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	08/27/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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

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	08/27/2025

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 0604 Level of Harm - Minimal harm or potential for 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 staff implemented appropriate interventions and oversight of restraints for two of eight sampled residents (Resident 38 and Resident 45) when: 1. Resident 38's mitten restraint (soft hand cover used to prevent a person from scratching or removing medical devices) was not properly worn or secured to Resident 38's right hand. 2. Resident 45's restraint was not reassessed monthly as required by the facility's policy and procedures (P&P) for Restraint, Physical Guidelines for Use and Assessment. These failures had the potential to result in unsafe restraint use, decreased resident safety and violation of residents' rights. Findings: 1. A review of resident 38's Face sheet (FS-Document containing resident demographics), indicated, Resident 38 was admitted to the facility on [DATE]. A review of Resident 38's History and Physical (H&P- a document containing demographic information), dated January 9, 2025, indicated, Resident 38 had a history of tracheostomy (trach-a small surgical hole made in the front of the neck into the windpipe to help a person breath) dependent, gastrostomy (G tube-a small tube placed through the skin into the stomach to give foods, liquids, and medicine) dependent, spastic quadriplegic cerebral palsy (a condition that makes all four limbs stiff and hard to control), and intractable epilepsy (seizures or a sudden burst of abnormal brain activity that causes temporary changes in movement, behavior, or awareness) that are very hard to control with medication). During an observation on August 24, 2025, at 2:07 PM, in room [ROOM NUMBER], Resident 38 was observed with right hand mitten restraint completely off, laying on stomach, and was lifting right arm near the trach. No staff or family members were present in the room. During a concurrent observation and interview on August 24, 2025, at 2:11 PM, with Licensed Vocational Nurse (LVN 3), in room [ROOM NUMBER], Resident 38 was observed to have mitten restraint completely off. LVN 3 verified and stated that Resident 38 should have mitten restraint to the right hand. LVN 3 stated it is important for the mitten restraint to be reapplied because Resident 38 tends to grab on things. A review of Resident 38's orders, dated April 11, 2024, indicated, Resident 38 had an order for Mitten to R [Right] Hand. indication for restraints: Pulling at Lines, Tubes, or Dressing. During an interview on August 24, 2025, at 4:54 PM, with Resident 38's father, he stated, the reason that Resident 38 was on restraint's because she puts her hands in her mouth, makes herself gag and pulls on things. During an interview on August 24, 2025, at 5:02 PM, with LVN 3, LVN 3 stated, it was a shared responsibility between Certified Nurse Assistant (CNAs) and LVNs for monitoring residents' restraints. LVN 3 further stated that improper restraint application can lead to pulling and dislodging devices. During a concurrent interview and record review on August 27, 2025, at 12:07 PM, with the Director of Nursing (DON) and the administrator (Admin), the facility's P&P titled, Restraint, Physical Guidelines for Use and Assessment, dated September 2020, was reviewed. The P&P indicated .Padded Hand mittens.to keep the resident's movements from pulling out tubes. tracheostomy tubes.wrap webbing around the resident's wrist and secure webbing with the slider buckle.tighten webbing sufficiently to prevent from removing mittens. The DON stated that the policy was not followed since Resident 38 was able to get out of the restraint. The DON further stated it is important to follow the policy to keep the residents from harming themselves. 2. A review of Resident 45's FS, indicated, Resident 45 was admitted to the facility on [DATE]. A review of Resident 45's H&P, dated May 8, 2025, indicated that Resident 45 had a history of agitation and restlessness with potential to harm self, intracranial hemorrhage (bleed inside the brain), trach dependent, and G-tube dependent. During an observation on August 24, 2025, at 10:15 AM, Resident 45 had a mitten restraint to right arm. During an interview on August 24, 2025, at 10:18 AM, with Charge Nurse (CN 1), CN 1 stated, the facility will reassess the need for restraints every month, the interdisciplinary team (IDT- a group of healthcare professional who work together to plan and coordinate a resident's care) will discontinue the restraint if the resident passes a 72-hour trial without needing the restraint. A concurrent interview and record review on August 24, 2025, at 3:10 PM, with CN 1, Resident 45's physical restraint medical symptom summary sheet, dated from January 1, 2025, through, August 2025, was reviewed. CN 1 confirmed, Resident 45's restraint was last reviewed on June 30, 2025 (55 days from last assessed). CN 1 stated sometimes they are a little late documenting it into the chart. CN 1 verified that the month of July was missing. CN1 stated, the person who updated the form was Minimum Data Set Nurse (MDSN). During a concurrent interview and record review on August 24, 2025, at 3:38 PM, with the MDSN, Resident 45's physical restraint medical symptom summary sheet, dated January 1, 2025, through, August 2025

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	08/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatments and services to promote wound healing and prevent pressure ulcer (PU- a sore that develops on the skin when there is too much pressure on one area for a long time) development for two of 12 sampled residents (Resident 7 and Resident 37) when: 1. For two residents (Resident 7 and Resident 37), who were at risk for PU development, the repositioning was not documented every two hours. 2. For Resident 37, low air mattress was programmed with the incorrect resident weight. These failures may have contributed to the development of pressure ulcers in Resident 7 and Resident 37, potentially exposing them to harm and resulting in prolonged hospitalization. Findings: 1a. A review of Resident 7’s “admission Record (contains medical and resident demographics), undated, indicated, Resident 7 was admitted to the facility on [DATE]. A review of Resident 7’s “History & Physical” (H&P- a document containing demographic information), dated September 8, 2024, indicated, Resident 7 has a history of decubitus ulcer (a sore on the skin from lying in one spot for too long) of coccyx (the small tailbone at the bottom of the spine), tracheostomy (trach- a small surgical hole made in the front of the neck into the windpipe to help a person breath) dependent, gastrostomy (G-tube-a small tube placed through the skin into the stomach to give foods, liquids, and medicine) dependent, and anoxic encephalopathy (brain damage caused by lack of oxygen). A review of Resident 7’s “Pressure Ulcer Treatment Care plan,” dated March 14, 2025, through August 23, 2025, indicated “turn and reposition at least q [every] 2 hours.” A review of Resident 7’s “Wound Care Note,” dated May 16, 2023, indicated, Resident 7 had a wound to the “Sacro coccyx [the lower end of the spine where the sacrum and tailbone meet] .type…partial thickness… Measurements (length/width/depth): 1 X [BY] 1 CM [Centimeter-unit of measurement] …. Right ischial tuberosity [the bones that support your weight when you sit down] …type: …partial thickness… measurements (length/width/depth) 2 x 3 cm…Braden score [BS-a tool used to assess a patient's risk for developing pressure injury. Score of 15-18 at risk, score 13-14 moderate risk, 10-12 high risk, 9 or below indicates very high risk] 10…turn q2h [every 2 hours]. ” A review of Resident 7’s “Wound Care note,” dated June 24, 2025, indicated Resident 7 had a wound to “Location: Sacro coccyx…type: Reopened Stage 4 [full thickness skin and tissue loss, muscle, tendons, ligaments cartilage or even bone is visible.] Pressure Injury [PI- a sore that develops on the skin when there is too much pressure on one area for a long time]…Measurements (length/width/depth): 1.8 cm X 2.5 cm X 1.2 cm…tunneling…1.8 cm… Location: Right ischial tuberosity…type: stage 3{full-thickness skin loss where subcutaneous fat is visible, but bone, tendon, or muscle is not exposed] pressure injury…measurements (length/width/depth): 1.5 cm x 0.5 cm x 1.7 cm…Braden score: 10… reposition: turn q2h…” (continued on next page)

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	08/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent interview and record review on August 27, 2025, at 12:29 PM, with the Director of Nursing (DON) and Administrator (Admin), Resident 7’s “ADLS [activity of daily living, including turns]”, dated August 1, 2025, through August 26, 2025, was reviewed. The “ADLS” for repositioning was completed as follows: On August 19, 2025, at 10:00 PM: position supine (on the back) On August 19, 2025, at 1:36 AM: position supine (3.5 hours without turn) On August 25, 2025, at 12:40 AM: position “head of the bed elevated” On August 25, 2025, at 10:02 AM: position “head of the bed elevated” (9 hours and 22 minutes without turn) The DON verified and confirmed that the nursing staff did not document repositioning every two hours and should have. The DON further stated that “head of the bed elevated” did not count as a turn. A follow-up concurrent interview and record review on August 27, 2025, at 12:32 AM, with the DON and Admin, the facility’s policy and procedure (P&P) titled, “Skin Care, prevention,” dated February 2024, was reviewed. The P&P indicated, “…Turn and reposition the dependent resident at least every two hours, and as needed…” The DON stated that the expectation for the staff was to turn the residents at least every two hours. The DON further stated that nursing staff did not follow the policy and should have to promote healing and to maintain the quality of life for the residents. 1b. A review of Resident 37’s “admission Record, undated, the “admission Record” indicated Resident 37 was admitted to the facility on [DATE]. During a review of Resident 37’s “History & Physical, dated August 25, 2025, the H&P indicated Resident 37 had diagnoses which included obesity (a chronic condition characterized by excessive body fat accumulation that poses a risk to health), encephalopathy (a broad term for any diffuse brain disease altering brain function), tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) to provide an artificial airway) and a gastric feeding tube (a thin, flexible tube inserted into the stomach through the abdominal wall to provide nutrition when a person cannot eat adequately by mouth). During an observation on August 26, 2025, at 5:45 AM, in Resident 37’s room, Resident 37 was lying on a low air loss mattress (a specialized mattress used to help treat and prevent pressure ulcers) and was turned to her left side. A sign titled, “turn clock” (schedule indicating at what times residents are supposed to be turned and in what direction) posted above the head of Resident 37’s bed indicated the resident was supposed to be turned to her left from two to four, and to her right from four to six. (continued on next page)

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	08/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on August 26, 2025, at 5:54 AM, with Certified Nursing Assistant 3 (CNA 3), in Resident 37’s room, CNA 3 acknowledged Resident 37 was turned to the left side despite the “turn clock” indicating the resident was supposed to be on her right side from four to six. CNA 3 further stated Resident 37 had been turned to her left side since 4:45 AM. CNA 3 stated residents were supposed to be turned every 2 hours. During further interview on August 26, 2025, at 6:04 AM, with CNA 3, CNA 3 stated at 4:45 AM she (CNA 3) had to change Resident 37’s brief and when she was done, she did not turn Resident 37 to the right side (as indicated on the turning schedule) because by the time 6:00 AM would have come around, she would not have had enough time to return back to Resident 37 to turn her because she knew she would have been busy changing all the other residents on the unit before shift change. CNA 3 then stated she wanted Resident 37 to be on the left side so she was turned to the correct side as indicated by the turning schedule at the time shift change occurred at 7:00 AM. During continued observation on August 26, 2025, at 6:50 AM, Resident 37 was still turned to her left side and no staff had turned Resident 37 from the time Resident 37 was initially observed to be turned to the left side at the 5:45 AM observation. During continued observation on August 26, 2025, at 7:13 AM, Resident 37 was still turned to her left side and no staff had turned Resident 37 from the time Resident 37 was initially observed to be turned to the left side at the 5:45 AM observation. During continued observation on August 26, 2025, at 7:48 AM, Resident 37 was still turned to her left side and no staff had turned Resident 37 from the time Resident 37 was initially observed to be turned to the left side at the 5:45 AM observation. During continued observation on August 26, 2025, at 8:15 AM, CNA 4 entered Resident 37’s room and turned Resident 37 from her left to her right side (Three hours and thirty minutes had passed since 4:45 AM). During an interview on August 26, 2025, at 2:09 PM, with Registered Nurse 3 (RN 3), RN 3 stated all residents were supposed to be turned every two hours for the prevention of pressure ulcers. During an interview on August 27, 2025, at 2:20 PM, with the DON, the DON stated residents were supposed to be turned every two hours as indicated on their turning schedule. During a review of Resident 37’s Minimum Data Set Assessment (MDS assessment – a comprehensive assessment of the resident), dated July 24, 2025, the MDS assessment indicated in section M0150 “Risk of Pressure Ulcers/injuries,” that Resident 37 was at risk for development of pressure ulcers/injuries. During a review of Resident 37’s care plan titled, “Pressure Ulcer Risk Care Plan,” dated February 15, 2025, the care plan indicated, “…At risk for further pressure ulcer related to: -history of resolved pressure ulcer; presence of compromised scarred tissue, -Immobility, -incontinent bowel…Interventions…Turn and reposition at least every 2 hours…” (continued on next page)

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	08/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s P&P titled, “Skin Care, Turning,” dated February 2024, the P&P indicated, “…It is the policy of this facility to turn and re-position all dependent residents a minimum of every two hours routinely, and as needed. It is the policy of this facility to provide skin care to dependent residents every two hours at the time of turning and as needed…” 2. A review of Resident 37’s “admission Record,” undated, the “admission Record” indicated Resident 37 was admitted to the facility on [DATE]. During a review of Resident 37’s H&P, dated August 25, 2025, the H&P indicated Resident 37 had diagnoses which included obesity, tracheostomy, and a gastric feeding tube. During an observation on August 24, 2025, at 12:11 PM, in Resident 37’s room, Resident 37 was lying on a low air loss mattress. The programmable setting of the low air loss mattress was set to 350 – (to) 500 pounds (lbs—unit of weight). During a concurrent observation and interview on August 24, 2025, at 12:23 PM, with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated she was the nurse assigned to Resident 37 and confirmed Resident 37’s low air loss mattress was set to 350 – 500 lbs. LVN 8 stated the weight setting was incorrect. LVN 8 then looked up Resident 37’s weight in the electronic health record and stated Resident 37 weighed 133 lbs. LVN 8 stated she was not aware the low air loss mattress was set for the incorrect weight and stated the programmed weight should have been 100 – 165 lbs. LVN 8 further stated it was important that the low air loss mattress was programmed accurately for the residents weight because it changed the way the air mattress worked and it was most beneficial to the residents if it was programmed to the residents correct weight. During a review of Resident 37’s physician’s orders, dated January 28, 2025, the physician’s orders indicated, “Low air loss overlay…Citadel 200 bed for wound management.” During a review of Resident 37’s care plan titled, “Pressure Ulcer Risk Care Plan,” dated February 15, 2025, the care plan indicated, “…At risk for further pressure ulcer related to: -history of resolved pressure ulcer; presence of compromised scarred tissue, -Immobility, -incontinent bowel…Interventions…Pressure redistribution mattress as needed…” During an interview on August 26, 2025, at 2:09 PM, with RN 3, RN 3 stated the Citadel 200 bed was supposed to be set specifically for the residents’ weight range. RN 3 further stated it was important to ensure the low air loss mattress was set appropriately because depending on the residents’ weight, the bed would adjust its settings. During an interview on August 27, 2025, at 2:20 PM, with the DON, the DON stated the Citadel bed was a low air loss mattress and staff were expected to ensure the bed setting was set to match the residents’ weight. The DON stated the bed used the programmed weight range to change the air flow in the mattress. (continued on next page)

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	08/27/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s P&P titled, “Skin Care, Prevention,” dated February 2024, the P&P indicated, “Policy: To maintain skin integrity; to prevent skin and tissue breakdown and the development of pressure sores…8.5 Consistently use pressure reducing devices such as pressure relief mattresses, static air, alternating air, gel, or water type mattresses or overlays as ordered…”

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	08/27/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of six sampled residents (Resident 5) received necessary treatment and services to maintain, increase range of motion (ROM- moving the joints to keep them flexible and prevent stiffness) or prevent further decline when nursing staff did not perform ROM as ordered by physician and specified in the care plan (a guide for nurses to follow regarding the plan of care). This failure had the potential to result in decreased mobility and pain and increased the risk of further contractures (muscles and tendons have tightened and shortened).Findings: A review of Resident 5's Face sheet (FS-Document containing resident demographics), indicated, Resident 5 was admitted to the facility on [DATE]. A review of Resident 5's History & Physical (H&P- a document containing demographic information), dated May 6, 2025, indicated, Resident 5 has a history of cerebral palsy (CP-a condition that affects movement, balance, and muscle control), tracheostomy (trach- a small surgical hole made in the front of the neck into the windpipe to help a person breath) dependent, gastrostomy (G-tube-a small tube placed through the skin into the stomach to give foods, liquids, and medicine) dependent, severely contracted, and epilepsy (seizures or a sudden burst of abnormal brain activity that causes temporary changes in movement, behavior, or awareness). A review of Resident 5's Active orders, dated January 19, 2023, indicated Range of motion LTC [long term care] BID [2 times a day] provide PROM [Passive range of motion- a health care provider moves resident's joints for them like bending an arm or leg] exercises to BUE [both arms] q [every] AM shift [7:30 AM to 7:00 PM] and BLE [both legs] q night shift [7:30 PM to 7:00 AM] as tolerated. A review of Resident 5's ROM Care Plan, dated April 2025, through October 2025, indicated, PROM exercises to BUE Q AM shift, BLE Q NOC [night] shift as tolerated. A concurrent interview and record review on August 26, 2025, at 1:45 PM, with Certified Nursing Assistant (CNA 1), Resident 5's Restorative Activity Prom, dated from July 31, 2025, through August 26, 2025, was review. The Restorative Activity Prom for repositioning was not completed every shift as follows: July 31, 2025: AM shift: no documentationAugust 1, 2025: AM and PM shift: no documentationAugust 2, 2025: AM and PM shift: no documentationAugust 3, 2025: AM and PM shift: no documentationAugust 11, 2025: AM and PM shift: no documentationAugust 12, 2025: AM and PM shift: no documentationAugust 13, 2025: AM and PM shift: no documentationAugust 14, 2025: PM shift: no documentationAugust 15, 2025: AM and PM shift: no documentationAugust 16, 2025: AM shift: no documentation CNA 1 verified and confirmed the missing ROM. CNA 1 stated, she was unable to provide other documented evidence to show Resident 5 received ROM every shift. CNA 1 stated it was important to complete the ROM as ordered to prevent residents from getting further contracted. CNA 1 stated that the CNAs were responsible for providing the ROM. During a concurrent interview and record review on August 27, 2025, at 11:27 AM, with the Director of Nursing (DON) and Administrator (Admin), the facility's policy and procedure (P&P) titled, Nursing care, restorative & supportive, dated February 2024, was reviewed. The P&P indicated, Restorative and supportive care shall include: .Providing range of motion to maintain joint mobility, prevent contractures or prevent further deterioration and complications of limited range of motion. The DON stated the policy was not followed, and the nursing staff was expected to follow the physician orders and complete documentation. The DON further stated that it was important to provide ROM as ordered for patient safety.

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	08/27/2025

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 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. Based on observation, interview, and record review, the facility failed to ensure the safety and security of medications when Licensed Vocational Nurse 5 (LVN 5) left 12 medications on a computer desk unattended, and unsecured in a resident's room. This failure had the potential to place all 87 residents living on the unit at risk of harm due to increased risk for medication diversion (when a medication is taken for use by someone other than whom it was prescribed.)Findings: During a concurrent observation and interview on August 26, 2025, at 8:46 AM, with LVN 5, in Resident 18's room, LVN 5 placed 12 medications on a portable computer desk located at the bedside of Resident 18. The 12 medications included:-Glycopyrrolate (a medication commonly used to treat stomach ulcers or to inhibit respiratory secretions) 1 milligram (mg - unit of measure) tablet crushed-Vitamin C 500 mg tablet crushed-baclofen (a muscle relaxant) 10 mg tablet crushed-sennosides/docusate/sodium (a combination medication used to treat constipation) 8.6 mg /(per) 50 mg tablet crushed-amlodipine besylate (medication used to treat high blood pressure) 5 mg tablet crushed-vitamin D3 10 micrograms (mcg - unit of measure) 400 international units (iu - unit of measure) tablet crushed-Famotidine (medication used to treat stomach ulcers) 20 mg tablet crushed-carmex ointment (lip moisturizer) 10 mg topical (applied to the skin)-calcium carbonate (an antacid commonly used to treat heartburn or upset stomach) 500 mg tablet crushed-mineral oil USP (commonly used to treat dandruff) 30 milliliters (ml - unit of measure) topical-polyethelene glycol powder (laxative used to treat constipation) 3350 17 grams (gm - unit of measure)-multivitamin w/minerals liquid 15 mls LVN 5, then left Resident 18's room to retrieve a blood pressure cuff and left the 12 medications on the computer table at the bedside of Resident 18 who was lying in bed. LVN 5 returned a few minutes later and stated the unit only had three blood pressure cuffs and she had to go find one. LVN 5 then administered all 12 medications to Resident 18. During an interview on August 26, 2025, at 9:00 AM, with LVN 5, LVN 5 stated she needed to get a blood pressure cuff so she had to leave Resident 18's room. LVN 5 further stated that she should not have left medications unattended, especially with the behavioral health unit (a hospital-based unit or standalone facility that provides intensive, structured care for individuals experiencing a mental health crisis or substance abuse issues) right next door. 5 acknowledged the increased risk of someone coming into the room and consuming or taking the medications when they were not supposed to. During an interview on August 27, 2025, at 2:20 PM, with the Director of Nursing (DON), the DON stated staff should never leave medications unattended if they were not locked in a drawer or locked in a medication cart. During a review of the facility's policy and procedure (P&P) titled, Safe Storage of Medications, dated January 2023, the P&P indicated, Purpose: To outline procedures for safe storage of medications. Policy: Medications will be stored under appropriate conditions to maintain medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors.All medications dispensed from the pharmacy and not immediately administered to the patient must be secured in an approved medication storage area, including locked medication carts, treatment carts, medication rooms, medication refrigerators, or automated dispensing machines.2.0 Medication storage areas must be secured at all times so that unauthorized persons cannot obtain access to them. 2.1 Medication carts and treatment carts containing medications must be locked unless under the direct supervision of the nurse or other licensed/registered personnel.

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	08/27/2025

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 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** Based on observation, interview, and record review the facility failed to maintain an infection control program for 14 of 85 sampled residents (Resident 16, 18, 22, 24, 33, 41, 43, 52, 63, 68, 77, 82 and 83) when: 1. For one resident (Resident 41), there was no date or staff initial on Resident 41's gastro enteral tube (G tube- a feeding tube inserted through abdomen into the stomach to provide nutrition, fluids, and medication directly to the digestive system) and water flush bag (a bag with water administered to residents through G tube). 2. For 10 residents (Resident 83, 82, 63, 77, 52, 68, 22, 60, 24, and 41), suction tubes(a plastic tube used to remove bodily fluids and secretions, or foreign materials from a body cavity or passage by creating vacuum) were not used according to the policy and procedures (P&P) for disposable equipment change associated with artificial airway(a medical device such as a tube or other devices inserted into a patient's respiratory track to maintain and open airway) and mechanical ventilators (a medical procedure where a machine is used to assist or replace a person's breathing). 3. For four resident (Resident 83, 33, 43 and 18), the facility staff did not use appropriate proper personal protective equipment (PPE- equipment used to minimize injuries and illness) during medication administration. 4. For one resident (Resident 16) the facility staff did not wear appropriate PPE during transfer of a resident from shower. These failures had the potential to place residents at a greater risk for spreading infection from cross-contamination (the transfer of harmful bacteria) causing a preventable infection and negative impact on residents' health and safety.Findings: 1. During a review of Resident 41’s “Record of Admission” (demographic data), undated, the “Record of Admission” indicated, Resident 41 was admitted to the facility on [DATE], with the diagnosis of respiratory failure (a medical condition in which the lungs are unable to adequately exchange oxygen and carbon dioxide father in the body). During a review of Resident 41’s “Orders”, dated August 7, 2025, the “Orders” indicated, Resident 41 was ordered to be on continuous GT feeding with [Formula Name] with the rate to be given at 55 milliliters [ml—unit measurement] per hour. During a concurrent observation and interview on August 24, 2025, at 10:40 AM, with Licensed Vocational Nurse (LVN 4), in Resident 41’s room, Resident 41’s G tube feeding bottle and water flash bag were observed with no date and initials on label. LVN 4 acknowledged that label did not have date and initials. LVN 4 stated that the nursing staff was expected to date and initial on the label for the G tube feeding bottle and water flush. LVN 4 further stated that G tube feeding bottle and water flush were scheduled to be changed every 24 hours, as this label did not have the date and initials it would be hard to say when it was hung. During a concurrent observation and interview on August 24, 2025, at 10:45 AM, with the Infection Preventionist (IP) nurse, Resident 41’s G tube feeding bottle and water flush bag were observed with no date and initials on the label. The IP nurse confirmed that G tube feeding and water flush bag has no date and initials on the label. The IP nurse stated the nursing staff were expected to complete the label with the details including date, time and initials when the G tube feeding was hung. The IP nurse further stated it was an infection control concern when the nursing staff did not know when the G tube feeding was hanged. (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on August 24, 2025, at 11:10 AM, with Registered Nurse 2 (RN 2), Resident 41’s G tube feeding bottle and water flush bag were observed with no date and initials on the label. RN 2 acknowledged that the label has no date and initials. RN2 stated that the nursing staff was expected to complete the label with date and initials to know when the G tube feeding was hung. RN 2 further stated, it was a concern for infection control since the bag should be changed every 24 hours as per policy. During a concurrent interview and record review on August 27, 2025, at 2:50 PM, with the IP, the facility’s policy and procedure (P&P) titled, “Administration of formula via feeding tube, gravity, bolus, pump”, dated March 2024, was reviewed. The P&P indicated, “…. Pump or infusion control method . 17.0 pump bags, syringes and tubing are to be changed every 24 hours and properly labeled with date, time and nurses initials”. The IP stated, the policy was not followed. 2a. During a review of Resident 83’s “Face sheet” (demographic data), undated, the “Face sheet” indicated, Resident 83 was admitted to the facility on [DATE], with the diagnosis of respiratory failure. During a review of Resident 83’s “Order”, dated May 17, 2023, the “Orders” indicated, Resident 83 needed suction twice daily. 2b. During a review of Resident 82’s “Face sheet”, undated, the “Face sheet” indicated, Resident 82 was admitted to the facility on [DATE], with the diagnosis of chronic respiratory failure. During a review of Resident 82’s “Orders”, dated January 18, 2017, the “Orders” indicated, Resident 82 needed to be evaluated for suction at least every two hours and as needed. 2c. During a review of Resident 63’s “Face sheet”, undated, the “Face sheet” indicated, Resident 63 was admitted to the facility on [DATE], with the diagnoses of respiratory failure and cardiac arrest (a condition in which the heart suddenly stops beating effectively). During a review of Resident 63’s “Orders”, dated November 22, 2023, the “Orders” indicated, Resident 63 needed to be evaluated for suction at least every two hours and as needed. 2d. During a review of Resident 77’s “Face sheet”, undated, the “Face sheet” indicated, Resident 77 was admitted to the facility on [DATE], with the diagnosis of chronic respiratory failure. During a review of Resident 77’s “Orders”, dated January 18,2017, the “Orders” indicated, Resident 77 needed to be evaluated for suction at least every two hours and as needed. (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2e. During a review of Resident 52’s “Face sheet”, undated, the “Face sheet” indicated, Resident 52 was admitted to the facility on [DATE], with the diagnoses of chronic respiratory failure and anoxic brain (a condition in which brain does not receive enough oxygen even when blood flow is adequate). During a review of Resident 52’s “Orders”, dated July 11, 2025, the “Orders” indicated, Resident 52 needed to be evaluated for suction at least every two hours and as needed. 2f. During a review of Resident 68’s “Face sheet”, undated, the “Face sheet” indicated, Resident 68 was admitted to the facility on [DATE], with diagnosis of respiratory failure. During a review of Resident 68’s “Orders”, dated April 18, 2024, the “Orders” indicated, Resident 68 needed to be evaluated for suction at least every two hours and as needed. 2g. During a review of Resident 22’s “Face sheet”, undated, the “Face sheet” indicated, Resident 22 was admitted to the facility on [DATE], with the diagnoses of bronchial asthma (a condition in which persons airway becomes inflamed narrow and swollen and produce mucus which makes difficulty to breathe), and cerebral palsy (a continental disorder of movement muscle tone and posture). During a review of Resident 22’s “Orders”, dated January 30, 2025, the “Orders” indicated, Resident 22 needed to be evaluated for suction at least every two hours and as needed. 2h. During a review of Resident 60’s “Face sheet”, undated, the “Face sheet” indicated, Resident 60 was admitted to the facility on [DATE], with the diagnosis of respiratory failure. During a review of Resident 60’s “Orders”, dated November 29, 2021, the “Orders” indicated, Resident 60 needed to be evaluated for suction at least every two hours and as needed. 2i. During a review of Resident 24’s “Record of “Face sheet”, undated, the “Face sheet” indicated, Resident 24 was admitted to the facility on [DATE], with a diagnosis of respiratory failure. During a review of Resident 24’s “Orders”, dated May 24, 2023, the “Orders” indicated, Resident 24 needed to be suctioned twice daily. 2j. During a review of Resident 41’s “Face sheet”, undated, the “Face sheet” indicated, Resident 41 was admitted to the facility on [DATE], with the diagnosis of Respiratory Failure. (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 41’s “Orders”, dated January 16, 2017, the “Orders” indicated, Resident 41 needed to be evaluated for suction at least every two hours and as needed. During an observation on August 24, 2025, from 10:00 AM through 11:00 AM, Resident’s 83, 82, 63, 77, 52, 68, 22, 60, 24, and 41 was observed to have suction tube (a medical tube that connect to a machine to get rid of patient’s fluid) with no labels connected to suction canister (a container used to store body fluids, such as mucus, blood, secretions using a negative pressure suction) by their bedside. During a concurrent observation and interview on August 24, 2025, at 11:15 AM, with Respiratory Therapist (RT1), the suction tubings with no labels were observed. RT1 acknowledged and confirmed that the suction tubings did not have labels. RT1 stated suction tubings were a shared responsibility between respiratory therapists and nursing staff. RT1 further stated, the section tube should be labeled with date and initials so that staff would know when the tubing must be changed. During a concurrent observation and interview on August 24, 2025, at 11:20 AM, with the IP, the suction tubing with no labels were observed. The IP confirmed that the suction tubing was missing labels. The IP stated staff were expected to place a label with date and initials according to the policy. The IP further stated, it is a concern for infection control as staff would not know when the suction tubing was placed and needed to be changed. During a concurrent interview and record review on August 27, 2025, at 2:55 PM, with the IP nurse, the facility’s P&P titled, “disposable equipment change associated with artificial airway and mechanical ventilators”, dated March 2023, was reviewed. The P&P indicated, “… purpose: to define the frequency at which disposable supplies associated with mechanical ventilation are changed… Procedures: all disposable equipment used in the provision of care to the patient with an artificial airway, including mechanical ventilation and aerosol therapy, is changed according to the frequency identified for each respective device. The Inline suction catheter is changed every 24 hours and as needed.1. 4.2 a sticker, indicating the day the unit is to be changed”. The IP stated the policy was not followed. 3a. During an observation on August 26, 2025, at 8:03 AM, in Resident 83’s room, LVN 1 was observed to administer medication to Resident 83 through G tube by wearing gloves. During an interview on August 27, 2025, at 8:40 AM, with LVN 2, LVN 2 stated that it was not necessary to wear gown while passing medications. LVN 2 further stated, some staff preferred to use gown while passing medications to prevent spilling off medications to their scrub. During an interview on August 27, 2025, at 8:48 AM, with Registered Nurse 1 (RN 1), RN 1 stated, staff were expected to wear gown and gloves while passing medications. RN 1 further stated, staff were expected to follow enhanced barrier precautions during the care provided for residents to prevent infections. 3b. A review of Resident 33’s “Record of Admission”, indicated, Resident 33 was admitted to the facility on [DATE]. (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 33’s “History and Physical (H&P - Contains medical history, diagnoses and assessments), dated April 28, 2025, indicated, Resident 33 has medical history of tracheostomy dependent, gastrostomy dependent, cerebral palsy, and epilepsy (seizures or a sudden burst of abnormal brain activity that causes temporary changes in movement, behavior, or awareness). During a medication administration observation on August 26, 2025, at 8:15 AM, with LVN 6, LVN 6 did not wear a gown despite having to give medication to Resident 33, through G-tube 3c. A review of Resident’s 43 “Record of admission” indicated, Resident 43 was admitted to the facility on [DATE]. A review of Resident 43’s H&P, dated February 11, 2025, indicated Resident 43 has medical history of Tracheostomy dependent, G-tube dependent, cerebral palsy, epilepsy and shaken baby syndrome (a serious brain injury caused by violently shaking an infant leading to bleeding, swelling or even death.) During a medical administration observation on August 27, 2025, at 8:15 AM, with LVN 7, LVN 7 did not wear a gown despite having to give medications to Resident 43 through G-tube. During an interview on August 27, 2025, at 8:18 AM, with LVN 7, LVN 7 stated, Resident 43 was not on any type of precautions such as droplet (keeping germs from spreading though cough sneezes or talking by using a mask, gown, gloves, and proper hand hygiene), contact precautions (keeping germs from spreading through touch by wearing a gown, gloves, and proper hand hygiene), or enhanced barrier precautions. LVN 7 stated that she was not wearing an isolation gown because she did not have a chance to grab it prior to administering medication. LVN 7 stated she puts on a gown when administering medications because of personal preference but indicated that the staff did not have to gown up unless they are on contact, droplet, or EBP precautions. 3d. During a review of Resident 18’s “Record of Admission”, undated, the “Record of Admission” indicated, Resident 18 was admitted to the facility on [DATE]. During a review of Resident 18’s H&P, dated July 10, 2025, the H&P indicated Resident 18 was admitted to the facility with diagnoses which included chronic respiratory failure with hypoxia (a long-term condition where the lungs and respiratory system cannot get enough oxygen into the blood, resulting in dangerously low blood oxygen levels (hypoxemia) over time), and anoxic brain injury (a condition where the brain does not receive enough oxygen for an extended period, leading to damage or death of brain cells). (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on August 26, 2025, at 8:51 AM, with LVN 5, LVN 5 was preparing to administer medications to Resident 18 who was lying in his bed. Resident 18 had a tracheostomy (a surgical procedure that creates an opening in the trachea (windpipe) to provide an artificial airway) and a gastric feeding tube (a thin, flexible tube inserted into the stomach through the abdominal wall to provide nutrition when a person cannot eat adequately by mouth). Without wearing a PPE gown (protective garment worn in healthcare which provide a physical barrier that covers the torso and arms, helping to prevent the transmission of microorganisms by acting as a barrier between healthcare workers and patients), LVN 5 accessed Resident 18’s gastric feeding tube with a 60 cubic centimeter (cc – unit of measure) syringe, checked gastric residual (volume of stomach contents), and verified correct placement (ensured the feeding tube was positioned in the stomach). LVN 5, while still not wearing a PPE gown, then administered 10 medications to Resident 18 through the residents gastric feeding tube. During an interview on August 26, 2025, at 2:38 PM, with LVN 5, LVN 5 stated when she administered medications to Resident 18, she did not have on a gown because a gown was optional and not required since Resident 18 was not in an isolation room (a room designated specifically with transmission based isolation precautions) because Resident 18’s room did not have an isolation sign posted outside the doorway and therefore it was not a requirement to wear a gown during patient care activities. During an interview on August 27, 2025, at 2:05 PM, with the IP, the IP stated all three of the skilled nursing facility units required EBP during high contact care activities. The IP further stated all residents in the skilled nursing facility were under EBP because they all either had a tracheostomy, required mechanical ventilation (the use of a machine that helps you to breathe or breathes for you), or had gastric feeding tubes and staff were supposed to wear a gown and gloves during the “six moments of care” which included: morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave a room, and cleaning and disinfecting the environment. During an interview on August 27, 2025, at 2:14 PM, with the DON, the DON stated staff were supposed to be following EBP and wear a gown and gloves when administering medications to residents who had a feeding tube. (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility’s P&P titled, “Enhanced Barrier Precautions,” dated March 2025, the P&P indicated, “The purpose of Enhanced Barrier Precautions (EBP) is to reduce the spread of multidrug-resistant organisms (MDROs) in the nursing homes…EBP Guidelines…1.5 EBP are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized…Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident activities include: -Dressing – Bathing/showering – Transferring – Providing hygiene – Changing linens – Changing briefs or assisting with toileting – Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator – Wound care: any skin opening requiring a dressing…Indwelling medical Devices: include, but are not limited to, central vascular lines (including hemodialysis catheters), indwelling urinary catheters, feeding tubes, and tracheostomy tubes…” 4. During a review of Resident 16’s “Record of Admission”, undated, the “Record of Admission” indicated Resident 16 was admitted on [DATE]. During a review of Resident 16’s H&P, dated May 17, 2025, the H&P indicated Resident 16 was in a vegetative state (a condition in which a person is awake but unaware of their surroundings or themselves) and had diagnoses which included chronic respiratory failure with hypoxia, and anoxic encephalopathy (a condition where the brain experiences a deprivation of oxygen which leads to widespread damage to brain cells), and was status post (previously had surgery for) tracheostomy and gastric feeding tube. During an observation on August 26, 2025, at 2:45 PM, in Resident 16’s room, Certified Nursing Assistant 2 (CNA 2) was returning from the shower with Resident 16. Resident 16 was dripping water, had towels draped over him and was lying in a shower bed (a mobile, water-resistant bed/gurney used to wash people with limited mobility) and had a tracheostomy and a feeding tube. CNA 2 stated the facility’s staff had just showered Resident 16 and were going to transfer him back to bed. CNA 2 was wearing a gown which was tied in the back, the head loop was around her neck, but the arm sleeves were not used and were instead tucked into the front of the gown similarly to how one would wear an apron. CNA 2 then transferred Resident 16 from shower bed to his regular bed while wearing her gown without the use of the sleeves. During an observation on August 26, 2025, at 3:03 PM, with CNA 2, CNA 2 retrieved linen from a linen cart which was outside Resident 16’s room. CNA 2 was still wearing her PPE gown like an apron and was not using the sleeves of the gown. (continued on next page)

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	08/27/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on August 26, 2025, at 3:07 PM, with CNA 2, CNA 2 was still wearing her PPE gown like an apron and stated she had just transferred Resident 16 to bed and changed his linens. When asked why she was wearing a PPE gown like an apron without the use of the arm sleeves, CNA 2 stated it was because she often would get too hot when she used the arm sleeves of the gowns so she would not use the sleeves, so she stays cooler. During an interview on August 27, 2025, at 2:05 PM, with the IP, the IP stated EBP were supposed to be used during the “6 moments of care” which included morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave a room, and cleaning and disinfecting the environment. The IP further stated as a part of EBP, staff were supposed to wear a gown and gloves when performing any of the “6 moments of care.” During a follow-up interview on August 27, 2025, at 2:08 PM, with IP, the IP stated, all residents in skilled nursing facility were required to be on EBP since all residents either had a tracheostomy, or a feeding tube. During a follow up interview on August 27, 2025, at 2:12 PM, with the IP, the IP stated, it was not appropriate for any staff member to wear a PPE gown without putting their arms in the sleeves. The IP further stated it was important to wear PPE appropriately to help prevent the spread of infection. During a review of the facility’s P&P titled, “Enhanced Barrier Precautions,” dated March 2025, the P&P indicated, “…1.7 EBP will be followed when performing transfers and assisting during bathing in a shared/common shower room and when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility…Definitions…Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes… High-contact resident activities include: -Dressing – Bathing/showering – Transferring – Providing hygiene – Changing linens – Changing briefs or assisting with toileting – Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator – Wound care: any skin opening requiring a dressing…”

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	08/27/2025

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 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide full visual privacy for two of 28 sampled residents (Resident 59 and Resident 70) when there was no curtain between Resident 59's and Resident 70's bed. This failure had the potential to compromise resident 59's and Resident 70's dignity and right to full visual privacy.Findings: A review of Resident 59's Face sheet (FS-Document containing resident demographics), indicated, resident 59 was admitted to the facility on [DATE]. A review of Resident 59's History & Physical (H&P- a document containing demographic information), dated February 11, 2025, indicated, Resident 59 has a history of cerebral palsy (CP-a condition that affects movement, balance, and muscle control), tracheostomy (trach- a small surgical hole made in the front of the neck into the windpipe to help a person breath) dependent, gastrostomy (G-tube-a small tube placed through the skin into the stomach to give foods, liquids, and medicine) dependent, and seizures (a sudden burst of abnormal brain activity that causes temporary changes in movement, behavior, or awareness.) A review of Resident 70's FS, indicated, Resident 70 was admitted to the facility on [DATE]. A review of Resident 70's H&P, dated June 23, 2025, indicated that Resident 70 has a history of down syndrome (a condition present at birth caused by an extra chromosome, leading to developmental and physical differences), trach dependent, G-tube dependent, and seizures. During an observation on August 24, 2025, at 12:10 PM, in room [ROOM NUMBER], there was no curtain dividing Resident 59 and Resident 70. During an interview on August 24, 2025, at 12:14 PM, with Charge Nurse (CN 1), CN 1 stated that the way the facility staff ensure privacy was having a curtain between residents. During a concurrent observation and interview on August 24, 2025, at 12:16 PM, with CN 1 in room [ROOM NUMBER], the room was observed without a curtain between Resident 59 and Resident 70. CN1 verified and stated she was unsure of how long or the reason of missing the curtain in the room. CN 1 further stated that Environmental Services (EVS) takes care of hanging curtains. CN 1 confirmed there should have been a curtain to provide privacy for both residents. During an interview on August 24, 2025, at 12:31 PM, with EVS Staff (EVSS1), EVSS 1 stated that she was unsure of why there was no curtain or who took off the curtain. During a concurrent interview and record review on August 24, 2025, at 11:39 AM, with the Director of Nursing (DON) and the Administrator (Admin), the facility's policy and procedures (P&P) titled, Resident Privacy and confidentiality, dated February 2024, was reviewed. The P&P indicated, . to assure the resident's right to personal privacy and confidentiality .Nursing staff will use curtain to provide full visual privacy during resident care, toileting, treatments and issues of dignity and other requested times . The DON indicated that the facility's P&P was not followed since there was no curtain in the room. The DON further stated it is important to follow the policy to provide each resident their right to be treated with dignity and respect.