

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098</p> <p>Based on interview and record review, the facility failed to ensure their weight change protocol was implemented for one of two residents (Resident 50) reviewed for nutrition when the Registered Dietitian Nutritionist (RDN) recommendations for Resident 50, which included weekly weights monitoring and administration of appetite stimulant (substances that increase hunger and food intake) were not carried out timely.</p> <p>These failures have the potential to place Resident 50 at risk for malnutrition (state of nutritional deficiency or imbalance that occurs when the body does not receive or absorb sufficient nutrients to meet its physiological needs), increasing the risk of further weight loss, frailty, and weakened immune function, muscle wasting, weakness, reduced mobility, and cognitive and psychological decline, potentially leading to confusion, lethargy, and depression.</p> <p>Findings:</p> <p>During a review of Resident 50's Admission Record (contains demographic and medical information), it indicated Resident 50 was admitted to the facility on [DATE] with diagnoses of acute kidney failure (a condition where kidney suddenly stop working properly, making difficult to eliminate waste), dysphagia (difficulty of swallowing foods, liquids or even saliva) and depression (a mental health condition that causes persistent sadness, hopelessness and loss of interest.)</p> <p>During a review of Resident 50's Nutritional Initial Screener dated July 28, 2024, at 1:57 PM, it indicated, 1. Admitting Diagnosis: Difficulty in walking, acute kidney failure .2. Diet, NAS diet, (not added salt) Regular texture ., 12. Appetite a. Poor (0-49%) ., 22. Most Recent Weight, Weight: 142 lbs. (pounds) .</p> <p>During a review of Resident 50's Care Plan dated, August 14, 2024, indicated, Nutritional risk r/t advancing age, weakness, decrease mobility, decrease strength .Goal, maintain weight acceptable to resident / responsible party and clinically appropriate ., Interventions ., monitor weight and notify MD for any undesirable weight changes ., Other dietary interventions .</p> <p>During a review of Resident 50's IDT (Interdisciplinary Team)Weight Variance (measurement of the spread of data points</p> <p>around their weighted mean, assigning different</p> <p>(continued on next page)</p>

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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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>importance to each data point based on its assigned weight), dated September 4, 2024, at 4:30 PM, it indicated .weight 128 lbs. (which is a equivalent of 14 pounds less from the RD evaluation, 9.86 % in, 38 days), Interventions: 1. Weekly weights x 4 d/t weight loss (weekly weight for four weeks due to weight loss), 2 fortify diet d/t weight loss.</p> <p>During a review of Resident 50's Vital Weights for the month of September 2024, there was no documented evidence to indicate Resident 50's weekly weights were taken on the following weeks: September 9, 2024 - September 15, 2024, September 16, 2024 - September 22, 2024, and September 23, 2024 - September 30, 2024. (Three of four weekly weights was not done.)</p> <p>During a review of Resident 50's IDT weight Variance dated November 5, 2024, at 2:45 PM, it indicated A. Weight, Most Recent Weight, Weight:113 lbs. (from last weight, -15 pounds less; 18.7%) .6. Interventions: Recommendations: 1. Appetite stimulant d/t weight loss/ poor appetite, weights x 4 d/t weight loss.) .</p> <p>During a review of Resident 50's Vital Weights for the month of November 2024, there was no documented evidence to indicate Resident 50's weekly weights were taken on the following weeks: November 5, 2024 - November 10, 2024, November 11, 2024 - November 17, 2024, and November 18, 2024 - November 24, 2024. (Three of four weekly weights was not done)</p> <p>During a review of Resident 50's clinical records, there was no documented evidence to indicate an appetite stimulant was ordered for Resident 50 for the months, November 2024 and December 2024.</p> <p>During a review of Resident 50's Physician Orders dated January 23, 2025, at 9:00 PM, it indicated Mirtazapine (aka Remeron- anti-depressive medication which can be used to improve appetite) Oral Tablet 15 mg give 1 tablet by mouth at bedtime for depression m/b (manifested by) decrease appetite. Start Date January 23, 2025, at 9:00 PM.</p> <p>During a phone interview and concurrent record review of Resident 50's clinical records, on March 5, 2025, at 11:19 AM, with the RD, the RD stated she recommended weekly weight monitoring and appetite stimulant to Resident 50 on November 5, 2024, due to continued weight loss. The record review indicated the appetite stimulant was not ordered until January 23, 2025 (79 days later, with no documentation explaining the delay). The RD stated she had concerns over the lack of follow - through with her recommendations. She stated weekly weight monitoring was essential for tracking fluctuations and ensuring timely interventions but stated she relies on facility staff to implement her recommendations and does not personally verify follow through.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on March 6, 2025, at 10:34 AM, with the Director of Nurses (DON), the DON reviewed Resident 50's clinical record stated Resident 50's weekly weights monitoring were not consistently performed as recommended by RD, specifically from September 9, 2024, through September 30, 2024, and November 5, 2024, through November 24, 2024. She further stated the appetite stimulant recommended by the RD on November 5, 2024, was not implemented until January 23, 2025 (resulting in 79 - day delay.) The DON stated these failures to a breakdown in communication and an oversight due to an email miscommunication, which led the Resident 50's name being omitted from the list of residents requiring interventions. She stated that while she typically ensures follow-up on RD recommendations through nursing staff, in this instance, she failed to confirm whether the orders were carried out.</p> <p>During a concurrent interview and record review on March 6, 2025, at 10:58 AM, with the DON, the DON reviewed the facility's policy and procedure (P&P) titled, weight Change Protocol dated 2023, which indicated, Early identification of a weight problem and possible cause (s) can minimize complications Assessment of resident experiencing weight changes should be completed in a timely manner. Residents will be weighed monthly and weekly for those newly admitted and those deemed to be at high risk for weight changes or according to the facility's policies. Variances are calculated from monthly and weekly weights that are obtained by facility staff. Resident who experience significant changes in weight or insidious weight loss will be assessed by the RD. The following criteria significant or insidious weight changes: Slow and progressive weight change trending away from weight goal. This can refer to weekly or monthly weights. 3# weight loss or gain in 1 week or as facility policy states, 5# weight loss or gain in 1 month .,5.0% weight loss or gain in 1 month .7.5% weight loss or gain in 3 months . The DON stated this policy was not followed.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098</p> <p>Based on observation, interview, and record review, the facility failed to ensure the Pain Assessment and Management policy was implemented for one of two residents (Resident 214) reviewed for pain, when Resident 214's PRN (pro re nata; as needed) pain medication was not administered as ordered by the physician.</p> <p>This failure had the potential to put Resident 214 in unnecessary prolonged pain and discomfort and had the potential for increased suffering, delayed recovery, and reduced mobility, ultimately affecting the resident's overall well-being.</p> <p>Findings:</p> <p>During a review of Resident 214's Admission Record (contains demographic and medical information), it indicated Resident 214 was admitted to the facility on [DATE], with the diagnoses for displaced intertrochanter fracture of the left femur (broken left hip), hypertension (elevated blood pressure), and type 2 diabetes mellitus (a condition where the body has trouble to regulating blood sugar.)</p> <p>During a review of Resident 214's Physician Orders, dated March 1, 2025, at 9:00 AM, it indicated Resident 214 had an order to receive Pregabalin (used to treat nerve pain) 100 mg (milligrams - unit of weight) give 1 capsule by mouth every morning and bedtime for nerve pain.</p> <p>During a review of Resident 214's Physician Orders dated, March 1, 2025, at 11:15 AM, it indicated Hydrocodone -Acetaminophen (Norco - is a opioid, pain medication use for severe pain) oral tablet 10-325 mg give 1 tablet by mouth every 6 hours PRN as needed for pain 1-10 NTE (not to exceed) more than 3 grams (grams unit on weight) in 24 hrs. (hours) Start Date, March 1, 2025 at 11:15 AM.</p> <p>During an observation on March 4, 2025, at 9:19 AM, inside Resident 214's room, Resident 214 was lying in bed, awake, alert, oriented x 3 and was able to verbalize needs. Resident 214 had a facial grimace and stated she was experiencing pain, with a pain scale (tool used to measure and quantify the intensity of pain; 10 means worst pain possible.) of 7/10 (severe pain) in the left hip when moving. She also stated she had not yet received her morning medications.</p> <p>During further observation on March 4, 2025, at 9:35 AM, License Vocational Nurse (LVN 1) entered Resident 214's room and took Resident 214's vital signs (measurements that indicate basic bodily functions and overall health). Resident 214 reported pain of 8/10 (severe pain) to LVN 1.</p> <p>During further observation on March 4, 2025, at 9:47 AM, LVN 1 administered Pregabalin 100 mg to Resident 214. LVN 1 did not offered or give Norco.</p> <p>During a subsequent interview on March 4, 2025, at 9:52 AM, with LVN 1, LVN 1 acknowledged the Norco should have been given as ordered to Resident 214.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on March 6, 2025, at 11:26 AM, with the Director of Nurses (DON), the facility's policy and procedure (P&P) titled Administering Medications, revised April 2019, was reviewed. The P&P indicated, Policy Statement, Medications are administered in a safe and timely manner, and as prescribed ., 4. Medications are administered in accordance with prescriber orders, including any required time frame .7. Medications are administered within one (1) hour of their prescribe time, unless otherwise specified (for example, before and after meal orders). 10. The individual administering the medication check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication The DON stated Norco should have been administered for Resident 214's 8/10 pain as ordered by the physician. The DON stated the facility policy was not followed and further stated there was no physician order requiring Norco and Pregabalin to be given separately or one hour apart.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098</p> <p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate (determined by calculating the percentage of medication errors (observed or identified preparation or administration of medications or biologicals which is not in accordance with prescriber's order; manufacturer's specifications; or accepted professional standards and principles) observed during a medication administration observation) were not 5 percent or greater. There were three medication errors identified out of 33 opportunities for errors, affecting one of 8 residents (Resident 214), resulting in an overall medication error rate of 9.09 % when three of Resident 214's were not administered in accordance with prescriber's order and facility policy on March 4, 2025.</p> <p>This failure had the potential to place Resident 214 at risk for dangerously high blood sugar, increasing the risk of serious health complications including infection (when harmful bacteria, viruses or fungi enter the body and start growing causing illness, delayed wound healing, and sepsis (severe infection that spreads through the blood and can damage organs or be life-threatening).Furthermore, this failure had the potential to put Resident 214 in unnecessary prolonged pain and discomfort and had the potential for increased suffering, delayed recovery, and reduced mobility, ultimately affecting the resident's overall well-being.</p> <p>Findings:</p> <p>During a review of Resident 214's Admission Record (contains demographic and medical information) indicated Resident 214 was admitted to the facility on [DATE], with the diagnoses for displaced intertrochanter fracture of the left femur (broken left hip), hypertension (elevated blood pressure), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar.)</p> <p>During a review of Resident 214's Physician Orders dated March 1, 2025, at 8:00 AM, it indicated Resident 214 had an order to receive Metformin HCL (used to treat high blood sugar levels) 850 mg (milligram- unit of measurement) Give 1 (one) tablet by mouth two times a day for diabetes with breakfast and evening .Start Date, March 1, 2025, at 8:00 AM, and Glipizide (used to treat high blood sugar levels) ER (Extended Release) tablet, Extended Release 24-hour 5 mg, give 1 tablet by mouth one time a day for diabetes hold if bs (blood sugar) is less than 100. Do not crush Start Date March 1, 2025, at 8:00 AM.</p> <p>During a review of Resident 214's Physician Orders dated, March 1, 2025, at 11:15 AM, it indicated Hydrocodone -Acetaminophen (Norco - opioid, pain medication use for severe pain) oral tablet 10-325 mg give 1 tablet by mouth every 6 hours PRN as needed for pain 1-10 NTE (not to exceed) more than 3 grams (grams unit on weight) in 24 hrs. (hours) Start Date, March 1, 2025 at 11:15 AM.</p> <p>During an observation on March 4, 2025, at 9:19 AM, inside Resident 214's room, Resident 214 was lying in bed, awake, alert, and oriented, able to verbalize need. Resident 214 had a facial grimace and stated she was experiencing pain, with a pain scale (tool used to measure and quantify the intensity of pain; 10 means worst pain possible.) of 7/10 (severe pain) in the left hip when moving. Resident 214 stated she had not yet received her morning medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a further observation on March 4, 2025, at 9:35 AM, License Vocational Nurse (LVN 1) entered Residents 214's room and took Resident 214's vital signs (measurements that indicate basic bodily functions and overall health) which included her blood sugar, which was 251mg/dL (milligrams per deciliter, used to measure the amount of sugar in the body.) Resident 214 reported pain of 8/10 (severe pain) to LVN 1.</p> <p>During further observation on March 4, 2025, at 9:42 AM, in Resident 214's room, LVN 1 administered Metformin HCL 850 and Glipizide ER 5 mg to Resident 214. (These medications were scheduled for 8:00 AM. The administration time was noted as being one hour and forty-two minutes after the scheduled time.)</p> <p>During further observation on March 4, 2025, at 9:47 AM, LVN 1 continued to administer Resident 214's medications. LVN 1 did not offered or give Norco.</p> <p>During a subsequent interview with LVN 1, on March 4, 2025, at 9:52 AM, LVN 1 stated the Resident 214's Metformin and Glipizide were administered late. LVN 1 also stated the Norco should have been given as ordered to Resident 214.</p> <p>During a concurrent interview and record review on March 6, 2025, at 11:26 AM with the Director of Nurses (DON), the facility's policy and procedure (P&P) titled Administering Medications Policy dated, revised April 2019, was reviewed. The P&P indicated, Policy Statement Medications are administered in a safe and timely manner, in accordance with prescriber orders, including any required time frame ., 7. Medications are Administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . The DON stated the staff did not follow the policy and that the delay in administering Metformin and Glipizide was not in compliance with the physician's orders. She further stated that Metformin was scheduled to be given with breakfast because it was more effective when taken with food to help regulate blood sugar levels through the day. The DON acknowledged that delaying diabetes medications can increase blood sugar. The DON also stated Norco should have been administered for Resident 214's 8/10 pain as ordered by the physician.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of eight residents (Resident 214) reviewed for medication administration was free of significant medication error (observed or identified preparation or administration of medications or biologicals which is not in accordance with prescriber's order; manufacturer's specifications (not recommendations); or accepted professional standards and principles, which causes the resident discomfort or jeopardizes his or her health and safety) when three of Resident 214's</p> <p>medications were not administered in accordance with physician's order and facility policy on March 4, 2025.</p> <p>This failure had the potential to place Resident 214 at risk for dangerously high blood sugar, increasing the risk of serious health complications including infection (when harmful bacteria, viruses or fungi enter the body and start growing causing illness, delayed wound healing, and sepsis (severe infection that spreads through the blood and can damage organs or be life-threatening).Furthermore, this failure had the potential to put Resident 214 in unnecessary prolonged pain and discomfort and had the potential for increased suffering, delayed recovery, and reduced mobility, ultimately affecting the resident's overall well-being.</p> <p>Findings:</p> <p>During a review of Resident 214's Admission Record (contains demographic and medical information) indicated Resident 214 was admitted to the facility on [DATE], with the diagnoses for displaced intertrochanter fracture of the left femur (broken left hip), hypertension (elevated blood pressure), and type 2 diabetes mellitus (a condition where the body has trouble regulating blood sugar.)</p> <p>During a review of Resident 214's Physician Orders dated March 1, 2025, at 8:00 AM, it indicated Resident 214 had an order to receive Metformin Hydrochloride (used to treat high blood sugar levels) 850 mg Give 1 (one) tablet by mouth two times a day for diabetes with breakfast and evening .Start Date, March 1, 2025, at 8:00 AM, and Glipizide (used to treat high blood sugar levels) Extended Release 24-hour 5 mg, give 1 tablet by mouth one time a day for diabetes hold if bs (blood sugar) is less than 100. Do not crush Start Date March 1, 2025, at 8:00 AM.</p> <p>During a review of Resident 214's Physician Orders dated, March 1, 2025, at 11:15 AM, it indicated Hydrocodone -Acetaminophen (Norco - opioid, pain medication use for severe pain) oral tablet 10-325 mg give 1 tablet by mouth every 6 hours PRN as needed for pain 1-10 NTE (not to exceed) more than 3 grams (grams unit on weight) in 24 hrs. (hours) Start Date, March 1, 2025 at 11:15 AM.</p> <p>During an observation on March 4, 2025, at 9:19 AM, inside Resident 214's room, Resident 214 was lying in bed, awake, alert, and oriented, able to verbalize need. Resident 214 had a facial grimace and stated she was experiencing pain, with a pain scale (tool used to measure and quantify the intensity of pain; 10 means worst pain possible.) of 7/10 (severe pain) in the left hip when moving. Resident 214 stated she had not yet received her morning medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During further observation on March 4, 2025, at 9:35 AM, License Vocational Nurse (LVN 1) entered Residents 214's room and took Resident 214's vital signs (measurements that indicate basic bodily functions and overall health) which included her blood sugar, which was 251mg/dL (milligrams per deciliter, used to measure the amount of sugar in the body.) Resident 214 reported pain of 8/10 (severe pain) to LVN 1.</p> <p>During further observation on March 4, 2025, at 9:42 AM, in Resident 214's room, LVN 1 administered Metformin HCL 850 and Glipizide ER 5 mg to Resident 214. (These medications were scheduled for 8:00 AM. The administration time was noted as being one hour and forty-two minutes after the scheduled time.)</p> <p>During further observation on March 4, 2025, at 9:47 AM, LVN 1 continued to administer Resident 214's medications. LVN 1 did not offered or give Norco.</p> <p>During a subsequent interview with LVN 1, on March 4, 2025, at 9:52 AM, LVN 1 stated the Resident 214's Metformin and Glipizide were administered late. LVN 1 also stated the Norco should have been given as ordered to Resident 214.</p> <p>During a concurrent interview and record review on March 6, 2025, at 11:26 AM with the Director of Nurses (DON), the facility's policy and procedure (P&P) titled Administering Medications Policy dated, revised April 2019, was reviewed. The P&P indicated, Policy Statement Medications are administered in a safe and timely manner, in accordance with prescriber orders, including any required time frame ., 7. Medications are Administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . The DON stated the staff did not follow the policy and that the delay in administering Metformin and Glipizide was not in compliance with the physician's orders. She further stated that Metformin was scheduled to be given with breakfast because it was more effective when taken with food to help regulate blood sugar levels through the day. The DON acknowledged that delaying diabetes medications can increase blood sugar. The DON also stated Norco should have been administered for Resident 214's 8/10 pain as ordered by the physician.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46917</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medications and treatment supplies were stored in accordance with the facility's policy and procedure when:</p> <ol style="list-style-type: none"> Two expired Central Line Trays (a kit containing the necessary supplies for maintaining a central venous catheter [long thin tube inserted into a large vein near the heart]) were found in the intravenous cart (IV cart-mobile cart used to store intravenous supplies) and were available for use. Six different types of expired dressings (pads or materials applied directly to wounds to protect them, promote healing, and absorb fluids), in various quantities were found inside the treatment cart and were available for use. A medication treatment cup filled with an unidentified cream was found underneath Resident 5's bed. <p>These failures had the potential for the medical and treatment supplies to loss sterility and adhesive strength, increasing the likelihood of infection and ineffective wound care, placing 88 residents' health at risk.</p> <p>Findings:</p> <ol style="list-style-type: none"> During a concurrent observation and interview on [DATE], at 9:14 AM, with the Registered Nurse (RN 1), the IV cart was inspected. Two central line trays with an expiration date of [DATE] (Expired for four months) were found inside the IV Cart. RN 1 validated the expiration date and stated they should not be inside the IV cart. <p>During a concurrent interview and record review on [DATE], at 8:00 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Labeling of Medication Containers, revised [DATE], was reviewed. The P&P indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .4. Labels for stock medications . c. The expiration date . The DON stated the policy was not followed.</p> <ol style="list-style-type: none"> During a concurrent observation and interview on [DATE], at 9:30 AM, with the Treatment Licensed Vocational Nurse (Tx LVN), the Treatment Cart was inspected. The following expired dressings were found: <ol style="list-style-type: none"> Six Dermafilm hydrocolloid dressings (dressing that maintain a moist wound environment that remains breathable to moisture vapor) dated [DATE], (Expired for more than 22 months) Four Medi honey Hydrogel dressings (flexible dressing with manuka honey and sodium alginate <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>which creates an antibacterial environment for wound protection) dated expired [DATE], (Expired for more than 14 months)</p> <p>c. Two Replicare dressings (dressing designed to create and maintain a moist wound environment by absorbing wound secretions to form a soft gel) dated [DATE], (Expired for more than 13 months)</p> <p>d. Six Cutimed Sorbact dressings (dressing that is used to treat infected wounds; coated with a hydrophobic fatty acid that binds to germs and removes them from the wound) dated [DATE], (Expired for more than 11 months)</p> <p>e. One DynaDerm hydrocolloid dressing (waterproof dressing that creates a protective patch over a wound, acting as a scab) dated [DATE], (Expired for more than months)</p> <p>f. One Mepilex Lite dressing (thin foam dressing designed to manage no- to low-exudate wounds) dated [DATE]. (Expired for more than 2 months)</p> <p>The Tx LVN validated the dressings were expired and stated the dressings should not be inside the treatment cart.</p> <p>During a concurrent interview and record review on [DATE], at 8:00 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Labeling of Medication Containers revised [DATE] was reviewed. The P&P indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .4. Labels for stock medications . c. The expiration date . The DON stated the policy was not followed.</p> <p>51099</p> <p>3. During a concurrent observation and interview on [DATE], at 9:45 AM, with Licensed Vocational Nurse 1 (LVN 1), in Resident 5's room, a medication treatment cup filled with an unidentified cream was found on the floor, underneath Resident 5's bed. LVN 2 verified the finding, and stated it was not supposed to be left in a resident's room or be within reach to a resident. LVN 2 further stated medications should be properly stored in either the medication room or one of the medication carts.</p> <p>During an interview on [DATE], at 4:15 PM, with the Director of Nursing (DON), the DON stated the expectation was for medications to be safely stored where it cannot be easily accessed by a resident. The DON further stated the medication treatment cup filled with an unidentified cream should have been disposed of and not left inside Resident 5's room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on [DATE], at 4:30 PM, with the Administrator (Admin), the facility's policy and procedure (P&P) titled, Storage of Medications, revised [DATE], was reviewed. The P&P indicated, .Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. The Admin stated the facility staff should have followed the P&P.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Haven Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 East Date Street San Bernardino, CA 92404	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51099</p> <p>Based on observation, interview, and record review, the facility failed to store and prepare food in accordance with professional standards for food safety when buildup of grime and debris were noted on the floor and walls of kitchen's walk-in refrigerator.</p> <p>This failure had the potential to result in accumulation of pathogenic microorganisms (germs or infectious agents that can cause disease) and attraction of insects or rodents, which could place the health and safety of 88 highly vulnerable residents who receives food from the kitchen at risk.</p> <p>Findings:</p> <p>During a concurrent observation and interview with the Dietary Supervisor (DS), on March 3, 2025, at 8:44 AM, in the kitchen, the walk-in refrigerator was inspected. There was buildup of grime and debris on the floors and walls, underneath the shelve racks. The DS acknowledged the finding, and stated it is unacceptable. The DS further stated the walk-in refrigerator should be free of grime and debris.</p> <p>During a concurrent interview and record review on March 5, 2025, at 9:09 AM, with the Administrator (Admin), the facility's policy and procedure (P&P) titled, Sanitation, revised 2023, was reviewed. The P&P indicated, .11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, and chipped areas 16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents, light fixtures, and the hood over stove, which will be cleaned by the maintenance staff. The Admin stated the facility staff did not follow the P&P. The Admin further stated the kitchen should be clean, including the walk-in fridge.</p> <p>During a review of the US FDA (United States Food and Drug Administration) Federal Food Code, dated 2022, section 6-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, it indicated, Equipment food-contact surfaces and utensils shall be clean to sight and touch .The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations .Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. The FDA Food Code, Section 4-601.11, further indicated, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted.</p>		