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	04/24/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49001 Based on observation, interview, and record review, the facility failed to ensure, supplies were kept in good condition for one out of twenty-five residents (Resident 54) when Resident 54's mattress was found peeled, discolored, and in disrepair. This failure had the potential for Resident 54 to experience physical discomfort, sleep disturbances, and increased risk of infections or skin breakdown. Findings: During an observation on April 21,2025, at 10:21 AM, in Resident 54's room, Resident 54 was awake lying in bed, half of the mattress at the foot of the bed, was peeled and discolored. During a concurrent observation and interview on April 21, 2025, at 04:50 PM, with the Administrator (ADMIN), in Resident 54's room, the ADMIN stated, Oh, we need to change this mattress right now. The ADMIN stated, Resident 54 has [name of the insurance company] insurance and Admin was going to contact them (the insurance company) to replace the mattress. During a review of Resident 54's Admission Record (contains medical and demographic information), the Admission Record indicated Resident 54 was admitted on [DATE], with diagnoses which included morbid obesity (a severe form of obesity characterized by a significantly excessive body weight that poses serious health risks) due to excess calories, type 2 diabetes mellitus (a chronic condition characterized by high blood sugar levels due to the body either not producing enough insulin or not using insulin properly) with other circulatory complications, anxiety disorder (a condition that causes excessive feelings of fear, dread, and worry that persist over time and interfere with daily life). During a concurrent interview and record review on April 22, 2025, at 03:15 PM, with the ADMIN, The ADMIN reviewed the facility's policy and procedure (P&P) titled, Physical Environment, undated. The P&P indicated, . 6. If equipment requires repair other than routine maintenance or servicing, the vendor through which the equipment was purchased will be contacted and arrangements made for repair/replacement. The ADMIN stated, Usually, we do call the vendor and take care of it right away.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation interview and record review the facility failed develop and implement comprehensive, person-centered care plans (a care plan that includes all the health problems, preferences and goals) for two of three residents (Residents 22 and 17) that were reviewed for care plans needs when: 1. Resident 22 did not have a care plan developed to address ongoing podiatry needs for long fingernails and toenails since admission, on October 4, 2024. 2. Resident 17 did not have a care plan developed for intravenous (IV) antibiotic therapy with Ceftazidime Intravenous Solution (a strong antibiotic given through a vein (IV) that helps kill bacteria caused infection). These failures had the potential to result in unmet medical needs for Residents 22 and 17, and can cause delay in treatment and lack of coordinated care, placing Resident 22 and 17 at risk for complications. Findings: 1. During a Review of Resident 22's Admission Record (contains demographic and medical information), it indicated Resident 22 was admitted to the facility on [DATE], with diagnoses which included, difficulty walking (trouble walking which may be due to weakness, pain or poor balance), chronic diastolic (congestive) heart failure (a long term heart condition that causes fatigue, shortness of breath and swelling) and transient ischemic attack (TIA) and cerebral infarction without residual deficits (mini-stroke, it happens when blood flow to the brain is briefly blocked. It may cause coordination problems, especially in the hands making it hard to do basic tasks). During a concurrent observation and interview on April 21, 2025, at 9:47 AM inside Resident 22's room, Resident 22 was lying on bed looking through the door. Resident 22 had long fingernails on both hands, his skin appeared dry. Resident 22 stated he asked the staff to cut his nails several times, but no one helped him. Resident 22 further stated he had not been seen by a podiatrist since he was admitted to the facility on [DATE]. During a review of Resident 22's Physician Order dated February 24, 2025, at 5:25 PM indicated, Nail care appointment with PCP (primary care physician), Dr. [name of the doctor] on March 17, 2025, at 1:20 PM [Name and name of the city where the hospital is located.] Pending transportation. One time only for nail care appointment . During a concurrent interview and record review on April 24, 2025, at 4:17 PM with the Assistant Director of Nurses (ADON), Resident 22's clinical records were reviewed. The ADON was not able to find documented evidence that Resident 22's had a care plan that address podiatry needs. The ADON stated staff did not initiate a care plan for Resident 22 for podiatry services and it should have been initiated upon admission on October 4, 2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50754 2. During a review of Resident 17's Admission Record, it indicated Resident 17 was admitted to the facility on [DATE], with diagnoses of acute osteomyelitis of the left ankle and foot (a serious bone infection that causes pain, swelling and redness and usually requires antibiotics through a vein to treat the infection deeply in the bone), end stage renal disease (the final stage of chronic kidney disease where the kidney stops working, making the body less able to fight infections and process medications) and immunodeficiency due to conditions classified elsewhere (a weakened immune system caused by another medical conditions. During a review of Resident 17's physician's order dated April 17, 2025, it indicated Resident 17 had an order for Ceftazidime 2 gram (unit of measurement) intravenously one time a day every Monday, Wednesday and Friday for OM (OM - Osteomyelitis, a serious infection in the bone) of the left foot for 12 days. Order end date April 30, 2025. During a further observation and interview on April 23, 2025, at 9:47 AM inside Resident 17's room. Resident 17 was observed lying in bed, awake, talking with his roommate and watching television. Resident 17's had a left hallux (pressure wound on the left big toe, this type of wound is caused by prolonged pressure that damages the skin) and. dry, cracked skin on both heels. Resident 17 stated he received antibiotic to treat the infection. During a concurrent interview and record review on April 24, 2025, at 4:29 PM with the ADON, Resident 17's clinical records were reviewed. The ADON was not able to find documented evidence that Resident 17 had a care plan that address IV antibiotic with Ceftazidime. The ADON stated staff did not initiated a care plan for Resident 17, for IV antibiotic therapy, and one should have been initiated when the antibiotic was started on April 18, 2025. During a concurrent interview and record review on April 24, 2025, at 4:32 PM with the ADON the facility's policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning, revised February, 2025, was reviewed. The P&P indicated, It is the policy of this facility that the IDT shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. The ADON acknowledged stated the staff did not follow the care plan policy. The ADON further stated that the nurses should have developed a care plan to address the IV Antibiotic and the podiatry services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observations, interviews and record review, the facility failed to provide proper hygiene and grooming care (help with keeping the body clean and neat including cutting nails, brushing hair, shaving and general personal appearance) for one of eight residents (Resident 22) when Resident 22 had long thickened and yellow toenails curling over the tips on both feet, as well as long, untrimmed fingernails on both hands. This failure had the potential for Resident 22 to experience pain, skin breakdown, fungal infection (infection caused by germs [fungus] that grow on the skin or nails, in toenails, it can make them thick, yellow brittle and sometimes painful), refusal of mobility and negatively impacted Resident 22's dignity and quality of life. Findings: During a Review of Resident 22's Admission Record (contains demographic and medical information), it indicated Resident 22 was admitted to the facility on [DATE], with diagnoses which included difficulty walking (trouble walking which may be due to weakness, pain or poor balance), chronic diastolic (congestive) heart failure (long term heart condition that causes fatigue, shortness of breath and swelling) and history of transient ischemic attack (TIA) (mini-stroke, it happens when blood flow to the brain is briefly blocked. It may cause coordination problems). During a concurrent observation and interview on April 21, 2025, at 9:47 AM, inside Resident 22's room, Resident 22 was lying on bed looking through the door. Resident 22 had long fingernails on both hands and his skin appeared dry. Resident 22 stated he asked the staff to trim his nails for several times, but no one helped him. Resident 22 further stated he had not been seen by a podiatrist since he was admitted on [DATE]. During a review of Resident 22's physician's order, dated February 24, 2025, it indicated, Nail care appointment with PCP (primary care physician), Dr. [name of the doctor] on March 17, 2025, at 1:20 PM [Name and name of the city where the hospital is located.] Pending transportation. One time only for nail care appointment . During a further concurrent observation and interview on April 24, 2025, at 8:10 AM, with Certified Nursing Assistant (CNA 3), inside Resident 22's room, Resident 22 was lying in bed, just finished with his breakfast. Resident 22 informed CNA 3 he wanted his nails, including his toenails to be trimmed. While wearing gloves CNA 3, removed resident's yellow socks to observe his feet. Resident 22's toenails were visible long, yellow in color, thick in appearance, and curling at the edges. The skin on the feet appeared dry and cracked. CNA 3 stated Resident 22's toenails had not been trimmed and he had not received podiatry care recently. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on April 24, 2025, at 9:54 AM, with the Assistant Director of Nurses (ADON), the ADON reviewed Resident 22's LN -Skin Evaluation - PRN (as need it) / Weekly (a form used to document all ulcers, wounds and other skin problems) form, dated March 6, 2025. The Skin evaluation indicated, . Noted the ff (findings found) R/L (right and left) hypertrophic toenails (something abnormally enlarged or overgrown) mildly dry skin to R/L foot . The ADON stated the nurses should have followed up. The ADON was not able to find documented evidence in the nurses' progress notes that address staff followed up on Resident 22's feet hypertrophic nails. During an interview on April 24, 2025, at 9:52 AM with the ADON, the ADON stated Resident 22 was not diabetic and therefore his nail care included trimming of fingernails and toenails, may be performed by CNA's and licensed nursing staff as a part of routine grooming. The ADON further stated nail care is documented under Activities of Daly living (ADL's), specifically withing the hygiene and grooming section of the resident's care plan. During a further interview on April 24, 2025, at 9:58 AM with the ADON, the ADON was able to find documented evidence that Resident 22 attended a podiatry appointment on March 17, 2025. The ADON stated nursing staff is expected to assess and document nail condition during body assessments and initiate appropriate follow-up when needed. During a concurrent interview and record review on April 24, 2025, at 9:59 AM with the ADON, the facility's policy and procedure (P&P) Podiatry services, undated, was reviewed. The P&P indicated, Procedure . A. As part of the admission assessment the nurse will inspect the condition of the patient's feet and will notify the attending physician of the patient need for podiatry care if necessary . 1. Routine uncomplicated foot care, including trimming of nails will be managed by the license nurse as part of general hygiene regiment. The ADON sated the policy was on place and stated the staff failed to follow it, as Resident 22's nails had not been trimmed and no documentation was found to explain the delay. The ADON further stated nursing staff is responsible for identifying and addressing hygiene related needs, including nail care, during routine assessments.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interviews and record review, the facility failed to ensure the bilateral side rails (an adjustable metal or rigid plastic bars that attach to the bed) were in place for one of eight residents (Resident 58) reviewed for safety when a physician order to install bilateral side rails was not carried out for 37 days (March 17, 2025). This failure had the potential to place Resident 58 at risk for falls or injury. Findings: During a Review of Resident 58's Admission Record (contains demographic and medical information), it indicated Resident 58 was admitted to the facility on [DATE], with diagnoses which included kidney transplant status (a transplanted kidney), congestive heart failure (a chronic condition where the heart doesn't pump blood as well as it should) and pancytopenia (a condition where all types of blood cells are low, reducing the body's ability to fight infection, carry oxygen and control bleeding, making any injury more serious). During a concurrent observation and interview on April 22, 2025, at 12:47 PM, in Resident 58's room, Resident 58, was lying in bed checking his cellphone and very close to the left edge of the bed. The bed did not have bilateral side rails in place. A trapeze (a triangular device suspended above the bed that allows resident to grasp and use their upper body strength to assist with repositioning or mobility) was attached above the bed. Resident 58 stated he requested to have bilateral side rails approximately two months ago and he was told he needed to sign a waiver. Resident 58 further stated he signed the waiver, but no side rails had been installed. Resident 58 stated, I feel unsafe of falling at any time because the trapeze alone was not enough, especially due to his above the right knee leg amputation. During an interview on April 24, 2025, at 9:30 AM, with the Assistant Director of Nursing (ADON), the ADON stated Resident 58 had signed a consent form for bilateral side rails use on March 17, 2025. The ADON further stated a side rail safety assessment and a physician's order were completed on the same date. The ADON acknowledge the side rails were not implemented at that time. The ADON stated although the order was present since March 17, 2025, it was not carried out. During a review of Resident 58's Fall Risk Evaluation (an assessment tool used to identify how likely a resident is to experience a fall, based on mobility, balance, history of falls, medications and medical conditions), dated March 18, 2025, it indicated, . Score 13 . Category: High Risk (resident is on high risk for falls) . E. Gait/Balance/Ambulation . 1. Requires use of assistive devices (i.e. cane, walker, wheelchair). During a review of Resident 58's Physician Orders dated, March 17, 2025, it indicated, B (bilateral) siderails recommended for bed positioning bed mobility and pressure relief. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 58's Use of Bed Rail Record of informed Consent, dated March 17, 2025, it indicated, [Resident 58's name], . I have been fully informed about the use of rail, the possible negative outcomes of their use and have been provided a copy of FDA's (Food and Drug administration, is a federal agency that provides safety guidelines for medical devices, including bed rails, to help prevent injuries such as entrapment, suffocation or falls) clinical guidance related to the use of bedrails . I have been informed that the decision to use or to discontinue the use of bed rail will be made based on the interdisciplinary team's (a group of healthcare professionals who work together to plan, coordinate, and deliver care for a resident) assessment to ensure my safety . After careful consideration of the information provided to me, I hereby . Give my permission for the use of bed rails, signed by Resident 58 and staff. During a review of Resident 58's Bed Rail Safety Evaluation, dated March 17, 2025, it indicated, IDT (interdisciplinary team)recommendations: . a. Bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bedrail . 1b. Justification (reason) For bed mobility and positioning as an enabler (is a device that helps a resident to do something more safety or easily, without limiting their movement [as bedrails). During a concurrent review and interview on April 24, 2025, at 12:24 PM, with the ADON, the facility's policy and procedure (P&P) titled Side Rails Use of, undated, was reviewed. The P&P indicated, 1. Resident will be assess upon admission for the use of side rails taking in consideration the following: entrapment, strangulation, suffocation, accidental suspension, major injury . 2. Side rails will be used for the purpose of bed mobility and positioning.3. If side rail is not use as an enabler, will be documented in the assessment. The ADON stated the policy was in place and the staff did not follow the policy as the Resident 58 side rails were not implemented despite a physician's order, completed safety assessment and documented justification for use as an enabler.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 50575 Based on observation, interviews, and record reviews, the facility failed to ensure proper disposal of garbage when one of two lids in the outside recycling receptacles was not closed and overflowing with trash. This failure had the potential to attract pests. Findings: During a concurrent observation and interview on April 22, 2025, at 7:45 AM, with the Registered Dietician (RD), in the garbage storage area, located outside the facility, there were three garbage containers. One container (the recycling container- a large container for holding or transporting waste or items for recycling) was not closed and it was overflowing with open cardboard boxes. The RD stated the recycling container should be close and should not be overflowing. During an interview on April 24, 2025, at 7:55 AM, with the Administrator (Admin), the Admin verbalized his expectation is for staff to break down boxes and flatten out boxes for recycling receptacle to close, because of potential to attract pests. The Admin further stated, I know we should have the recycling bins closed. During a review, of the facility's policy and procedure (P&P) titled, Garbage and Trash, (undated), was reviewed. The P&P indicated, .3. Adequate, clean, vermin-proof areas must be provided for storage and rubbish. Trash, .2. Garbage and trash cans must be inspected daily. During a review of the FDA (Food and Drug Administration) Food Code 2022, 5-501.15, indicated, (A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview and record review the facility failed to maintain infection control practices for one of eight residents (Resident 74) when Resident 74's oxygen tubing (is a small, flexible plastic tube that connects an oxygen source [like a machine or a tank]) was found on the floor under the bed. This failure had the potential to spread infectious disease (disease cause by bacteria, viruses, fungi or parasite) to Resident 74. Findings: During a review of Resident 74's Admission Record (contains demographic and medical information), it indicated Resident 74 was admitted to the facility on [DATE], with diagnoses of acute chronic diastolic (congestive) heart failure (the heart can't pump blood well, so fluid can back up into the lungs, causing trouble breathing), paroxysmal atrial fibrillation (the heart has episodes of irregular beating) and muscle weakness (generalized) (when muscles are very weak and can make it hard to breathe deeply.) During a concurrent observation and interview on April 21, 2025, at 9:12 AM, with Licensed Vocational NUrse (LVN 1), inside Resident 74's room. Resident 74 was lying down in bed, awake and with the head of the bed elevated. There was an oxygen concentrator (a machine that delivers oxygen) turned on, next to the bed. The oxygen tubing was connected to a humidifier (a container that adds moisture to the oxygen to keep the nose and throat from getting dry) and the nasal cannula (a soft, flexible tube with two small prongs that go in the nose) it was lying on the floor under Resident 74's bed. LVN 1 acknowledged the oxygen tubing was on the floor and stated it should not be there because it was contaminated. During a review of Resident 74's physician's order, dated January 14, 2025, it indicated, .Continuous oxygen (oxygen that is given without stopping, all day and night) at (1-2) L/ MIN (at flow rate of 1 to 2 liters per minute) via nasal cannula/ mask (a plastic mask that covers the nose and mouth) to keep oxygen saturation above 90% (the goal is to keep oxygen in the blood measured as a percentage at above 90%, is when the body is getting enough oxygen to function properly) every shift. During a concurrent interview and record review on April 23, 2025, at 9:37 AM, with the Infection Preventionist Nurse (IP) the facility's policy and procedure (P&P) titled, Oxygen, Use of, undated, was reviewed. The P&P indicated, It is the policy of this facility to promote resident safety in administered oxygen . Procedures: use the following guidelines will observe in oxygen administration . 2. Tubing should be kept off the floor. The IP stated the staff did not follow the facility's policy. The IP further stated that the oxygen tubing should not be touching the floor to prevent bacterial contamination (harmful germs are present on something and can spread to people).