STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055708	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arrowhead Springs Healthcare	1335 N. Waterman Avenue 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44262 Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided to prevent avoidable accidents for one of three sampled residents Resident1 (R1) when: 1. Resident 1 fell out of bed, sent to acute hospital for open laceration to right side of head. 2. No floor mats at bedside as recommended. This failure contributed to Resident 1 sustaining an open injury to forehead and being set out to hospital for further evaluation and received staples. Findings: During review of Residents 1's Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses to include: urinary tract infection (urine infection), syncope and collapse (fainting, loss of consciousness), hypertension (high blood pressure), history of falling. During a concurrent interview and record review of Resident 1's Medical Record with Infection Prevention Nurse (IP), reviewed and verified the following: 1. Admission Fall Risk assessment dated [DATE], at 7:43PM: High Risk. 2. Situation Background Assessment Recommendation (SBAR) Note dated February 05, 2025, at 10:58PM: Fall with abrasion to Right side of head. Unwitnessed fall, resident was found on floor right side of bed. Resident is alert/oriented X2 (person, place, time and event), Resident in pain. Resident has cut on right side of head about 7cm with moderate bleeding. Resident is able to move all extremities with discomfort. Vital taken with first aid to injury. Resident said he was trying to roll on his side and found himself on the floor . [name] notified 10:58PM, sent to emergency room . 3. Interdisciplinary Team (IDT) Note February 07, 2025, at 6:12PM, Fall, episodes of confusion, resident received 4 staples to right side of head. Neuro checks, bed will remain in lowest position with the call light within reach, recommended bilateral floor mats to reduce the risk of injury from potential future falls.: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Careplan: Has had an actual fall with laceration wound to Right side of head poor balance, poor communication/comprehension, psychoactive drug use, unsteady gait .interventions bed in lowest position, floor mat, room assignment to the nurse station. During an observation on February 19, 2025, at 10:55 AM., in room [ROOM NUMBER]-A, Resident 1, (R1) wearing yellow colored fall risk band on right wrist. No Floor Mats noted on each side of bed. No Falling star noted on (R1) name tag outside of door. During an observation and interview on February 19, 2025, at 12:07PM, with Certified Nursing Assistant CNA (CNA1) CNA1 states, we know by the falling star next to their name, at the name doorway if they are a fall risk resident. I ask the charge nurse if any resident is a fall risk. Or we ask physical therapy, they do have a wrist band, Fall Risk. In the charting it will say required low bed or mats. According to the charting, Resident 1 should have had floor mats. The falling star on the door does alert you to any issues with Fall Risk residents.: Observation of electronic medical records, CAN 1 shows Resident 1 charting, it does show floor mat with falling star in system for resident. During an interview on February 19, 2025, at 12:19PM, with Certified Nursing Assistant CNA (CNA2) CNA2 states, the residents have yellow wrist band with Fall Risk, some have floor mats, and some have tab alarm. If a resident is a Fall Risk and I don't see any floor mats I will let the nurse and maintenance aware. We do have falling stars at doorways to notify us if a resident is a Fall risk. During an observation and interview on February 19, 2025, at 11:10AM, with License Vocational Nurse (LVN) right outside of (R1) room, LVN states, (R1) fell a couple days ago, on admission day. Interventions for falls, on admission the info comes from the admitting hospital, we monitor all residents for fall risk though. Fall High risk residents get a low bed and floor mats at bedside. So far since the initial fall, he has been ok. When asked, is there a reason why (R1) has no floor mats, he did have a fall in facility? LVN states, He should have had a floor mats. I will get maintenance to get him floor mats . all residents have fall risk bands. Observation LVN telling maintenance, Oh can you get me some floor mats. During an interview on February 19, 2025, at 12:43PM, with Infection Prevention Nurse (IP Nurse) IP Nurse states, (R1) was a High Fall Risk on admission. He did have a fall on admission, we did Change of Condition and sent him out to acute hospital. He came back with staples to head. He did have floor mats; he was moved to another room. We did a room change February 14, 2025; he should have had the floor mats during the room change. We will place the mats and the falling star at door. During a review of the facility's policy and procedure titled, Fall Management System revised [February 2025], the policy and procedure indicated, It is the policy of this facility to provide an environment that remains as free of accident hazard as possible. It is also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. 2. Residents with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes. A. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled, Change of Condition revised [December 2023], the policy and procedure indicated, It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain highest practicable physical mental and psychological well-being in accordance with the interdisciplinary comprehensive assessment and plan of care.