

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Waterman Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110 Based on observation, interview and record review the facility staff failed to assist with activity of daily living (ADL) for 2 of 3 sampled Residents (Resident 1 and 3). This failure led to Resident 1 experiencing Moisture-Associated Skin Damage (MASD), characterized by skin inflammation and erosion due to extended exposure to moisture sources such as urine or stool. These failures posed a significant risk to the psychosocial well-being, health, and safety of both clinically compromised Residents 1 and 3. Findings: A review of Resident 1 Face Sheet (contain resident demographic), the Face Sheet indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that included Tear of Lateral Meniscus (an injury to one of the bands of rubbery cartilage that act as shock absorbers for the knee) A review of the SBAR (change of condition report) dated February 25, 2025, revealed a change in skin color or condition, specifically noting moisture-associated skin damage (MASD) on the left buttock, which extends to the right buttock. During an interview on March 6, 2025, at 12:03 PM, with Resident 1, Resident 1 reported that the staff did not change her diaper last night until this morning. She mentioned that when she activated her call light, the staff entered the room only to turn it off without inquiring about her needs, indicating that this occurs frequently during the night. She also noted that she did not have any bed sores upon her admission to the facility, but she now has developed a bed sore on her buttock. During an interview on March 6, 2025, at 1:04 PM, with the Certified Nursing Assistant (CNA 1), CNA 1 indicated that staff are required to change the resident's diaper every two hours or as necessary. He also mentioned that he would respond to the call light promptly upon noticing it. Additionally, the call light should be positioned within easy reach. During an interview on March 6, 2025, at 1:25 PM, with the Wound Care Nurse (WCN 1), the WCN 1 stated during the admission assessment of Resident 1, MASD was observed beneath the left breast, but there is no record indicating that MASD was present on the resident's buttocks. (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview and record review on March 11, 2025, at 10:05 AM, with the Assistant Director of Nursing (ADON 1). The Plan of Care (POC) record for Resident 1 was reviewed. ADON 1 confirmed that on March 3, 4, and 5 of 2025, Resident 1 was given a diaper change only three times over a 24-hour period. ADON 1 indicated that it is possible Resident 1 may be experiencing Moisture-Associated Skin Damage (MASD) due to the lack of care provided. A review of the facility policy and procedure (P&P) titled, Pressure Ulcer/Injury Risk assessment dated [DATE], indicated, .5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessments, the condition of the skin, the resident's overall clinical condition, and the resident's stated wishes and goals. a. The interventions must be based on current, recognized standards of care. b. The effects of the interventions must be evaluated. c. The care plan must be modified as the resident's condition changes, or if current interventions are deemed inadequate . A review of Resident 3 Face Sheet (contain resident demographic), the Face Sheet indicated Resident 3 was admitted to the facility on [DATE], with a diagnosis that included muscle wasting and atrophy (the thinning or loss of muscle tissue and mass). During an interview on March 6, 2025, at 12:35 PM, with Resident 2. Resident 2 expressed a desire to turn on her television. It was observed that the call light was secured beneath her bed padding. When inquired whether she could activate her call light, the resident indicated that she was unaware of its location. Upon being informed that the call light was situated under her padding and asked if she could reach it, the resident attempted to do so but was unable to succeed. During an interview on March 6, 2025, at 12:38 PM, with the CNA (CNA 2), CNA 2 indicated that the call light should not be positioned beneath the padding; rather, it ought to be secured to the resident's blanket or placed within the resident's reach. She explained that while attempting to tidy the bed in a hurry, she inadvertently placed the call light under the padding. She acknowledged her mistake, stating, my bad, it should not be placed there. A review of the facility P&P titled, Answering Call Light dated October 2010, indicated, .5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .		