

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Arrowhead Springs Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1335 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to inform residents, in writing, of services available and the charges for those services, including charges for items and services not covered by Medicare or Medicaid for three of four sampled residents (Resident 120, 121, and 122) when Resident 120, 121, and 122 did not receive written notification of their estimated out-of-pocket cost on the required Skill Nursing Facility Advance Beneficiary Notice of Non-coverage form (a form a facility gives a resident to let them know Medicare may stop paying for their stay or certain services). These failures had the potential to prevent residents from receiving the information necessary to understand their potential financial liability and make informed decisions regarding continued care. During a record review of Resident 122's Skill Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form, dated December 2, 2025, the SNF ABN form was missing the required cost-per-day amount for continued stay in the facility. During a record review of Resident 120's SNF ABN form, dated February 12, 2026, the SNF ABN form was missing the required cost-per-day amount for continued stay in the facility. During a record review of Resident 121's SNF ABN form, dated January 19, 2026, the ANF ABN form was missing the required cost-per-day amount for continued stay in the facility. During an interview on June 3, 2026, at 5:38 AM, with the Administrator (Admin) and the Admissions Concierge (AC), the Admin stated the facility does not include the cost of stay on the SNF ABN paperwork, and the AC verbally informs residents of the out-of-pocket cost. The AC stated the cost is posted in four locations throughout the facility and the residents are informed verbally. During an interview on June 3, 2026, at 7:28 AM, with the Admissions Director (AD), the AD confirmed residents were not provided written notice of their daily cost to remain in the facility once Medicare coverage ends. During a follow up interview on June 3, 2026, at 8:25 AM, with the AD, the AD stated the facility does not have a written policy addressing beneficiary notification and they just follow the regulation.		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055708	If continuation sheet Page 1 of 15

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to update Pre-admission Screening and Resident Review (PASARR - a federally mandated program that requires all individuals seeking admission to a Medicaid-certified nursing facility to be screened to ensure individuals who are identified to have a significant mental illness (SMI), intellectual or developmental disability (I/DD)) are not inappropriately placed in nursing homes for long term care) for two of five sampled residents (Resident 17 and 76) for PASARR when: 1. Resident 17 did not have his diagnoses of post-traumatic stress disorder (PTSD - a mental health condition triggered by experiencing or witnessing a terrifying, shocking, or dangerous event) included in the PASARR assessment used to admit the resident into the skilled nursing facility. 2. Resident 76 did not have his diagnoses of paranoid schizophrenia (a brain condition where a person loses touch with reality and becomes trapped in a world of intense fear, false beliefs, and imaginary sounds) included in the PASARR assessment used to admit the resident into the skilled nursing facility. These failures resulted in Resident 17 and Resident 76's conditions not being identified prior to admission and had the potential to result in Resident 17 and Resident 76's need for treatment and services not being accurately assessed, placing them at risk for inadequate care. 1. During a review of Resident 17's admission Record (contains medical and demographic information), the admission Record, indicated Resident 17 was admitted on [DATE], with diagnoses which included cervical region spinal stenosis (narrowing of the back bone (spine) in the neck region where the nerves pass), PTSD and sleep apnea (sleep disorder where a person's breathing repeatedly stops and starts while sleeping). During a review of Resident 17's PASARR assessment dated [DATE] (PASARR assessment used to admit the resident into the facility), the PASARR indicated NO to the question 9, Diagnosed Serious Mental Illness [SMI]. Does the individual have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder. During a concurrent interview and record review on June 4, 2026, at 11:28 AM, with the Minimum Data Set Nurse (MDS 1), Resident 17's PASARR assessment, dated April 29, 2026, was reviewed. The MDS 1 acknowledged the PASARR assessment did not accurately indicate Resident 17 had PTSD. The MDS 1 stated it should have been identified that the PASARR did not include Resident 17's PTSD and a revision to the PASARR should have been completed. The MDS 1 further stated it was not done. 2. During a review of Resident 76's admission Record, the admission Record, indicated Resident 76 was admitted on [DATE], with diagnoses which included hemiplegia (total loss of voluntary muscle function and movement on one side of the body) and hemiparesis (partial loss of voluntary muscle function and movement on one side of the body), cerebral infarction (brain tissue death due to lack of blood supply) and paranoid schizophrenia (a brain condition where a person loses touch with reality and becomes trapped in a world of intense fear, false beliefs, and imaginary sounds). During a review of Resident 76's PASARR assessment dated [DATE] (PASARR assessment used to admit the resident into the facility), the PASARR indicated NO to the question 26, Diagnosed Mental Illness Does the resident have a diagnosed mental disorder such as Schizophrenia/Schizoaffective Disorder. During a concurrent interview and record review on June 2, 2026, at 5:15 PM, with the MDS 1 and the MDS 2, Resident 76's PASARR assessment, dated March 29, 2019, was reviewed. The MDS 1 and the MDS 2 acknowledged the PASARR assessment did not accurately indicate Resident 76 had paranoid schizophrenia. The MDS 1 and the MDS 2 stated it should have been identified that the PASARR did not include Resident 76's Paranoid schizophrenia and a revision to the PASARR should have been completed. The MDS 1 further stated it was not done. During a concurrent interview and record review on June 4, 2026, at 11:50 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, PASRR dated February 2026, was reviewed. The P&P indicated, 2. Based upon the assessment, the facility will ensure proper referral to appropriate state agencies for the provision of specialized services to resident with MI/MR (Mental (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	illness/Mental retardation). The DON stated the P&P was not followed. The DON further stated the PASARR screening reassessment should have been done for Resident 17 and Resident 76.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review, the facility failed to provide the appropriate treatment to three Residents (Resident 2, 13 and 24) fed by enteral means. The three Residents did not receive the correct volume of enteral feeding (liquid nutrition through a soft tube that goes directly into your stomach or small intestine) ordered by the physician when: Resident 4 did not receive the physician ordered volume of enteral feeding (75 mL (milliliter)/hr. (hour), or 300 mL) during the observation period of 6:00 am to 10:00 am on June 1, 2026. The Licensed Vocation Nurse (LVN-1) also did not know how much of the enteral feeding was infused during the prior shift for the dose period starting at 2:00 pm on June 1, 2026, until the start of her shift at 7:00 am which is necessary to ensure that Resident 4 received the full dose of 1500 mL. Resident 13 did not receive the physician ordered volume of enteral feeding during the dose period of June 1, 2026, at 1:00 pm to June 2, 2026, at 10:00 am, when the resident only received 800 mL (milliliters, a unit of volume) of the ordered 1400 mL of enteral feeding (difference of 600 mL). Resident 24 did not receive the physician ordered volume of enteral feeding during the dose period of June 1, 2026 at 1:00 pm to June 2, 2026 at 10:00 am, when the resident only received 1200 mL of the ordered 1800 mL of enteral feeding (difference of 500 mL). This failure had the potential to result in malnutrition, weight loss and electrolyte imbalance for three of six residents who relied solely on enteral feeding for nutrition and hydration. Findings: 1. During a review of Resident 4's Face Sheet (contains demographic and medical information), indicated that Resident 4 was admitted to the facility, with a diagnosis of: Sequelae (the long term problems) of cerebral infarction (blocked blood vessel in the brain), pneumonitis (swelling or irritation of the lungs) due to inhalation of food and vomit and diabetes mellitus (condition where the body cannot properly regulate blood sugar). During a review of Resident 4's Order Summary report, order date May 21, 2026, indicated Resident 4 had an order to receive Enteral feed order every shift Continuous via g-tube (gastrostomy tube- is a soft, flexible tube placed through a small opening in the belly straight into the stomach) [Brand name] Formula 1.2 @75mL/hr (hour) x (for) 20 hrs. to provide 1500 mL, 1800 kcals (a unit of energy measurement used in nutrition). Pump on at 2:00 pm. Off at 10:00 am or desired volume reached. During an observation on June 2, 2026, at 8:41 am, in Resident 4's room, Resident 4 was lying in bed, the enteral feed bottle was hung and indicated [Brand name] formula dated June 2, 2026, start time 0600 (6:00 am) infusing, formula measured above 1500 mL line. During an observation on June 2, 2026, at 11:15 am in Resident 4's room, Resident 4 was lying on the bed, with [Brand name] formula dated June 2, 2026, the enteral bottle was hung and indicated start time 0600 (6:00 am), measured at 1400 mL. Feeding pump was off, attached to resident. During a concurrent observation and interview on June 2, 2026, at 11:24 am with Licensed Vocation Nurse (LVN-1), in Resident 4's room, LVN-1 stated that the enteral feeding was turned off at 10:00 am per the physician's order. When asked how much formula Resident 4 received, LVN-1 stated we don't keep track, we turn it off when it is time. LVN-1 stated that the previous shift did not let her know how much had been infused so that she could ensure the correct volume was administered during her shift. During an interview on June 3, 2026, at 8:41 am, with Registered Dietitian (RD), the RD stated that the nursing staff should ensure that Resident 4 received the entire 1500 mL as ordered. RD further stated that there is not a record of how much formula was infused prior to 6:00 am on June 2, 2026. RD confirmed on June 2, 2026, from 6:00 am to 10:00 am, Resident 4 should have received 300 mL, but only 100 mL were given. During an interview on June 3, 2026, at 9:42 am with the Director of Nursing (DON), the DON stated that the nursing staff should provide the full dose of enteral feeding formula and extend the feeding duration when needed to provide the full dose. During a review of the facility's policy and procedure titled, Medication administration- General Guidelines, dated May 2022, indicated . Medications are administered in accordance with written orders of the prescriber. During a review of the facility policy and procedure titled, Enteral Feeding Administration, dated January 2026, (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, it is the policy of this facility to administer enteral feeding at a constant controlled infusion rate per physician's orders. 2. During a record review of Resident 13's Face Sheet, Resident 13 was admitted to facility with a history of Parkinsons Disease (brain disorder that makes it hard to control movement), Cerebral palsy (condition that affects how the brain controls muscles and movement, causing problems with coordination, balance, or posture), and dysphagia (difficulty swallowing). During a record review of Resident 13's Order Summary report, order start date March 16, 2026, indicated Resident 13 had Enteral Feed order every shift Continuous via g-tube [Brand name] Formula 1.5 @70 mL/hr. x 20 hrs. (hours) to provide 1400 mL, 2100 kcals. Pump on at 2:00 pm. Off at 10:00 am or desired volume reached. During an observation on June 2, 2026, at 11:51 am, in Resident 13's room, [Brand name] formula dated June 1, 2026, at 1:00 pm was connected to the feeding pump. Feeding pump was turned off, Resident 13 was not in the room. 700 mL of formula remained in bottle. During an interview on June 2, 2026, at 3:29 pm, with LVN-2, LVN-2 stated that she hung formula bottle on June 1, 2026, at 1:00 pm. LVN-2 stated the order was for 1400 mL, so the resident should receive 1400 mL. When asked if Resident 13 received the full dose, LVN-2 stated, I can't say (Resident 13) got exactly 1400 mL, but I think she got close. During an interview on June 3, 2026, at 8:42 am, with the RD, the RD stated Resident 13 did not get the entire prescribed dose of enteral feeding for the dose period of June 1, 2026, at 1:00 pm and June 6, 2026, at 10:00 am. She stated the Resident received 800 mL of the prescribed 1400 mL, she did not get the remaining 600 mL. RD stated that the nursing staff should have continued to provide the enteral feeding to Resident 13 until the ordered dose was given. During an interview on June 3, 2026, at 9:42 am, with the Director of Nursing (DON), the DON stated that the nursing staff should provide the full dose of enteral feeding formula and extend the feeding duration when needed to provide the full dose. During a review of the facility's policy and procedure titled, Medication administration- General Guidelines, dated May 2022, indicated .Medications are administered in accordance with written orders of the prescriber. During a review of the facility policy and procedure titled, Enteral Feeding Administration, dated January 2026, indicated, it is the policy of this facility to administer enteral feeding at a constant controlled infusion rate per physician's orders. 3. During a record review of Resident 24's Face Sheet, Resident 24 was admitted to facility with Hemiplegia (one-sided weakness) and hemiparesis (one-sided weakness with limited movement) following Cerebral infarction, dysphagia following Cerebral infarction and Aphasia (difficulty speaking) following cerebral infarction. During a record review of Resident 24's Order Summary Report, order date February 17, 2026, indicated Resident 24 had Enteral Feed order every shift Continuous via g-tube [Brand name] Formula 1.5 @ 90 mL/hr. x 20 hrs. to provide 1800 mL, 2700 kcals. Pump on at 2:00 pm. Off at 10:00 am or desired volume reached. During an observation on June 2, 2026, at 8:44 am, in Resident 24's room, Resident 24 was lying in bed and was unresponsive. The [Brand name] enteral feeding formula bottle was hung and dated June 1, 2026, 300 mL of formula remained in the bottle. During an observation on June 2, 2026, at 12:03 pm, in Resident 24's room, [Brand name] enteral feeding formula bottle dated June 1, 2026, start time 1:00 pm measured below 300 mL, feeding pump was turned off and disconnected from Resident 24. During an interview on June 2, 2026, at 3:22 pm with LVN-2, LVN-2 confirmed that Resident 24 did not receive the entire 1500 mL from the enteral feeding hung on June 1, 2026 at 1:00 pm to June 2, 2026 at 10:00 am, and that a second formula bottle should have been hung for the entire 1800 mL to be administered. During an interview on June 3, 2026 at 8:42 am with the RD, the RD confirmed that Resident 24 did not receive the ordered 1800 mL of enteral feeding formula from the dose period of June 1, 2026 at 1:00 pm to June 2, 2026 at 10:00 am, and that the LVN should have finished the entire 1500 mL formula bottle, and hung a second bottle in order to provide the additional 300 mL of formula for a total of 1800 mL that was ordered by the physician. During an interview on June 3, 2026, at 9:42 am with the Director of Nursing (DON), the DON stated that the nursing staff should provide the full dose of enteral feeding formula and extend the feeding duration when needed to provide the full dose. During a review of the facility policy and procedure titled, Medication administration- General Guidelines, dated May 2022, (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated .Medications are administered in accordance with written orders of the prescriber.During a review of the facility policy and procedure titled, Enteral Feeding Administration, dated January 2026, indicated, it is the policy of this facility to administer enteral feeding at a constant controlled infusion rate per physician's orders.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was assessed and authorized to self - administered medications of 13 residents (Resident 47) reviewed for medication administration when three medications were found at the Resident 47's bedside within reach and readily accessible, without a completed self-administration of medications assessment (a clinical evaluation to determine if a resident can safely store, manage, and take their own medications independently or with minimal supervision), interdisciplinary team (IDT - a group of medical support professionals who work together to create and execute a patient - centered care plan) review, or physician authorization. This failure had the potential to result in improper medication use, medication errors and cause harm to Resident 47 due to unsupervised access to prescribed medications. During a review of Resident 47's admission Record (contains demographic and clinical information), it indicated Resident 47 was admitted to the facility on [DATE], with the diagnoses of chronic obstructive pulmonary disease (COPD - a chronic lung disease that makes it difficult to breathe, and displacement fractures of glenoid cavity of scapula of glenoid cavity of scapula right shoulder (broken bones in right shoulder). During an observation on June 1, 2026, at 11:36 AM, inside Resident 47's room, Resident 47 was lying in bed with the head of the bed elevated and wearing a sling on the right arm. Resident 47 stated, I fractured my right shoulder as the reason for wearing the sling. Three medications were observed unattended on the resident's bedside table: one tube of Diclofenac gel (a medication used to relieve pain and inflammation), one Tube of Nystatin (a medication used to treat fungal skin infections) cream and Fluticasone Propionate/Salmeterol inhaler (a medication used treat COPD). Resident 47 informed the surveyor that she uses the medications herself. During a concurrent observation and interview on June 1, 2026, at 11:49 AM, with License Vocational Nurse (LVN 5), LVN 5 stated Fluticasone Propionate/Salmeterol inhaler had a handwritten open date of May 16, 2026, with 52 doses remaining out of 60 doses. LVN 5 further stated Diclofenac gel, Nystatin cream and Fluticasone Propionate/Salmeterol inhaler belonged to Resident 47 and it was unsafe to leave the medications unattended on Resident 47's bedside table. During a review of Resident 47's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Section C (cognitive-involving consciousness intellectual activity patterns), dated May 19, 2026, the MDS indicated, Resident 47 had a BIMS (Brief Interview for Mental Status - tool used to screen how a resident is functioning cognitively) score of 12 (a BIMS score 8-12 suggests resident is moderate cognitively impaired). During a concurrent record review and interview on June 4, 2026, at 11:05 AM, with the Director of Nursing (DON), Resident 47's electronic health records were reviewed. The DON stated Resident 47 did not have a self-administration of medication assessment, physician authorization, interdisciplinary team (IDT) review or care plan that supporting self - administration of medications. During a concurrent interview and record review on June 4, 2026, at 11:06 AM, with the DON, the facility's policy and procedure (P&P) titled, Self - Administration of Medication, dated February 2026, was reviewed. The P&P indicated, . 1. If a resident desire to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate. 2. The residents cognitive, communication, visual, and physical ability to carry out this responsibility will be evaluated. If the interdisciplinary team determines that this resident is unable to carry out this responsibility, the interdisciplinary team may withdraw the right. 3. If the resident is a candidate for self - administration of medications, this will be indicated in the chart. 4. Resident will be instructed regarding administration of medication by the nurse. 5. Nursing will be responsible for recording self - administered doses in the resident medication administration record. 6. Storage and location of drug administration (e.g., resident's room, nurses' station, or activities room) will comply with state and federal requirements for medication storage. 7. Interdisciplinary team may include Medical Director or Primary Care Physician the Director of Nursing Services and other Nursing Representative, and Social (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services. 8. Appropriate notation of these determinations will be place in the resident's care plan. The DON confirmed that the policy was not followed by the staff.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS-a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS]) assessments were accurately coded for one (1) of 26 residents (Resident 107) when Resident 107's assessment did not reflect the resident's status, care, and services in active diagnoses under Section I (Active Diagnosis section). This failure had the potential to cause inaccuracies in identifying Resident 107's care and support needs. During a review of Resident 107's admission Record (contains medical and demographic information), the admission Record, indicated Resident 107 was admitted on [DATE], with diagnoses which included end stage renal disease (kidneys can no longer filter waste and excess fluid from the blood), anxiety disorder (mental health condition characterized by excessive, persistent fear or worry that interferes with daily life) and anemia (body lacks enough healthy red blood cells to transport sufficient oxygen to tissues). During a concurrent interview and record review on June 4, 2026, at 11:48 AM, with the Director of Nursing (DON), Resident 107's MDS Annual Assessment (an assessment for a resident that must be completed every 366 days following the previous assessment), dated August 8, 2025, was reviewed. The MDS Annual Assessment under Section I titled Active Diagnoses. Psychiatric/Mood Disorder (health condition characterized by significant disturbances in thinking, emotional regulation, or behavior) 15700. Anxiety Disorder was left blank, indicating Resident 107 did not have an active diagnosis of anxiety disorder. The DON verified and stated the MDS was coded incorrectly, and Resident 107 did have the diagnosis of anxiety disorder. During a concurrent interview and record review on June 4, 2026, at 4:22 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Resident Assessment Instrument/MDS 3.0, dated February 2025, was reviewed. The P&P indicated, Purpose To ensure accurate, timely, and compliant completion of the Minimum Data Set (MDS) assessments . The DON stated the P&P was not followed.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASARR - a federally mandated program that requires all individuals seeking admission to a Medicaid-certified nursing facility to be screened to ensure individuals who are identified to have a significant mental illness (SMI), intellectual or developmental disability (I/DD)) was completed for one of five sampled residents (Resident 1) for PASARR when Resident 1 stayed more than 30 days in the facility. This failure had the potential to result in Resident 1's condition not being identified prior to admission and the need for treatments and services not being accurately assessed, placing Resident 1 at risk for unmet needs. During a review of Resident 1's admission Record (contains medical and demographic information), the admission Record, indicated Resident 1 was admitted on [DATE], with diagnoses which included right lower extremity deep vein thrombosis (blood clot in the deep vein of right leg), pneumonia (inflammation (immune system's natural, protective response to injury, infection or toxins) and fluid in lungs) and cerebral infarction (brain tissue death due to lack of blood supply). During a review of Resident 1's PASARR assessment dated [DATE] (PASARR assessment used to admit the resident into the facility), the PASARR result of Level I screening indicated Exempted Hospital Discharge, which means the resident didn't have a PASSAR screening before hospital discharge and should have had a PASARR screening completed if the resident stayed more than 30 days in the skilled nursing facility. During a concurrent interview and record review on June 3, 2026, at 12:35 PM, with the Minimum Data Set Nurse (MDS 1), Resident 1's PASARR Level I screening result, dated April 15, 2026, was reviewed. The MDS 1 acknowledged she didn't know the meaning of the PASARR Level I screening result Exempted Hospital Discharge. The MDS 1 stated the PASARR screening should have been completed since Resident 1 stayed 49 days in the facility (19 days late to complete the PASARR screening). The MDS 1 further stated it was not done. During a concurrent interview and record review on June 4, 2026, at 11:52 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, PASRR dated February 2026, was reviewed. The P&P indicated, .1. A PASARR form shall be completed on every resident upon admission unless it is done by the hospital . The DON stated the P&P was not followed. The DON further stated the PASARR screening should have been done.		

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NAME OF PROVIDER OR SUPPLIER Arrowhead Springs Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1335 N. Waterman Ave. San Bernardino, CA 92404	
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent with three medication errors of 36 observed opportunities, affecting two on thirteenth observed residents (Resident 123 and 45), resulting in an overall error rate of 8.3 percent when: 1. Resident 123 was not given Omeprazole (a medication used to reduce stomach acid) as ordered. This failure had the potential for Resident 123 to have increased stomach discomfort or increased stomach acid. 2. Resident 45 received Vitamin D3 (a vitamin that helps with strong bones, muscles, and the immune health) 5000 IU (International Units- unit of measurement) instead of Vitamin D3 1000 units (unit of measure), as prescribed by the physician. This failure had the potential to cause Vitamin D toxicity (abnormally high levels of calcium in the blood, which can result in nausea, vomiting, altered mental status, cardiac abnormalities, and kidney damage). 3. Resident 45 had an order to receive Vitamin B12 (an essential water-soluble nutrient the body needs to form healthy red blood cells and maintain a functioning nervous system) 500 mcg (micrograms- unit of measurement) and it was not given within 60 minutes of the scheduled time. This failure had the potential to delay the therapeutic effect of Vitamin B12 in Resident 45 and contribute to worsening symptoms like fatigue, dizziness, headache, nausea, and weight loss. 1. During a review of Resident 123's admission Record (contains demographic and clinical information), it indicated Resident 123 was admitted to the facility on [DATE], with the diagnoses of noninfective gastroenteritis (stomach and intestines become inflamed) and colitis (inflammation or irritation of the stomach and intestines that can cause abdominal pain, nausea, diarrhea, and digestive discomfort), protein-calorie malnutrition (resident is not getting enough nutrition, which can lead to weight loss, weakness, and poor overall health), and adult failure to thrive (a condition in which an older adult experiences weight loss, decrease appetite, weakness and decline functioning). During a review of Resident 123's Physician Orders, dated May 27, 2026, it indicated, Omeprazole Oral Tablet Delayed Release (Omeprazole) give 20 mg [milligram&mdash;unit of measurement] by mouth in the morning for GI (gastrointestinal) PPX (prophylaxis, prevention). During a concurrent observation and interview on January 3, 2026, at 5:43 AM, in Resident 123's room, a license Vocational Nurse (LVN 5) was preparing Resident 123's medication. LVN 5 stated that Omeprazole 20 mg was unavailable because it had not been delivered by the pharmacy and was not available in the medication room. LVN 5 further stated Omeprazole was an important medication used to reduced stomach acid and help prevent gastrointestinal irritation. During a concurrent interview and record review on June 4, 2026, at 10:56 AM, with the Director of Nursing (DON), Resident 123's, eMAR &mdash; Medication Administration Note (digital system used to track and document when residents receive medications), dated June 3, 2026, at 5:43 AM, was reviewed. The eMAR &mdash; Medication Administration Note indicated LVN 5 documented, Omeprazole Oral Tablet Delayed Release, Give 20 mg by mouth in the morning for GI PPX awaiting pharmacy. The DON confirmed Resident 123 missed one dose of Omeprazole on June 3, 2026. During a concurrent interview and record review on June 3, 2026, at 10:42 AM, with the DON, the facility's policy and procedure (P&P) titled, Preparation and General Guidelines, dated December 2019, was reviewed. The P&P indicated, .The facility has sufficient staff and medication distribution system to ensure safe administration of medications without unnecessary interruptions., Medication are administered in accordance with written orders of the prescriber . The DON confirmed that the policy (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not followed by the staff. 2. During a review of Resident 45's face sheet (contains demographic and medical information), the face sheet indicated Resident 45 was admitted to the facility on [DATE], with diagnoses which included fracture of the left femur (a break in the thigh bone), chronic kidney disease stage 2 (a condition when the kidneys are damaged and cannot filter blood as they should), and atherosclerotic (the buildup of fats, cholesterol and other substances in and on the artery walls) heart disease. During a review of Resident 45's Physician Order, dated May 18, 2026, it indicated, Resident 45 had an order for Vitamin D3 oral tablet give 1000 units by mouth one time a day for supplement. During a medication administration observation on June 3, 2026, at 8:20 AM, in Resident 45's room, a Licensed Vocational Nurse (LVN 4) administered Vitamin D3 5000 IU orally to Resident 45, not the prescribed dose of Vitamin D3 1000 units. During a concurrent observation and interview on June 3, 2026, at 9:54 AM, with LVN 4, LVN 4 acknowledged and stated the wrong dose of Vitamin D3 was given to Resident 45. LVN 4 further stated Resident 45's prescribed dose of Vitamin D3 is 1000 units and took the correct medication bottle from the medication cart to demonstrate. During a concurrent interview and record review, on June 4, 2026, at 11:49 AM, with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Medication Administration- General Guidelines, dated May 2022 was reviewed. The P&P indicated, Five rights. right dose. for each medication being administered. The DON stated the policy was not followed. 3. During a review of Resident 45's face sheet, the face sheet indicated Resident 45 was admitted to the facility on [DATE], with diagnoses which included fracture of the left femur, chronic kidney disease stage 2, and atherosclerotic heart disease. During a review of Resident 45's Physician Order, dated May 18, 2026, it indicated, Resident 45 had an order for Vitamin B12 oral tablet give 500 mcg by mouth one time a day for supplement. During a medication administration observation on June 3, 2026 at 8:22 AM, with LVN 4 in Resident 45's room, Resident 45's Vitamin B12 was scheduled to be administered at 9:00 AM. LVN 4 stated the Vitamin B12 was not in the medication cart and could not be administered at that time. During a review of Resident 45's Progress Notes, dated June 3, 2026, the Progress Notes indicated, . 10:50 AM. Vitamin B12 was administered. During a concurrent interview and record review, on June 4, 2026, at 11:47 AM, with the DON, the facility's P&P titled, Medication Administration- General Guidelines dated May 2022 indicated, .medications are administered within [60 minutes] of scheduled time. The DON stated the policy was not followed.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored and secure for one of 13 resident (Resident 47), when Fluticasone Propionate/Salmeterol inhaler (a medication used to help control and prevent symptoms of chronic obstructive pulmonary disease [COPD]), Nystatin cream (a medication used to treat fungal skin infections) and Diclofenac Sodium Topical gel (a medication used to relieve pain and inflammation) were found unattended and readily accessible on Resident 47's bedside table. This failure had the potential to result in improper medication use, medication errors, adverse drug reactions by Resident 47 or others. During a review of Resident 47's admission Record (contains demographic and clinical information), it indicated Resident 47 was admitted to the facility on [DATE] with the diagnoses of chronic obstructive pulmonary disease (COPD - a long term lung disease that makes it hard to breath because the airways are damaged or blocked), gastroesophageal reflux disease (GERD - [gastroesophageal reflux disease] without esophagitis (a condition where stomach acid frequently flows back into the esophagus), displacement fracture (broken) of glenoid cavity of scapula, right shoulder (fracture of the right shoulder).During a review of Resident 47's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing home residents) Section C (cognitive-involving consciousness intellectual activity patterns), dated May 19, 2026, the MDS indicated, Resident 47 had a BIMS (brief Interview for Mental Status - tool used to screen how a resident is functioning cognitively) score of 12 (a BIMS score 8-12 suggests resident is moderately impaired).During an interview with Resident 47 on June 1, 2026, at 11:25 AM, inside the resident's room, Resident 47 confirmed she was still using the three medications observed on the bedside table, including the Fluticasone Propionate/ Salmeterol inhaler, Nystatin cream, and Diclofenac Sodium topical gel 1% (one percent-strength of medication).During a concurrent observation and interview on June 1, 2026, at 11:49 AM, with License Vocational Nurse (LVN 5), LVN 5 confirmed the inhaler had a handwritten open date of May 16, 2026, with 52 doses remaining out of 60 doses. LVN 5 confirmed that the Diclofenac gel, Nystatin cream and inhaler belonged to Resident 47 and acknowledged that it was unsafe to leave medications unattended on Resident 47's bedside table.During a review of Resident 47's Physician Orders, dated May 15, 2026, the Physician Orders indicated, Advair Diskus Aerosol Powder Breath Activated 250 - 50 mcg [microgram-unit of measurement]/Dose (fluticasone - salmeterol) 1 inhalation inhale orally every 12 hours for bronchospasm (narrowing of the airways that can make it difficult to breath) PPX [prophylaxis] R/T [related to] COPD - chronic pulmonary disease.During a review of Resident 47's care plan [an individualize plan for resident's health condition, and service goals] for COPD, dated May 16, 2026, the care plan indicated, interventions, give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Monitor for difficulty breathing (Dyspnea) on exertion. Remind resident not to push beyond endurance.During a review of Resident 47's Physician Orders, dated May 15, 2026, the Physician Orders indicated, Diclofenac Sodium External Gel 1 %, (Diclofenac Sodium (topical) Apply to joint / pain/shoulder topically every 6 (six) hours as needed for pain 2 grams (unit of weight).During a review of Resident 47's care plan, dated May 15, 2026, the care plan indicated, Interventions Administer analgesia medication as per orders. Give 1/2 (half) hour before treatments of care. Monitor / document for side effects of pain medication. Observed for constipation; new onset or increase agitation, restlessness, confusion, hallucinations.Report occurrences to physician.During a concurrent interview and record review on June 4, 2026, at 10:49 AM, with the Director of Nursing (DON), the Physician Order, dated May 19, 2026, was reviewed. The Physician Order indicated, Nystatin external cream 100000 UNIT/GM (Nystatin (topically every day shift for rash apply 1 gram each armpit. The DON confirmed the medication observed on Resident 47's (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside table had been discontinued and acknowledged the medication should not have been left unattended in the resident's room.During a concurrent interview and record review on June 4, 2026, at 10:52 AM, with the DON, the Physician Order, dated May 28, 2026, at 1:46 PM, was reviewed. The Physician Order indicated Nystatin External powder 100000 Unit/GM Nystatin (topical) apply to R (right) underarm topically every day shift for MASD (moisture associated skin damage), (a skin irritation caused by excess moisture trapped against the skin, which can result in redness, rash, discomfort and breakdown of the skin) for 14 days. And was subsequently discontinued. The DON confirmed the mediation observed on Resident 47's bedside table had been discontinued and acknowledged the medication should not have been left unattended in the resident's room.During a concurrent interview and record review on June 4, 2026, at 10:58 AM, with the DON, the facility's policy and procedure (P&P) titled, Medication Storage in the facility dated Revised January 2018 the P&P indicated, Medications and biological are stored safety, securely, and properly , following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members lawfully authorized to administer medications. Procedures.C. All medications dispensed by the pharmacy are store in the container with the pharmacy label., F. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart.I. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. The DON stated the policy was not followed by staff.		

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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. Based on observation, interview, and record review, the facility failed to ensure staff followed effective infection control practices for three (3) of 107 residents (Residents 60, 54, and 52) when one licensed vocational nurse (LVN 3) did not clean and disinfect a reusable medication tray (used to prepare and transport medication to residents) between medication administration. This failure had the potential for cross-contamination (the transfer of harmful bacteria), which could expose residents to harmful organisms (capable of causing infection, illness, or adverse health effects) and lead to preventable healthcare-associated infections (HAIs- infections that residents acquire while receiving care in a healthcare facility) for 107 highly vulnerable residents. During an observation on June 3, 2026, at 5:37 AM, in Resident 60's room, with LVN 3, after LVN 3 gave medication to Resident 60. LVN 3 then placed a used medication cup, a used spoon with applesauce on it, and a used water cup back onto the medication tray and returned it to the medication cart. LVN 3 discarded the used cups and spoon, removed gloves, and performed hand hygiene, without cleaning or disinfecting the medication tray. LVN 3 began preparing medications for Resident 54, on the same medication tray. During an observation on June 3, 2026, at 5:41 AM, in Resident 54's room, LVN 3 placed Resident 54's medication, in a medication cup on the same uncleaned medication tray. LVN 3 assisted Resident 54 in taking the medication with water and returned the used medication cup back on the medication tray before returning it to the medication cart. During an observation on June 3, 2026, at 5:49 AM, in Resident 52's room, LVN 3 threw Resident 54's medication cup in the trash and proceeded to prepare medication for Resident 52 without disinfecting the medication tray. LVN 3 prepared and placed Resident 52's two medication cups and a water cup directly onto the medication tray. During an interview on June 3, 2026, at 5:55 AM, with LVN 3, in Resident 52's room, LVN 3 stated infection control practices must include disinfecting supplies that are reusable between residents. LVN 3 further stated and acknowledged the medication tray should have been cleaned and disinfected after giving medication to one resident and before preparing medication for another resident to prevent cross-contamination from resident to resident. During a concurrent interview and record review on June 4, 2026, at 11:45 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Cleaning, Disinfection, and sterilization of Resident Care equipment, dated February 2026, indicated, Noncritical items. require routine cleaning and disinfection. frequency. between each resident use. The DON stated the policy was not followed.		