30 AM. Resident 3 stated that during the program, residents, and activity staff, including CNA 1, engaged in a conversation. Resident 3 further stated that he heard CNA 1 tell him, F**k [f word is swearing words to curse someone] off, Resident 3. When he tried to clarify what CNA 1 had said, she repeated the same phrase. Furthermore, Resident 3 stated When she said my name, I knew the F word was directed at me, and she should not have said it. I haven ' t seen her since then. During a concurrent record review and interview on November 22, 2024, at 3:35 PM, with the Human Resources (HR), a facility document titled California Notice of Change in Relationship of CNA 1 indicated Name: CNA 1 . Your employment status has changed for the reason checked below: . discharged effective 11/14/2024 [November 14, 2024] . Involuntary - Violation of company policy . The HR stated the facility has terminated CNA 1 ' s employment. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent record review and interview on November 22, 2024, at 3:45 PM with the HR, a facility document titled Walk Away Policy and Procedure, signed by CNA 1 on May 1, 2024, indicated . that any staff member who becomes frustrated when assisting a resident must walk away from the situation, absent of an emergency and request assistance so as to prevent a resident from being subject to inappropriate conduct which includes, but is not limited to, verbal, mental, sexual, or physical abuse, . The HR stated that CNA 1 should have walked away but did not do so. During a follow up observation and interview with Resident 3, on December 31, 2024, at 10:35 AM, Resident 3 was sitting up on his bed. Resident 3 stated he felt upset when CNA 1 used the F word at him. He further stated, I feel relieved I did not see her [CNA 1] around anymore. During a phone interview on January 3, 2025, at 10:35 PM, with Activity Assistant (AA), she stated that on November 12, 2024, around 9:30 AM, during an activity program, a resident was transferred to the hospital, leaving the wheelchair in the Gallery Room. She then asked CNA 1 to return the wheelchair to the resident's room. As she went out to retrieve the wheelchair, she overheard CNA 1 say, F**k off, [Resident 3's first name]. When Resident 3 attempted to clarify what CNA 1 had said, CNA 1 repeated the same phrase. The AA further stated that she told CNA 1 the behavior was unacceptable and reported the incident to the Assistance Director of Nursing (ADON), who sent CNA 1 home that day. Furthermore, the AA stated that CNA 1 should have simply walked away if she was frustrated or upset, but she did not. During an interview and concurrent record review, December 31, 2024, at 10:45 AM, with the ADON, the ADON reviewed the facility's policy and procedure titled, Resident Rights revised December 2016, indicated . Policy Statement. Employees shall treat all residents with kindness, respect, and dignity. Policy interpretation and implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to : . b. be treated with respect, kindness, and dignity; . The ADON stated the policy and procedure was not followed. Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 3) was treated with respect and dignity when a Certified Nursing Assistant (CNA 1) used profanity (language that is rude, offensive, or vulgar, often involving swear words, or disrespectful terms) with Resident 3 during an activity program on November 12, 2024. This failure compromised Resident 3's dignity and violated his right to respect, which had the potential for Resident 3 to experience psychosocial harm (mental harm and suffering). Findings: A review of Resident 3's Admission Record (a document containing clinical and demographic data), indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of chronic obstructive pulmonary disease (group of lung conditions that causes breathing difficulties) and hypertension (blood pressure that is higher than normal) A review of Resident 3's for titled History and Physical dated August 12, 2024, indicated . This resident [Resident 3] has the capacity to understand and make decisions . (continued on next page)

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