STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A208	A. Building B. Wing	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shandin Hills Behavior Therapy Center	4164 North 4th Avenue San Bernardino, CA 92407

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110 Based on observation, interview and record review, the facility failed to prevent one of four sample residents (Resident 1) from being abuse by another Resident (Resident 2), when Resident 2 struck Resident 1 while he was in line with many other residents for medication. This failure resulted in Resident 1 suffered a scratch below the left eyebrow, a bruise on the left forehead, and a scratch on the left arm. Findings: On February 25, 2025, at 9:15 AM, the facility was entered to investigate a facility-reported incident related to an injury to Resident 1 caused by Resident 2 struck Resident 1 without provocation. During an interview on February 25, 2025, at 9:41 AM with Resident 1, Resident 1 stated that as he was standing in line to receive his medication, Resident 2 approached him and punched him. He stated there were a lot of them waiting in line when it occurred. He further stated that he had a bruise on his left forehead, a scratch below his left eyebrow, his jaw felt tense, and a scratch on the left arm resulting from the incident. During a review of Resident 1's admission record (a document that gives a summary of resident's information), the document indicated Resident 1 was admitted to the facility on [DATE], with a diagnosis that included Schizophrenia (a serious mental health condition that affects how people think, feel and behave). During a review of Resident 1 record titled Change in Condition Evaluation , dated February 22, 2025, indicated, at approximately 8:55 AM, Resident 1 was waiting in the hallway for his medication when Resident 2 approached without warning and began hitting Resident 1 causing Resident 1 to fall to the ground. Code was called and Resident 2 was immediately verbally redirected, Resident 2 behavior instantly ceased and began to walk away toward his room. Neuro checks performed on Resident 1. Resident 1 is alert oriented, able to communicate and follow commands, Resident 1 stated 5/10 headache, and refused pain medication. Doctor and conservator notified. During a review of Resident 1 ' s Minimum Data Set (facility assessment tool), dated October 19, 2024, under Section C, it indicated his Brief Interview for Mental Status (BIMS) score was 14. (A BIMS score of 13 to 15 suggests the patient is cognitively intact.) (continued on next page)

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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on February 25, 2025, at 9:58 AM with the License Vocational Nurse (LVN 1), LVN 1 stated she was the medication nurse when the incident happened and that there were approximately 10 to 15 residents in the hallway when there should have only been 4 to 5 people waiting in line for their medication. said she thinks the incident may have been avoided if the number of residents waiting in line had been kept at 4 to 5 people at a time. During an interview on February 25, 2025, at 10:23 AM with Resident 2, Resident 2 stated there were around 10 to 11 people there when he struck Resident 1 and there were couple of staff too. During a review of Resident 2's admission record, the document indicated Resident 2 was admitted to the facility on [DATE], with a diagnosis that included Schizophrenia (a serious mental health condition that affects how people think, feel and behave). During a review of Resident 2 record titled Change in Condition Evaluation , dated February 22, 2025, indicated, at approximately 8:55 AM, during the morning medication pass, staff reported Resident 2 approached Resident 1 without provocation and began striking Resident 1 multiple times with Right hand, closed fist, causing Resident 1 to fall and spill the water he was holding. Resident 2 continued to hit Resident 1 while hovering over Resident 1. Staff quickly intervened, called code, and verbally directed Resident 2 to stop the behavior. Resident 2 immediately ceased and walked to his room without further incident. A review of Resident 2's care plan for Aggressive Behavior with an initiation date of October 24, 2024, and last re-evaluated November 3, 2024, showed that Resident 2 is at risk for Aggressive Behavior . During a review of Resident 2 ' s Minimum Data Set (facility assessment tool), dated October 19, 2024, under Section C, it indicated his Brief Interview for Mental Status (BIMS) score was 14. (A BIMS score of 13 to 15 suggests the patient is cognitively intact.) During an interview on February 25, 2025, at 10:36 AM, with another resident (Resident 3), Resident 3 stated on Saturday, there were around 15 people in the hallway lining up to get their medication when Resident 2 struck Resident 1. During a review of Resident 3's admission record (a document that gives a summary of resident's information), the document indicated Resident 3 was admitted to the facility on [DATE], with a diagnosis that included Paranoid Schizophrenia (a serious mental health condition that affects how people think, feel and behave accompanied by paranoia). During a review of Resident 3 ' s Minimum Data Set (facility assessment tool), dated October 19, 2024, under Section C, it indicated his Brief Interview for Mental Status (BIMS) score was 14. (A BIMS score of 13 to 15 suggests the patient is cognitively intact.) During an interview on February 25, 2025, at 10:42 AM, with another resident (Resident 4), Resident 4 stated there was around 12 people lining up to get medication, when the incident happened. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's admission record (a document that gives a summary of resident's information), the document indicated Resident 4 was admitted to the facility on [DATE], with a diagnosis that included Schizophrenia (a serious mental health condition that affects how people think, feel and behave). During a review of Resident 4 ' s Minimum Data Set (facility assessment tool), dated October 19, 2024, under Section C, it indicated his Brief Interview for Mental Status (BIMS) score was 15. (A BIMS score of 13 to 15 suggests the patient is cognitively intact.) During interview on February 25, 2025, at 10:50 AM, with the Program Director (PD 1), PD 1 stated although staff seemed to be aware that a small number of people lining up at one time is ideal to prevent problems from developing, PD 1 indicated that the facility lacks policy and procedure (P&P) that specifies how many residents should be lining up at one time for medication administration. She acknowledged that the situation may have been exacerbated by the large number of individuals waiting in line for medication on the day of the incident. A review of the facility P&P titled Resident-to-Resident Altercations dated September 2022, indicated, .1. Facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to the staff .