

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2025
NAME OF PROVIDER OR SUPPLIER Community Hospital of San Bernardino Dp Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of four sampled residents (Resident 1) was safely reconnected to the ventilator (a machine that supports or controls a person's breathing when they cannot breathe adequately on their own) following a shower. This failure resulted in an avoidable interruption in Resident 1's life supporting respiratory assistance and requiring a code blue response (an emergency code indicating a patient needs immediate medical attention), which had the potential to cause brain damage from lack of oxygen, and lead up to death. Resident 1 was subsequently transferred to Intensive Care Unit (ICU) for close observation and treatment. Findings: A review of Resident 1's face sheet (contain demographic and medical information), indicated Resident 1 was admitted to the facility on [DATE], with diagnoses including sepsis (a life threatening medical emergency that happens when the body's extreme response to an infection causes widespread inflammation and tissue damage) and respiratory failure (a condition where the lungs does not have enough oxygen in the blood). A review of Resident 1's Physician Notes, dated [DATE], indicated, Resident 1 is Ventilator dependent, on Ventilator support attached via a tracheostomy (a surgical procedure to create an opening to create an opening in the neck into the windpipe, called trachea, to establish a direct airway for breathing), with anoxic brain injury (occurs when the brain is completely deprived of oxygen, leading to brain damage), encephalopathy (any disorder that affects the brain function or structure) and chronic respiratory failure (a long term condition where the lungs cannot supply enough oxygen to the blood or remove enough carbon dioxide). A review of Resident 1's Nursing Progress Note, dated [DATE], indicated, approximately around 1:40 PM Respiratory Therapist (RT 1) came to charge nurse and says that patient unresponsive. A review of the facility's document for Resident 1 titled, CODE BLUE RECORD, dated [DATE], indicated that CPR (cardiopulmonary resuscitation-an emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped) initiated at 1:45 PM. During a concurrent interview, and record review on [DATE], at 4:50 PM, with the Director of Cardiopulmonary (related to heart and lungs) Services (DCPS), the facility's policy and procedure (P&P), titled, Manual ventilation [technique to provide assisted breathing by a staff] of Residents During Shower Procedure in NCU [Neurological Care Unit-area for patient with brain condition], dated [DATE], was reviewed. The P&P stated .7.0 The RCP (Respiratory Care Practitioner) is responsible for powering on the ventilator, confirming proper ventilator function and reconnecting the resident. The DCPS stated looking at the incident it appears that RT 1 reconnected Resident 1 to the ventilator following shower; however, RT 1 did not resume ventilation from standby mode (device is not active to save power). During an interview on [DATE], at 1:30 PM, with Registered Nurse (RN 1), RN 1, stated on [DATE], she oversaw 28 residents in the unit, including 15 who were on ventilators. The last time she checked Resident 1 was at approximately 12:00 PM. RN 1 further stated at the time Resident 1 had returned from shower room, she does not recall checking the ventilator or its setting. At approximately 1:45 PM, RT1 came and told her that Resident 1 was unresponsive, so RN 1 immediately went to Resident 1's room and code blue was initiated. During an interview on [DATE], at 1:45 PM, with Certified Nursing Assistant (CNA 1), CNA 1 stated that she took Resident 1 to shower room with CNA 2 and RT 1 on [DATE], at 10:30 AM. CNA 1 saw RT 1 disconnected Resident 1 from ventilator and attached it to Ambu bag (a device used to provide positive pressure ventilation to patients who are not breathing or have difficulty breathing). Upon returning from the shower RT 1 disconnected Ambu bag and reconnected Resident 1 back to the ventilator. CNA 1 further stated she did not see the ventilator being turned on. During an interview on [DATE], at 2:00 PM, with RT 1, RT 1 stated that on [DATE], he assisted with Resident 1's shower. RT 1 reported shower took approximately 30 minutes, from 10:30 AM to 11:00 AM. RT 1 stated, he disconnected Resident 1 from the vent and connected to Ambu bag to 10 liters per minute (L/min) of oxygen cylinder for transfer to shower gurney (hospital stretcher or transport bed). Upon returning from the shower, RT 1 stated he reconnected Resident 1 to the ventilator, resumed ventilation from standby mode, and performed dressing change on tracheostomy. RT 1 further stated during routine rounds at 1:35 PM, RT 1 found Resident 1 was lying in bed, pale, eyes closed, unresponsive, no pulse or respirations, and the ventilator was on standby mode. RT 1 notified charge nurse and code blue started immediately. During an interview on [DATE], at 2:25 PM, with CNA 2, CNA 2 stated that she was working with CNA 1 on [DATE], and helped with showering Resident 1. which took 30 minutes to complete the task. CNA 2 further stated RT1 connected Resident 1 back to the ventilator and</p>		