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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056053	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Post Acute	1311 East Date Street 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records by not documenting resident-reported falls for one (1) of three (3) sampled residents (Resident 1).This failure resulted in a medical record that did not reflect Resident 1 reported change of condition.Findings: During a review of Resident 1's face sheet (contains demographic and medical information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included subsequent encounter for fracture (the patient is in the healing or recovery phase, receiving routine follow-up care) and Alzheimer's disease (the most common form of dementia, a brain disorder that slowly destroys a person's memory and thinking skills). During a review of Resident 1 ' s Minimum Data Set (facility assessment tool), dated March 3, 2026, under Section C, it indicated her Brief Interview for Mental Status (BIMS- screening tool to assess resident's cognition) score was 12. (A BIMS score of 8-12 suggests moderate problems with thinking and memory). During a concurrent interview and record review on March 17, 2026, at 3:34 PM, with two License Vocational Nurses (LVNs 1 and 2), LVNs 1 and 2 reviewed Resident 1's clinical records and could not find documentation indicating that Resident 1 reported fall within the facility. During a telephone interview on March 18, 2026, at 2:28 PM, with RN 1, RN 1 stated that on March 3, 2026, she went to Resident 1's room after hearing a scream, and found Resident 1 in bed, who claimed to have fallen. She stated that Resident 1 appeared disoriented and was unable to provide an answer when asked further about her alleged fall. She stated that she conducted a thorough assessment of the resident's body and found no indications of injury. During telephone interview on March 18, 2026, at 3:44 PM, with the Director of Nursing (DON), the DON stated she was unable to locate RN 1's documentation regarding Resident 1's reported fall. She further stated RN 1 should have documented the incident despite Resident 1's history of Alzheimer disease. She further stated that according to the policy a change of conditions must be documented. During telephone interview on March 19, 2026, at 8:14 AM, with RN 1, RN 1 stated, she failed to document Resident 1's reported fall and her assessment, admitting it was her oversight. RN 1 acknowledged that the policy mandates documentation of all incidents. A review of the facility Policy and Procedures (P&P), titled, Charting and Documentation, dated July 2017, indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.2. The following information is to be documented in the resident medical record: .c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident.

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