STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056107	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Convalescent Center of San Bernardino	1676 Medical Ctr Dr. San Bernardino, CA 92411

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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 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. 47360 Based on observation, interview, and record review, the facility failed to ensure safe storage of medications when seven packets of protein supplement (a nutritional supplement given to support dietary needs) were expired and available for resident use. This failure had the potential to affect the health and safety of 15 medically compromised residents placing them at risk for infection and at risk of administering a supplement with decreased potency, that may not achieve desired effect. Findings: During a concurrent observation and interview on April 23, 2025, at 7:30 AM, with Registered Nurse 1 (RN 1), an inspection of medication cart 6 (MC6- a mobile locked cart containing resident medications and supplements) was conducted. Seven protein supplement 15 Grams (a unit of measurement) of protein 60 calorie pouch were found with an expiration date of February 22, 2025. RN 1 stated, the seven protein supplements were expired by 60 days and should have been disposed and not available in the medication cart. During a concurrent interview and record review on April 23, 2025, at 9:06 AM, with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, Safe Storage of Medications, dated January 2023, was reviewed. The P&P indicated, .Medications will be stored under appropriate conditions to maintain medication integrity, promote availability of medication when needed . The DON stated, the facility's P&P was not followed and expired medications and supplements should not be in the medication cart.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41337 Based on observation, interview, and record review, the facility failed to prevent cross contamination from a Certified Nursing Assistant 1 (CNA 1) when CNA 1 did not wash her hands prior to handling a meal tray, and removed food from the tray to heat in the microwave with her bare hands. Furthermore, CNA 1 did not heat the food to the correct temperature. These failures put Resident 10, who was already medically compromised, at risk for food-borne illness (caused by eating or drinking something that is contaminated with bacteria, viruses, or parasites, that can make people sick). Findings: During an interview with the Dietary Services Supervisor (DSS), on April 21, 2025, at 10:15 AM, DSS stated the nursing staff heat the food in the microwave. She stated they heat the food to 165 degrees Fahrenheit (a scale for measuring temperature, in which water freezes at 32 degrees and boils at 212 degrees) and next to the microwave there is a thermometer (device used to measure temperature) supplied with alcohol pad available to ensure it is heated to the correct temperature. During an observation on April 21, 2025, at 11:30 AM, CNA 1 walked to the kitchen to get Resident 10's lunch from the refrigerator. She did not wash her hands before entering the kitchen. CNA 1 grabbed the lunch tray and walked out of the kitchen to the microwave. She removed the cover from the lunch tray, that had hard boiled eggs, peas and green beans. She removed the hard-boiled eggs with her hands and then put the cover back on and put it in the microwave to 2:22 minutes. After 1:20 minutes she pulled the meal out and felt it with her hands to see if it was warm enough. She put it back in for another 15 seconds. She put the warmed food back onto the tray and carried the tray to the resident's room. During an interview with CNA 1 on April 21, 2025, at 3:10 PM, CNA 1 stated there is not a certain temperature she needs to heat the food. CNA 1 stated she heats up the meals based on the resident preference. She stated she should have washed her hands prior to grabbing the meal from the refrigerator in the kitchen. During an interview with the Licensed Vocational Nurse 1 (LVN 1) on April 22, 2025 at 8:13 AM, LVN 1 stated that the CNA 1 should have taken the temperature of the food and that they provide a thermometer next to the microwave. LVN 1 stated that handwashing should be done prior to handling the meal tray. During an interview with the Registered Dietitian (RD), on April 22, 2025, at 10:01 AM, RD stated the food needs to be heated to 165 degrees Fahrenheit and there is a thermometer for nursing staff to use. RD stated that the nurse should wash her hands prior to handling the meal tray. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's document titled, Food and Nutrition Services Standard Operating Procedure, dated August 1, 2004, the facility's document indicated, 15. Reheating: use appropriate cooking equipment for reheating food to 165 degrees Fahrenheit in less than two hours. In addition, 1. In the FNS (food and nutrition services) Department, all employees associated with the handling of food will wash hands. 2. Hands are to be washed with soap and water at the following times: a. before: i. each shift, ii. Handing food or clean utensils/dishes/equipment, iii. Putting on gloves.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed when: 1. An action plan was not initiated in a timely manner following a positive water test for Legionella (a bacteria that grows in water systems such as air conditioners or hot water tanks and can cause a lung infection) performed on February 4, 2025. 2. An open enteral feeding system (a feeding bag filled with formula that delivers liquid nutrition through a tube to a resident's stomach) was not labeled correctly with the date and time for Resident 7. 3. Sterile respiratory water (a type of water free of germs, used in nebulizers and humidifiers), a tracheostomy mask (a mask that delivers humidified water to a surgical opening in the neck when a resident is unable to breathe normally), and a nebulizer (a device used to deliver medications via mist to a resident's airway) were not labeled with the date and time for Resident 7. These failures had the potential to result in cross-contamination (the transfer of harmful bacteria) causing a preventable infection to 15 residents whose health conditions are already highly compromised. Findings: 1. A review of form titled, Analytic result. Water testing: Q 1 [quarter 1] 2025 Viable Legionella Bacteria, it indicated, .Date sampled: 02/04/2025 [February 4, 2025]. Dated reported: 02/17/2025 [February 17, 2025] We are providing you with the Legionella analytical results that were sampled at your facility on February 4th , 2025. Water samples of interest were collected and analyzed for the presence of viable Legionella species using the CDC Method. Results are expressed as one of the following terms: 1. No Detection (ND): No Legionella is detected in the sample 2. <1 [less than one] colony forming unit/ml (cfu/ml) [unit of measurement colony forming unit/ milliliter]: Legionella was detected between the minimum detection limit of 0.4 cfu/ml and 1 cfu/ml in the water sample 3. Whole number: Legionella is detected at 1 [one or less than one] in the sample. The goal is zero detectable Legionella in a water source . The following summarizes results from this sampling period: For domestic water, five (5) of the ten (10) samples showed the presence of Legionella bacteria: - Rm A 204 RR Sink - Hot detectable Legionella bacteria with counts at < 1cfu/ml. - Rm A 215 RR Sink - Hot showed detectable Legionella bacteria with counts at 1cfu/ml. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- Rm A 209 RR Sink - Cold showed detectable Legionella bacteria with counts at 18cfu/ml. - P 106 RR Sink - Hot showed detectable Legionella bacteria with counts at < 1cfu/ml. - P 116 RR Sink - Hot showed detectable Legionella bacteria with counts at < 1cfu/ml The Following Recommended Actions are Advised: . All affected fixtures should be temporarily isolated if directed by Infection Prevention. Examples of System Isolation may consist of: 1) Disabling the water supply to the fixture until remediation has been conducted, 2) Isolating the room where the fixture is located from normal use, and 3) Installation of microbiological filters to prevent exposure to Legionella. It is recommended that positive fixtures and adjacent taps be thoroughly flushed for 5-minutes a day for a period of 7 to 10 days. It is important to verify the hot water temperature reaches the target temperature implementing a chlorination procedure per the SOP [Standard of Procedure] in your Water Safety Plan, as a majority of samples collected in the domestic water system show the presence of Legionella bacteria. All positive locations should be re-tested following completion of corrective actions in order to re-establish acceptable control. Continue to follow all preventative actions as part of your Utility Water Safety Program, including routine testing of the water systems During an interview on April 24, 2025, at 8:15 AM with the Director of Facility Management (DFM), the DFM stated that he manages the Engineering Department responsible for water management at the facility and is aware of the positive water test for Legionella performed on February 4, 2025. During a concurrent interview and record review on April 24, 2025, at 8:30 AM with the Director of Nursing (DON), the DON reviewed the water test result for Legionella performed on February 4, 2025. The DON stated, I was not aware of the positive water test for Legionella report and the recommendation dated February 17, 2025, until today [April 24, 2025]. The DON further stated that the result and recommendation were not communicated to the nursing department for follow-up and implementation. (The action plan was not implemented, leaving 15 residents with tracheotomies exposed to Legionella-contaminated water for two months and seven days.) During an interview on April 24, 2025, at 8:45 AM with the Administrator (Admin), the Admin stated, I was not aware of the positive water test for Legionella performed on February 4, 2025. He further explained that proper communication should have been initiated by the water management committee to both the facility's administration and the nursing department regarding this result and its associated recommendation, but it was not communicated for implementation. The action plan of remediation (corrective measures taken to resolve an identified issue or hazard) is designed to isolate the water system and minimize exposure to Legionella-contaminated water for 15 residents with tracheotomies was not implemented.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on April 24, 2025, at 9:00 AM with the DFM, the DFM reviewed the water management program and water safety plan binder but was not able locate any documented evidence of recommendation remediation following the positive water test for Legionella report dated February 17, 2025. The DFM was not able to explain as why both the facility administration and the nursing department were not notified of the positive water test for Legionella. Furthermore, the DFM stated that he should have notified the facility's administrator and DON as soon as the results were available, but he did not. During an interview on April 24, 2025, at 10:00 AM with the Infection Prevention Nurse (IPN), the IPN stated, I was not aware of the positive water test for Legionella until today. I received the result because I mentioned that the surveyor was in the facility and had asked for it. A concurrent interview and record review on April 24, 2025, at 11:00 AM, was conducted with the Admin and DFM. They reviewed the agency's undated policy and procedure (P&P) titled, Water Management Program and Water Safety Plan [name of the facility], which indicated the following: .1. Introduction. The goal of the Water Management Plan is to control the growth and survival of Legionella and other waterborne pathogens in water systems, and to control epidemic in the facility. This water plan documents the actions that [named of the facility] specifically for the purpose of managing waterborne pathogens, including Legionella bacteria in the utility water systems . Domestic water action plan . [chart organization plan] .is Legionella detected -> yes -> Isolate the system to minimize exposure of water to patients as directed by Infection Prevention -> is localized or systematic -> Localized. 1. Flush the affected fixtures according to the SOP in Section 4, and record date, time, location on a log sheet. 2. Inspect fixtures and disinfect/descale per SOP in Section 4 or replace the fixtures. 3. Retest for Legionella following corrective actions. 4. If detections persist, a droplet disinfection may be considered by the Water Management Team. Systematic. 1. Perform System Chlorination . 2. If applicable, consider Hot Water Storage Tank Disinfection . 3. Flush the affected fixtures according to the SOP in Section 4, and record date, time, location on a log sheet. 4. Inspect fixtures and disinfect/descale per SOP in Section 4 or replace the fixtures. 5. Retest for Legionella following corrective actions. 6. The need for permanent secondary disinfection should be discussed by the Water Management Team. -> Resample for Legionella within 5-10 days after corrective actions. Note 1: Examples of System Isolation may consist of: 1. Disabling the water supply to the fixture until remediation has been conducted 2. Isolating the room where the fixture is located from normal use 3. Installation of microbiological filters to prevent exposure to Legionella bacteria . (continued on next page)

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	056107	A. Building B. Wing	04/24/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DFM stated that, according to the facility's P&P, remediation should have been implemented following the positive water test for Legionella, and the water should have been retested afterward. The Admin stated the facility's P&P was not followed and he should have known the result promptly, as the necessary corrective actions would have been implemented immediately. A concurrent interview and record review on April 24, 2025, at 12:30 PM was conducted with the DON and IPN. The DON and IPN reviewed the facility's P&P titled, Performing an Outbreak Investigation, revised March 2021, which indicated, .Policy. Suspected disease outbreaks will be investigated . to ensure that methods to prevent further transmission are implemented Procedures. 1.0 Communication . 2.0 Establishing appropriate control measures . The DON stated the facility does not have a specific P&P for addressing a positive Legionella test and the facility follows this P&P in cases of potential or actual outbreaks. The IPN stated that appropriate control measures to minimize exposure to Legionella-contaminated water should have been implemented immediately, but they were not. Furthermore, both DON and IPN stated that the facility's P&P was not followed. 47360 2. During a review of Resident 7's History and Physical (H&P - a document containing the formal and complete assessment of a resident and the current health problem), dated February 14, 2025, indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses including respiratory failure (the inability of the respiratory system to meet the oxygen needs of the body), tracheomalacia (a weak windpipe that can collapse with breathing or coughing) and gastric-tube dependence (relies on a feeding tube for nutrition instead of eating food by mouth). During an observation on April 21, 2025, at 9:22 AM, in Resident 7's room, an enteral feeding bag was full of formula at Resident 7's bedside. The tube feeding was not connected to the resident and not infusing. The formula bag was dated as 4/2 [April 2] and did not include time it was prepared or nurse's initials. During a concurrent observation and interview, on April 21, 2025, at 9:22 AM, with Licensed Vocational Nurse 1 (LVN 1), in Resident 7's room, LVN 1 confirmed the date was written 4/2 [April 2] on the label and there was no time. LVN 1 stated, the label must be incorrect because 4/2 [April 2] was 19 days ago and the formula bag needs to be changed every 24 hours. LVN 1 stated, the nurse that started the feeding did not correctly date the system and should have dated it as 4/21/25 and there should have been a time on the label as well. LVN 1 stated, time and date is important because the open tube feeding system needs to be changed every 24 hours for resident safety. During a concurrent interview and record review, on April 24, 2025, at 9:06 AM, with the Infection Prevention Nurse (IPN), the facility's policy and procedure (P&P) titled, Administration of Formula Via Feeding Tube, Gravity, Bolus, Pump dated May 2011 was reviewed. The P&P indicated, . 3.1.17 Pump bags, syringe and tubing (open system) are to be changed every 24 hours and properly labeled with date time, and nurses initials . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The IPN stated, the formula bag needs to be dated properly to ensure it is changed out every 24 hours to prevent bacterial growth since the open system allows for more formula to be added throughput the day. The IPN further stated, if the bag system is not changed every 24 hours, it could lead to an infection. 3. During an observation on April 21, 2025, at 8:48 AM in Resident 7's room, a tracheostomy oxygen mask was handing outside the crib, it was connected to an oxygen source and sterile water for humidity. The sterile water and the tracheostomy oxygen mask and nebulizer were not labeled as when they needed to be changed. During a concurrent observation and interview, on April 21, 2025, at 9:08 AM with Respiratory Therapist 1 (RT 1), RT 1 was not able to determine when the sterile respiratory water or tracheostomy mask and nebulizer had last been changed and when the resident respiratory items need to be changed next. The RT 1 stated nursing is to change the items out on a regular basis to prevent growth of bacteria (germs) and prevent infection. During a concurrent interview and record review, on April 24, 2025, at 9:22 AM, with the Infection Prevention Nurse (IPN), the facility's policy and procedure (P&P) title, Frequency for Change of Disposable Respiratory Equipment dated May 2022, it indicated, .All disposable respiratory equipment used in the provision of respiratory care, including .aerosol delivery devices, are changed according to the frequency identified for each respective device .3.0 Sterile respiratory water is placed every 48 hours or when depleted . 8.0 Aerosol nebulizers are changed every Monday, Wednesday, and Friday. 8.1 The nebulizer and/or aerosol tubing is changed whenever there is evidence of gross soiling . The IPN stated, the sterile respiratory water needed to be changed every 48 hours. The IPN stated, tubing and nebulizer mask needed to be changed every Monday, Wednesday and Friday. The IPN further stated, these items needed to be labeled to identify when they needed to be changed. The IPN stated, changing these respiratory devices on a regular basis prevents infection and is essential based on the resident population treated at this facility as they all have tracheostomies and require respiratory support.

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	056107	A. Building B. Wing	04/24/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44841 Based on interview, and record review, the facility failed to implement their policy and procedure (P&P) on antibiotic stewardship (a set of practices aimed at ensuring the safe and effective use of antibiotics [medications used to treat infections]) for one of six sampled residents (Resident 167) reviewed for antibiotic used when the Infection Control Preventionist (ICP) nurse did not accurately analyze the collected data to identify purpose of the antibiotic use to indicate the rationale and common clinical conditions necessary to ensure the appropriate use of antibiotic therapy for Resident 167. This failure had the potential to place Resident 167 at risk for adverse events, including the development of anti-biotic resistant organisms, from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 167's History and Physical (H&P - a document containing the formal and complete assessment of a resident and the current health problem), dated April 3, 2025, indicated, Resident 167 was admitted to the facility on [DATE] with diagnoses which included Chronic respiratory failure (a long-term condition in which the lungs are unable to provide enough oxygen to the body's tissues) with hypoxia (shortness of breath, fatigue, confusion, and bluish skin) and tracheostomy dependent (a person relies on a tracheostomy tube [a surgical opening in the neck that creates an airway when normal breathing is impaired] for breathing over a long period). During a record review on April 23, 2025, at 3:00 PM of Resident 167's physician's order dated April 11, 2025, the physician's order indicated, . Daptomycin [a powerful antibiotic given through an intravenous (IV - a method of delivering fluids, medications, or nutrients directly into a person's bloodstream) to help treat serious bacterial infections] 275 mg [milligram - unit of measure] IV Q [every] 24 hours. Indication: UTI (Urinary Tract Infection is an infection that affects any part of the urinary system) stop 04/13/25 [April 13, 2025] and Avibactam - Zeftazidime Intravenous [a strong antibiotic administered through an IV to treat serious bacterial infections] 2.5 gr [gram - milligram is unit of measure] IV Q 8 hours indication: infection criteria . CR PSA (a serious bacterial infection caused by Pseudomonas aeruginosa that is resistant to strong antibiotics called carbapenems stop 04/15/25 [April 15, 2025]. During a record review on April 23, at 3:45 PM with the ICP nurse, the ICP nurse reviewed form titled, Revised McGeer Criteria for Infection Surveillance Checklist, indicated as follows: a. Resident name: [Resident 167 name] . UTI . Criteria [was filled to indicated criteria data] .Fever [checked] and . microbiologic criteria [checked] . [ ] UTI criteria met. [ ] UTI criteria not meet. [left blank]. b. Resident name: [Resident 167 name] . Wound infection . Criteria [was filled to indicated criteria data] . Redness [checked] . tenderness [checked] and . fever [checked] . [checked] SSTI [Skin and Soft Tissue Infection] criteria met. (continued on next page)

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	056107	A. Building B. Wing	04/24/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ICP nurse stated the facility used the McGeer Criteria (a criteria helps staff determine whether a patient has a true infection that needs treatment or if the symptoms are due to something else to be able to provide the best treatment) to monitor outcomes of true infection (means that the criteria indicate a real infection) versus untrue infection (patients might show some of these signs but don't actually have an infection) to ensure the appropriate use of antibiotic therapy. During a concurrent interview and record review on April 23, 2025, at 4:05 PM, with the Director of Nursing (DON) and the ICP nurse, the DON and ICP nurse reviewed Resident 167's clinical records of infection notes but was not able locate any documented evidence of infection notes to indicate whether the usage of the two antibiotics was for a true infection or an untrue infection. The ICP nurse stated she should have been conducting an analysis (looking for trends, spikes, or unusual patterns in the data) and reviewing the McGeer Criteria to confirm whether Resident 167 has a true infection, ensuring the appropriate use of antibiotic therapy. During an interview and concurrent record review on April 23, 2025, at 4:15 PM with the DON and ICP nurse, the DON and ICP nurse reviewed the facility's P&P titled, Antimicrobial Stewardship Program [programs to ensure effective and safe use of antibiotics] effective October 2010. The P&P indicated, Purpose: . To provide a guideline for the rational and safe use of antimicrobial- therapy throughout the facility, including the emergency department and long term care units .Antimicrobial medication use will be monitored by a clinical pharmacist under the direction of this physician-led multidisciplinary, collaborative work-group. Discussions with prescribing physicians regarding individual patient therapies will be conducted after evaluation of specific patient demographics and clinical data, evidence-based, national consensus guidelines and local susceptibility information, in order to provide the best possible patient outcomes . Procedure: 1.10 . takes actions on improvement opportunities identified in the antimicrobial stewardship program by collecting, analyzing and presenting antimicrobial use and resistance data to the Infection Control Committee, Pharmacy and Therapeutics Committee, Quality Improvement Committee, or other appropriate committees for review, action and quality improvement . The DON and the IPN stated that the analysis should have been conducted to identify trends in antimicrobial use, prevent unnecessary prescriptions, and reduce the spread of drug-resistant infections, but it was not. Furthermore, the IPN stated that the facility's P&P was not followed.