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	05/13/2025

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on interview and record review, the facility failed to complete a safe transfer and discharge for 1 of 3 sampled residents (Resident 1 and 2) when: 1. Resident 1 history of dementia was transferred to a lower level of care Room and Board, and Ombudsman not included in discharge planning. 2. Resident 2 was transferred to another facility dementia unit without Conservator and Ombudsman included in discharge planning. This failure resulted in Residents 1 and 2 being transferred without capacity to understand and make decisions, not being informed of rights regarding transfer/discharge and the added protection of the Ombudsman (patient rights advocate who ensures residents are not inappropriately discharged). Findings: 1. During a review of Resident 1 ' s Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: dementia (memory loss, forgetfulness) hypertension (high blood pressure), diabetes type II (body does not produce enough insulin, or resist insulin). During a review on April 29, 2025, Resident 1 ' s Medical Record reviewed are as follows: 1. History and Physical (H&P) dated September 21, 2021, Has the capacity to understand and make decisions. 2. [Name] Health Progress Note/History & Physical dated November 21, 2024: Behavioral Disturbances Associated with Dementia: The patient .exhibits verbal outburst and physical aggression, aligning with behavioral and psychological symptoms of dementia. Plan: Asses potential triggers for the aggressive behavior .(Facility cannot provide recent H&P if the resident has the capacity to understand and make decisions) 3. Notice of Proposed Transfer/Discharge Notification Date February 27, 2025: Social Worker notified (Niece) .Transfer to Room and Board (lower level care) .The transfer or discharge is appropriate because your health has improved .Resident unable to sign. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Discharge Summary February 27, 2025, at 1400 (no resident signature or family notification documented). 5. Social Services Note February 07, 2025, 16:05: Met with the family of resident to discuss possible discharge. Residents family thinking about taking patient back to [country name] .Resident is Alert and oriented with episodes of confusion and forgetfulness .The team will continue to monitor the resident for any behavioral changes and concerns. Resident has episodes of refusals of care and medication regimen. 6. Social Services Note February 27, 2025, 11:43: Resident will discharge today to lower level of care. Resident is Alert and Oriented, self-responsible and able to make all needs known .Residents family are not involved and would not like to have any responsibility with his care. Resident will discharge to a Room and Board with meds and Home Health. 7. readmitted from Hospital March 05, 2025. 8. Notice of Proposed Transfer/Discharge Notification Date March 06, 2025: Person notified: (niece). Transfer to [skilled nursing facility], The transfer/discharge is necessary for your welfare and your needs cannot be met in the facility .Resident unable to sign. 9. Discharge Summary March 06, 2025, at 0800 (no resident signature or family notification documented). 10. Social Service Note: March 06, 2025, 1714: Resident discharged to another SNF today at 9:00AM. Resident is Alert/Oriented self-responsible and able to make all his needs known .Resident is noted to be a little aggressive to staff member but calmed down after a few minutes. SW reached out to the resident niece and notified of discharge . 11. No Integrated Discharge Team (multi-disciplinary team) IDT meeting regarding transfer planning documentation provided. During an interview on April 29, 2025, with the Social Worker (SW), SW stated, Resident 1 had a lot of aggression and refusals. On February 07, 2025, the niece was involved in discharge planning, she wanted to help me, but no one wanted to be responsible for him .the resident was telling family he wanted to go back home. No one wanted to take over care of him. The administrator at the Room & Board came to assess resident. He seen the 1:1 due to residents ' aggression, the resident is very ambulatory, he does everything. He can be aggressive we don ' t want other residents to get hurt. At the time it was safe for Resident 1 to make his decision to transfer to room and board. We were worrying about the other patients. His roommates were not safe, we had a lot of room changes and nothing changed. This resident was alert with periods of confusion, and he is refusing care, it was beneficial to send out, we were thinking about other residents. He had aggression and Room & Board they called 911, sent to [acute hospital], then he came back here, we readmitted him. We felt our residents were in danger, he was throwing things, we looked at other Skilled Nursing Facilities, we told the SNF about his aggression. It felt in conversation he understands everything with the interpreter in Spanish. We did involve the family in discharge planning, when the family washed their hands of him to make his decisions. For him at that time he did need the ombudsman to be involved. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on April 29, 2025, with the Director of Nursing (DON), DON stated, Resident 1 Family did not disagree to the transfers. We did not force him; he was interviewed by the Room & Board. He is self-responsible, he makes his own decisions. When there is a problem with the residents and us the facility we call the Ombudsman. We tried calling the Ombudsman many times, in general they tell you they are the advocate of residents, so whatever the resident decides. I fell it was safe for him, there was not so many people at the Room and Board and the SNF, is a smaller facility. He gets triggered right away, this is not a quiet place and we have to protect the other residents. They came here, the admin from the admitting SNF to assess him as well they said we will take him and accepted the challenge. The second time it was a safe transfer, I have not gotten a call from them regarding any problems with him. He does have the capacity and makes his own decisions. The niece was informed. We felt he didn ' t like the residents here and no compatibility. We had him on 1:1, even with the 1:1 he hit another resident. There was an accepting Room & Board, the day after that they took him they sent him out due to altered mental status. He was very aggressive. He was sent to acute hospital, we accepted him back from the hospital and we kept looking for placements. He was transferred to SNF, he ' s probably doing good because we have not had a call from them since he was transferred there. 2. During a review of Resident 2 ' s Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with contact Responsible Party Public Guardian: Conservator [contact information]. Diagnoses to include: schizoaffective disorder (combination of symptoms, mood disorder, depressive, delusions, hallucinations), cognitive communication deficit (difficulties that arise from impaired cognitive functions), chronic obstructive pulmonary disease (block airflow, hard to breathe). During a review on April 29, 2025, Resident 2 ' s Medical Record reviewed are as follows: 1. Facesheet: Resident 2 has assigned Conservator since admission June 09, 2023. 2. History and Physical dated September 01, 2024: Has the Capacity to understand and make decisions. Brief Interview for Mental Status= 07 out of 15. 3. Social Service Note dated February 24, 2025, at 0844: This writer reached out to conservator and left a voice message to let her know that the patients wandering is now a risk for elopement at the facility and that IDT would like to transfer her to another Skilled Nursing Facility SNF to better monitor her of her wandering and her own safety. Social Worker (SW) is awaiting response at this time. 4. Discharge Summary: discharge date and time February 27, 2025, at 1900 to SNF, self-responsible, Reason: Resident 2 is at risk for elopement due to her wandering. (SW) reached out to the conservator and left a voice message to let them know that it will be safer for her to transition to another facility who can monitor her wandering episodes. 5. Physician Order February 27, 2025, May discharge to another SNF [name post acute]. (No reason for transfer documented) (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on May 13, 2025, with the Social Worker (SW), SW stated, Resident 2 had a conservator since admission, having a conservator is because resident cannot make own medical decisions. We include in care conferences, not all will attend the meetings, but we let them know about them. When we would call the conservator, we would always talk to the front desk person. They will only call us for court hearings, that ' s the only time we will hear back from them. The transfer was for safety reasons. The conservator was called but we left a voice message, then we had the (IDT) to makes the decisions for the resident. We did not involve the Ombudsman in the discharge planning, we sent the notification after the day Resident 2 was discharged . The resident knew the transfer was for the dementia unit, I know it was for a lock dementia unit and she knew she would benefit there. I have not heard back from the conservator .the other facility will be reaching out to her, I ' m assuming they already have it. The SNF was a smaller one and will monitor her behavior. I never heard back from conservator. During an interview on May 13, 2025, with the Director of Nursing (DON), DON stated, For Resident 2, the conservator usually they will not respond. The conservator makes the decisions for the residents. I cannot wait because of safety of patient very dangerous is she goes outside she will assault the other residents. We called the conservator for D/C planning, no response. We made the decision in the IDT meeting, because she is conserved this is why we did not call the ombudsman. We in IDT meeting made the decision for the resident. The resident was made aware of where she was going by those who interviewed her from other facility, the Administrator and (DON) they came to assess her. The priority is safety of resident, we notified the ombudsman after, it was safety issue I was afraid of. During a review of the facility ' s policy and procedure titled, Transfer or Discharge revised March 2025, the policy and procedure indicated, Once admitted to the facility, residents have the right to remain in the facility. Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record. During a review of the facility ' s policy and procedure titled, Attending Physician Responsibilities revised August 2014, the policy and procedure indicated, Providing Appropriate, Timely medical Orders and Documentation .4. The physician will provide documentation required to explain medical decisions and to help the facility comply with its legal and regulatory requirement. During a review of the facility ' s policy and procedure titled, Care Planning-Interdisciplinary Team revised March 2022, the policy and procedure indicated, The interdisciplinary team is responsible for the development of resident care plans. 4. The resident, the resident ' s family and or the resident ' s legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident ' s care plan. 6. If it is determined that participation of the resident or representative is not practicable for development of the care plan, an explanation is documented in the medical record. When a resident is transferred or discharged , his or her medical records shall be documented as to the reasons why such action was taken. 4. Documentation from the Care planning Team concerning all transfers or discharges must include, as a minimum, and as they may apply: c. That the resident and/or representative (sponsor) participate in a predischarge orientation program.