STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555522	A. Building B. Wing	10/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Hospital of San Bernardino Dp Snf	1805 Medical Ctr Dr. San Bernardino, CA 92411

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents are free of accidents for one of three residents (Resident 1) when Licensed Vocational Nurse (LVN 1) and Certified Nursing Assistant (CNA 1) did not ensure the attachment holding the bar and scale of the Hoyer lift (a mechanical device used to transfer people from one surface to another) was properly secure prior to Resident 1's transfer. This failure resulted in the attachment holding the bar and scale of the Hoyer lift became disconnected which caused Resident 1 falling from the Hoyer lift, sustaining a head laceration (cut), and requiring suture and closed observation in the Intensive Care Unit (ICU).Findings: 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 including anemia (insufficient red blood cells), chronic respiratory failure (when lungs are too weak to keep oxygen in and carbon dioxide out of the body for a long time), and cerebrovascular accident (CVA - when blood cannot get to a part of the brain and causes it to die from lack of oxygen). A review of Resident 1's clinical record, Physical Therapy Progress Summary, dated August 29, 2025, indicated, Resident 1 was dependent, total assistance. Impaired RLE (right lower extremity), impaired LLE (left lower extremity). Impaired attention and concentration, impaired orientation, impaired memory/learning. A review of Resident 1's clinical record, Physician Note, dated October 2, 2025, indicated, Resident 1 .presents from the NCU [neuro care unit] after a fall. The patient [Resident 1] developed a laceration on the back of her head. The patient [Resident 1] was admitted to the hospital for a head CT [computed tomography - x-ray that takes detailed pictures of brain and skull]. The head CT was negative for intracranial [inside skull] hemorrhage [bleeding]. The patient [Resident 1] had a 4 cm [centimeter-unit of measurement] laceration on the back of her head. Laceration sutured in the ICU [Intensive Care Unit]. The patient [Resident 1] will be transferred back to the floor. A review of Resident 1's clinical record, Change of Condition (details significant deviations from a resident's baseline status, including physical, cognitive, behavioral, or functional changes), dated October 2, 2025, indicated, Upon arrival in room found patient [Resident 1] laying on ground with head on side of Hoyer lift and ventilator's (machine that assists in breathing when lungs cannot on their own) still connected to patient and left-hand mitten in place. Full body assessment done and noted laceration to back of head around 2 inches in length small amount of blood and pressure applied to stop bleeding. A review of Resident 1's clinical record, RRT [Rapid Response Team-a group of health care profession who are called to bedside to assist in a sudden critical intervention] Activation and Response - Text, dated October 2, 2025, indicated, .Primary Call Reason: Other: Fall. RRT called had a fall from Hoyer lift, Per NCU staff patient [Resident 1] was lifted above the level of the bed when she [Resident 1] fell from the Hoyer lift.Patient [Resident 1] taken to CT then to ICU bed 10.Interventions: Other: Cleansed wound on head. and Outcome: Transferred to ICU. During an interview on October 9, 2025, at 11:42 AM, with the Unit Manager (UM), the UM stated, Licensed Vocational Nurse (LVN 1) and Certified Nursing Assistant (CNA 1) used the Hoyer lift to weigh Resident 1. A sling was used and in the process of lifting, the attachment holding the sling and scale was disengaged and Resident 1 fell to the floor. During a concurrent observation and interview on October 9, 2025, at 11:50 AM, with the UM and Maintenance Staff (MS 1), in the maintenance room, both acknowledged the lift equipment present in the room was the lift equipment used to lift Resident 1. MS 1 demonstrated the attachment hook that would hold the scale and bar. The scale and bar had interlocking hooks that go on top of each other and had a red safety latch to ensure them from being disengaging. MS 1 stated, It would take a lot to actually get the attachment to disconnect all of a sudden. You would need to hold down the safety latch to get the hook out or have it sway enough where the hook is angled to where it can disconnect MS 1 further stated, When we took it [the lift] out of the floor and assessed it, we didn't see any physical problems, or anything fault about it. There's no physical wear or anything. During an interview on October 9, 2025, at 12:00 AM, with the UM, the UM stated, Staff are trained on proper use of the lift equipment. The UM further stated all new employees are provided with orientation and yearly competency checks to ensure proper training with the lift equipment. During a concurrent interview and record review on October 9, 2025, at 12:03 PM, with the UM, the facility's document titled, Clinical Engineering Request: 696164 (Work Order), dated October 2, 2025, was reviewed. The Work Order indicated biomed inspection was completed for [name of lift equipment] scale #132309953, confirming no mechanical defect. The UM stated, based on the work order, there was no issue with the machine or the strap at the time of the fall. A