STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555896	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arrowhead Healthcare Center, LLC	4343 N. Sierra Way San Bernardino, CA 92407

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 35183 Based on observation, interview, and record review, the facility failed to post the results of the facility's most recent survey in a place readily accessible to residents, in a universe of 55 residents (Residents 1 to 55), when the survey results were posted in a lobby area whose residents' lobby access door was set to remain locked at all times. This failure had the potential to cause the residents' inability to read the survey results and assess areas like safety, staff competency, and compliance with regulations, which directly impacts their well-being and quality of life within the skilled nursing facility. Findings: During an observation, and interview, with a Registered Nurse Supervisor (RNS 1) and a Licensed Vocational Nurse (LVN 1) on December 17, 2024, at 1:57 PM, the survey results binder was observed posted to a front lobby wall and one door was noted between the residents' living area and the front lobby area. RNS 1 and LVN 1 were seated at the front lobby reception area, and stated the door to the lobby was usually closed and automatically locked on the residents' side for safety to keep the residents from leaving the building. RNS 1 stated the residents did not have free access to the survey results binder due to the door being closed and locked most of the time, They would have to request to see the last survey results binder. During an interview with the Administrator (Admin) on December 17, 2024, at 2:10 PM, the Admin stated the residents' access door to the lobby was normally closed and locked, on the residents' side, to keep the residents from exiting the building unmonitored. The Admin stated the residents did not have free access to the survey results binder and should have. A review of the facility's policy and procedure (P&P) titled, Residents Rights, dated January 2019, indicated, Each resident has a right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside of the facility. The Facility will protect and promote the rights of each resident including each of the following rights: . The resident has a right to examine the results of the most recent survey of the facility conducted by the Federal or State surveyors and with any plan of correction in effect with respect to the facility .

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
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 40171 Based on interview, and record review, the facility failed to provide evidence staff discussed with one of nineteen sampled residents (Resident 32) whether the resident had an existing advance directive (a legal document that explains how an individual wants medical decisions to be made if the individual is incapable of making their own decisions) and was educated on his rights to establish a new advance directive if desired. This failure had the potential for Resident 32 to receive end of life care not in accordance with his wishes and for life sustaining measures to be rendered against what the resident wanted. Findings: During a concurrent interview, and record review, on December 19, 2024, at 11:00 AM, with the Director of Nursing (DON), the DON was asked to provide evidence regarding if Resident 32 had an advance directive in place. The DON provided a copy of Resident 32'sPhysician Orders for Life-Sustaining Treatment (POLST) (written medical orders that addresses a limited number of critical medical decisions) signed by the resident on January 10, 2020. During a record review of Resident 32's POLST signed by Resident 32 on January 10, 2020, the POLST indicated in section D - Information and Signatures regarding Advance Directives (section regarding facility discussion with resident or resident representative, regarding advance directives), was unanswered and left blank. Section D did not indicate whether or not Resident 32 had an advance directive in place which was available and reviewed by facility, did not have an advance directive available, or had no advance directive at all. During a concurrent interview, and record review, on December 19, 2024, at 11:15 AM, with Registered Nurse Supervisor 1 (RNS 1), Resident 32's POLST, signed by the resident on January 10, 2020, was reviewed. RNS 1 acknowledged the POLST section D regarding advance directives was left blank. RNS 1 stated all residents were supposed to have an Advance Directive Acknowledgement form (a form which acknowledges a resident was educated about their right to formulate an advance directive, and includes specifics regarding their wishes for medical care). RNS 1 then reviewed Resident 32's clinical record and stated he was unable to find evidence that an Advance Directive Acknowledgement form was completed for Resident 32. RNS 1 further stated it was the responsibility of the social worker to complete the advance directive acknowledgement form and POLST form with residents or resident representatives. During a concurrent interview, and record review, on December 19, 2024, at 11:32 AM, with the Social Services Director (SSD), the SSD stated all residents were supposed to either have a POLST form, or an Advance Directive Acknowledgement form completed. Resident 32's POLST, signed by the resident on January 10, 2020, was reviewed. The SSD confirmed section D of the POLST regarding advance directives was left blank and stated it was supposed to have been completed but it was not. Resident 32's clinical record was then reviewed. The SSD stated Resident 32's clinical record did not have an advance directive acknowledement form and she was unable to find any other documented evidence to indicate advance directives were discussed with Resident 32. (continued on next page)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Social Service Department - Advance Directives, (undated), the P&P indicated, The facility will ensure that a resident's choice concerning the development of advance directives relative to his/her refusal of medical surgical treatment are followed in accordance with the facility's advance directive policy and procedure and current state law .Prior to, or upon admission, the Admission Coordinator or Social Services staff member will provide Resident's or their surrogate decision maker with written information concerning the residents right under state law to accept or refuse medical or surgical treatment and the resident's right to prepare an advance directive .The Resident or Surrogate Decision Maker will be asked to complete an Advance Directive Acknowledgment indicating that the facility has provided information about the right to accept/refuse medical treatments, the rights to formulate an advance directive, the right that an advance directive is not required and that the facility will honor the advance directive as permitted by law .

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on interview, and record review, the facility failed to provide two of three sampled residents (Residents 17 and 28) with beneficiary liability protection notifications (A notification letter which explain resident rights regarding financial liability and the right to appeal) when: 1) Resident 17 was not provided with estimated costs on the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN - informs the resident about potential non-coverage and the option to continue services with the resident accepting financial liability for those services). 2) Resident 28 was not provided with estimated costs on SNF ABN and the Notice of Medicare Non-Coverage (NOMNC -informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization) was not provided to the resident at least two days before the end of a Medicare covered Part A stay. This failure had the potential for Residents 17 and 28 to be uninformed regarding their specific rights and protections related to financial liability for potential incurred medical expenses as well as the right to appeal. Findings: 1) During a review of Resident 17's Admission Record (contains medical and demographic information), the Admission Record, indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus, schizophrenia (a chronic mental illness that affects a person's thoughts, feelings, and behaviors), and dysphagia (difficulty swallowing). During a review of the document titled, Beneficiary Notice - Residents discharged Within the last Six Months (a list of residents who were discharged from Medicare covered Part A stay with benefit days remaining in the past 6 months), undated, the document indicated Resident 17 was discharged from Medicare Part A services on June 7, 2024. The document also indicated the resident remained in the facility. During a review of Resident 17's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), dated May 30, 2024, the form indicated, Beginning on 6/8 [June 8, 2024], you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs .Care: Skilled Services . Estimated Cost: NA [not applicable] During a concurrent interview and record review on December 19, 2024, at 8:09 AM, with the Business Office Manager (BOM), Resident 17's SNF ABN form dated May 30, 2024 was reviewed. The BOM stated she oversaw the beneficiary notices at the facility. The BOM acknowledged Resident 17's SNF ABN form indicated NA where Estimated Cost was indicated. The BOM stated the total cost of the daily room rate was supposed to be indicated on the form instead of NA. The BOM further stated the current daily room rate was three hundred twenty five dollars (325.00 $). (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During a review of Resident 28's Admission Record (contains medical and demographic information), the Admission Record, indicated Resident 28 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (a chronic disease that occurs when the body is unable to regulate blood sugar levels), benign neoplasm of cerebral meninges (a noncancerous tumor that originates in the meninges, the membranes that cover the brain), and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities). During a review of the document titled, Beneficiary Notice - Residents discharged Within the last Six Months undated, the document indicated Resident 28 was discharged from Medicare Part A services on July 2, 2024. The document also indicated the resident remained in the facility. During a review of Resident 28's Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN), dated July 1, 2024, the form indicated, Beginning on 7/3/24 [July 3, 2024], you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs .Care: Skilled Services PT/OT [physical therapy/Occupational therapy] .Estimated Cost: NA [not applicable] During a concurrent interview and record review on December 19, 2024, at 8:09 AM, with the Business Office Manager (BOM), Resident 28's SNF ABN form dated May 30, 2024, was reviewed. The BOM acknowledged Resident 28's SNF ABN form indicated NA where Estimated Cost was indicated. The BOM stated the total cost of the daily room rate was supposed to be indicated on the form instead of NA. The BOM further stated the current daily room rate was three hundred twenty-five dollars (325.00 $). During a review of Resident 28's Notice of Medicare Non-Coverage (NOMNC) form, dated July 1, 2024, the form indicated, The effective date coverage of your current skilled nursing services will end 7/2/24 [July 2, 2024] (one day prior to when the form was signed by the resident). During a concurrent interview and record review on December 19, 2024, at 8:02 AM, with the BOM, Resident 28's NOMNC form dated July 1, 2024, was reviewed. The BOM stated the NOMNC form was supposed to be provided to Resident 28 three days or more in advance, but it was not. The BOM further stated she did not know why the NOMNC form was not provided timely to Resident 28 and there was another business office manager at the time the form was provided to the resident. During a review of the facility's policy and procedure (P&P) titled, Medicare Termination Notification, dated November 2017, the P&P indicated, .2. When a resident is covered on Medicare Part A: and covered services are terminated where the beneficiary has remaining SNF [skilled nursing facility] days available and continues to reside in the facility: a. Notify the resident/resident representative no later than 2 days prior to the last day of coverage in writing by providing them with the Medicare Provider Non-Coverage (Generic Notice) .b. provide the beneficiary and/or resident representative with the SNF ABN .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 46696 Based on interview, and record review, the facility failed to ensure a resident representative was notified of transfer in writing for one of 20 sampled residents (Resident 17). This failure had the potential to cause confusion about the transfer process and possibly leave the resident and the resident representative unable to make an informed decision about the transfer. Findings: During a review of Resident 17's Face sheet (a document containing demographic information) dated December 19,2024, the Face sheet indicated, Resident 17 has a diagnosis of schizophrenia (a chronic mental illness that affects how a person thinks, feels, and behaves) and metabolic encephalopathy (a brain dysfunction that occurs when a chemical imbalance in the blood affects the brain). The face sheet also indicated who the resident representative, emergency contact, and guardian is (Resident Representative 1). During an interview on December 17, 2024, at 8:18 AM, with resident representative (RR 1), RR 1 stated, Last month [Resident 17] was sent to the hospital for vomiting dark liquid, I was told they would transfer [Resident 17] and hold the bed, by phone call. During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN-a nurse responsible for collecting and submitting assessment data for nursing home patients) on December 19,2024, at 10:45 AM, the [facility name] Healthcare notice of proposed transfer/discharge notice dated, 11/26/2024 was reviewed. The [facility name] Healthcare notice of proposed transfer/discharge notice indicated, 1. Resident name [Resident 17] b. Resident representative [Resident Representative 1] c. Verbally communicated on: 11/26/24 . d. Verbally Communicated to: [Resident Representative 1] . 2. Transfer/ Discharge was necessary due to: 1. The transfer/ discharge is necessary for your welfare and your needs cannot be met in the facility, the MDSN stated, the transfer document indicates we notified the resident representative via phone. During a concurrent interview and record review on December 19,2024 at 10:50 AM with Social Services Director (SSD-a hospital resource that help people in need with a variety of needs, including medical appointments, cost assistance, and psychosocial support), the State Operations Manual S483.15(c)(3) was reviewed. The State Operations Manual S483.15(c)(3) indicated, Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. SSD stated, We did not provide this in writing to the resident representative.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46696 Based on observation, interview, and record review, the facility failed to accurately code the Resident Assessment Instrument-Minimum Data Set (RAI-MDS - a computerized resident assessment tool) for four of nineteen sampled residents (Residents 25, 27, 32, and 56) when: 1) Resident 25's RAI-MDS assessment dated [DATE], incorrectly indicated Resident 25 had only minimal hearing loss, and did not have a hearing aid. 2) Resident 27's RAI-MDS assessment dated [DATE], incorrectly indicated Resident 27 was not considered Pre-Admission Screening and Resident Review (PASRR) level 2 by the state. 3) Resident 32's RAI-MDS assessment dated [DATE], incorrectly indicated Resident 32 received insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood). 4) Resident 56's RAI-MDS assessment dated [DATE], incorrectly indicated Resident 56 had an indwelling urinary catheter (a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine). These failures had the potential to result in unmet care needs for the residents (Residents 25, 27, 32, and 56) and for the residents' clinical records to inaccurately reflect their health status. Findings: 1) During a review of Resident 25's Face Sheet dated December 19,2024, the 'Face Sheet indicated, Diagnosis information, Schizophrenia, and bipolar disorder. During an interview on December 16, 2024, at 10:41 AM with Resident 25, Resident 25 stated, I do not have a hearing aid, but I would like one. Communication was facilitated with a writing board as she was only able to hear some of the words spoken. During a review of Resident 25's Audiology consult note dated February 6,2024, the Audiology Consult note indicated, hearing aids will be ready on February 21, 2024. During an interview and concurrent record review on December 19,2024 at 2:15 PM with the Social Services Director (SSD), Resident 25's Psychosocial Discharge Planning eval [evaluation] dated November 11,2024, indicated, 4b. Other information provided: Resident has hearing aids and refuses to wear them. The SSD, stated, She refuses the wear the hearing aids, I have them in my office storage for her. During a review of Resident 25's MDS dated [DATE], the MDS indicated, Section B0200 Hearing, coded 1. Minimal difficulty, and Section B0300 Hearing aid, coded 0. No (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on December 19,2024 at 1:50 PM with MDS nurse, Resident 25's Quarterly MDS dated . November 19,2024 was reviewed. The Quarterly MDS indicated, Section B0200 Hearing coded, 1.) Minimal difficulty and B0300 hearing aids coded, 0.) No. The MDS nurse stated, I will update the MDS, I don't feel like minimal is correct for her, it been getting worse. I will do corrections on her MDS documentation it should be coded correctly. She also has hearing aids and I answered No, which is also wrong. 2) During a review of Resident 27's Face Sheet dated, December 19,2024, the Face Sheet indicated, Diagnosis Information, Schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania) and bipolar (a mental illness that causes extreme mood swings, or shifts from mania to depression) type. During a review of Residents 27's Preadmission Screening and Resident Review (PASRR) dated, September 13,2022, the PASSAR indicated, Your Level 1 screening was conducted at [facility name], followed by a Level 2 Evaluation on July 25,2022, by [social worker name]. The results of this Level 2 evaluation are provided in the PASRR Determination Report attached to this letter. Facility Staff will receive a copy of this Determination Report, will discuss the results with you in a timely manner, and will incorporate the recommendations into your care plan. During a review of Resident 27's Minimum Data Set (MDS), dated [DATE], the MDS indicated, A1500, Preadmission Screening and resident review (PASRR), Is the resident currently considered by the state level 2 PASRR process to have serious mental illness and/or intellectual disability or related conditions? Data entered, 0 No. During a concurrent interview and record review with the MDS Nurse, on December 17,2024 at 5:16 PM the Resident Assessment Instrument 3.0 User manual (RAI Manual) dated October 2024, was reviewed. The RAI Manual indicated, A1500: Preadmission Screening and Resident Review (PASRR) . Steps for Assessment 2. Review the Level I PASRR form to determine whether a Level II PASRR was required. 3. Review the PASRR report provided by the State if Level II screening was required. Coding Instructions o Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: - PASRR Level I screening did not result in a referral for Level II screening, or - Level II screening determined that the resident does not have a serious Mental Illness and/or Intellectual disability (ID- is a neurodevelopmental condition that can affect a person's mental health) /Developmental Disabilities (DD-A group of conditions that can be caused by physical, learning, language, or behavioral impairments.) or related conditions. Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. The MDS nurse stated, If the resident ever had a level 2 PASSR we would have to document, 1. yes, I made a mistake. 40171 3) During a review of Resident 32's Admission Record (contains medical and demographic information), the Admission Record, indicated Resident 32 was admitted to the facility on [DATE], with diagnoses which included epilepsy (seizure disorder), schizophrenia (a serious mental health condition that affects how people think, feel and behave), and alcohol abuse. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32's RAI-MDS, dated [DATE], the RAI-MDS indicated in section N- Medications, that Resident 32 received insulin. During a review of Resident 32's Medication Administration Record (MAR - a document used by staff to record medications administered to the resident), dated September 2024, the MAR indicated Resident 32 did not receive insulin at any time for the month. During a concurrent interview and record review on December 19, 2024, at 4:03 PM, with the Minimum Data Set Nurse (MDSN), Resident 32's RAI-MDS assessment, dated September 20, 2024, was reviewed. The MDSN stated the RAI-MDS assessment indicated Resident 32 had received insulin. The MDSN then reviewed Resident 32's clinical record and stated the resident did not receive insulin and the RAI-MDS assessment dated [DATE], was incorrect. The MDSN further stated she was the one who completed the RAI-MDS assessment, and it was done in error. During a review of the MDS 2.0 Manual titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.18.11, dated October 2023, section 1.3 Completion of the RAI, indicated, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status .(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts .In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) . 4) During a review of Resident 56's Admission Record, (contains medical and demographic information), the Admission Record, indicated Resident 56 was admitted to the facility on [DATE], with diagnoses which included benign prostatic hyperplasia (a noncancerous condition that causes the prostate gland to enlarge), obstructive and reflux uropathy (a condition in which the flow of urine is blocked), and contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). During a concurrent observation and interview on December 16, 2024, at 3:52 PM, Resident 56 did not have an indwelling urinary catheter. Resident 56 stated he had not had an indwelling catheter for a few months and that it had been removed. During a review of Resident 56's RAI-MDS, dated [DATE], the RAI-MDS indicated in section H - Bladder and Bowel, that Resident 56 had an indwelling catheter. During a concurrent interview and record review on December 19, 2024, at 4:07 PM, with the Minimum Data Set Nurse (MDSN), Resident 56's RAI-MDS assessment, dated November 19, 2024, was reviewed. The MDSN stated the RAI-MDS assessment indicated Resident 56 had an indwelling catheter. The MDSN then reviewed Resident 56's clinical record and stated the catheter had been discontinued in August 2024 and the RAI-MDS assessment dated [DATE], was incorrect. The MDSN further stated she was the one who completed the RAI-MDS assessment, and it was done in error. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on December 19, 2024, at 4:12 PM, with the MDSN, the MDSN stated the facility did not have a policy and procedure (P&P) regarding completion of the RAI-MDS assessments and the facility used the current RAI-MDS assessment manual as the facility's P&P. During an interview on December 19, 2024, at 4:13 PM, with the DON, the DON stated it was important that the RAI-MDS assessments were coded correctly to ensure the facility documented a complete and accurate assessment of the resident. During a review of the MDS 2.0 Manual titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1, dated October 2024, section 1.3 Completion of the RAI, indicated, The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20(b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status .(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts .In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations .It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) .

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Arrowhead Healthcare Center, LLC	4343 N. Sierra Way San Bernardino, CA 92407

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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** 40171 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 51) reviewed for pressure ulcers (injuries to skin and underlying tissue resulting from prolonged pressure on the skin) received care and services for skin breakdown as was specified in the resident's care plan (an individualized plan for the medical care of a resident) and physician's orders when: -Resident 51's low air loss mattress (a mattress that uses air to help prevent and treat pressure wounds, and to regulate temperature and moisture levels) was not set to the correct pressure as specified by physician orders. -Resident 51 did not have on heel protectors [device that provides cushioning, support, and pressure relief to the heel] while in bed. -Resident 51's Electronic Medical Record (EHR) included a nursing weekly summary (weekly progress note created by licensed staff) which inaccurately specified Resident 51's skin was intact. These failures had the potential for Resident 51's to experience worsening pressure ulcers, for the delay in the identification and subsequent treatment of new pressure ulcers, and the clinical record to inaccurately reflect Resident 51's altered skin integrity. Findings: During a review of Resident 51's medical record, the Admission Record (contains medical and demographic information), indicated Resident 51 was initially admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (a chronic metabolic disease that occurs when the body can't control its blood sugar levels), pressure ulcer of sacral region (low back/upper buttocks area stage 2 [a shallow open sore]), and pressure-induced deep tissue damage of right heel (Deep Tissue Injury [DTI] - a form of pressure-induced damage to underlying tissues, including muscles, bones, and subcutaneous layers [a layer of connective tissue that lies immediately below the skin and contains fat, larger blood vessels, and nerves]). During a concurrent observation and interview on December 17, 2024, at 3:50 PM, in Resident 51's room, with Certified Nursing Assistant 5 (CNA 5), Resident 51 was in bed and was not wearing heel protectors. In addition, Resident 51's low air loss mattress was set to a setting of 80 millimeters of mercury (mmHg). CNA 5 observed Resident 51 in bed and confirmed the resident was not wearing heel protectors and his low air loss mattress was set to 80 mmHg. Prior to leaving the room, CNA 5 did not attempt to put on Resident 51's heel protectors and did not ask the resident if he wanted them on. During a concurrent observation and interview on December 17, 2024, at 3:55 PM, in Resident 51's room, with the Director of Nursing (DON), Resident 51 was observed in bed. The DON stated Resident 51 was supposed to have on heel protectors while in bed and acknowledged Resident 51 did not have on heel protectors. The DON then observed the low air loss mattress and acknowledged it was set to 80 mm/hg. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on December 17, 2024, at 4:20 PM, with the DON, Resident 51's physician's orders were reviewed. An order dated November 13, 2024, indicated, May use low air loss mattress at air pressure range of 155 to 165 [mm/Hg]. Monitor mattress air pressure q [every] shift. If pressure is out of range, adjust bed and document variance and actions taken in progress note. Every shift. The DON stated Resident 51's low air loss mattress was supposed to be set between 155-165 mm/Hg but it was not because it was only at 80 mm/Hg. Upon Further review of Resident 51's physician's orders, an order dated November 13, 2024, indicated, Resident may have bilateral heel protectors while in bed. Monitor placement every shift for DTI. During a review of Resident 51's care plan (untitled), dated November 13, 2024, the care plan indicated, [name of Resident 51] was readmitted from acute hospital with DTI to right heel. Interventions for the care plan included, Apply heel protectors daily while in bed .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations .Pressure reducing mattress . During a concurrent interview and record review on December 17, 2024, at 4:15 PM, with the DON, Resident 51's weekly nursing assessment titled, NW-Weekly Summary, dated December 12, 2024, was reviewed. The Assessment indicated in section G (section for Skin/Wound), No evidence of impaired skin integrity at this time. The DON stated the weekly nursing summary was incorrect and the nurse who completed the weekly assessment did not identify Resident 51 had a deep tissue injury to the heel and therefore the documentation was not accurate. During an interview on December 19, 2024, at 3:21 PM, with the DON, the DON stated the purpose of a low air loss mattress was to help prevent skin breakdown for residents who cannot or will not reposition themselves in bed. The DON further stated the purpose of heel protectors were to help prevent skin breakdown to the heels. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Care Planning, revised May 2019, the P&P indicated, .2. The facility will develop and implement a comprehensive person-centered care plan consistent with resident rights and aimed to provide services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .Weekly Assessments: A. Weekly resident assessments are completed by a licensed staff nurse to ensure effectiveness of the current plan of care and to document residents' progress towards individualized goals, as well as early detection of changes in condition and identification of new/altered resident needs. B. Components of a weekly assessment should include, when appropriate, the following: 1) Skin integrity assessment - 100% head to toe body check .b. Check findings against current treatment orders and weekly pressure injury report. Check that identified sites are correctly described and located. Correct errors .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 37) reviewed for accidents had a fall mat (a cushioned mat which may aid in lessening the severity of injury during a fall) next to her bed as was specified in the resident's care plan (an individualized plan for the medical care of a resident). This failure had the potential for Resident 37 to sustain a serious injury during a fall in which the severity of the injury may have been lessened if the fall mat had been in place. Findings: During a review of Resident 37's Admission Record (contains medical and demographic information), the Admission Record, indicated Resident 37 was admitted on [DATE], with diagnoses which included dementia (a chronic condition that causes a decline in mental abilities, such as thinking, remembering, and reasoning, that interferes with daily life), legal blindness, psychotic disorder (a severe mental disorder that causes abnormal thinking and perceptions), and impulse disorder (a mental health condition that makes it difficult to control impulses or urges, which can lead to harmful behaviors). During an interview on December 16, 2024, at 12:01 PM, with Resident 37's representative (RR 37), RR 37 stated she was informed by facility staff, that Resident 37 had experienced a fall from bed some months ago (could not remember exactly what month). During an observation on December 17, 2024, at 2:18 PM, in Resident 37's room, Resident 37 was lying in bed and did not have a fall mat noted next to or near her bed. Resident 37 was nonverbal and did not respond to questioning. During a concurrent observation and interview on December 17, 2024, at 2:41 PM, with Licensed Vocational Nurse 1 (LVN 1), in Resident 37's room, Resident 37 was lying in bed and did not have a fall mat next to or near her bed. LVN 1 stated she did not know why Resident 37 did not have a fall mat next to her bed. During a review of Resident 37's Fall/Risk Evaluation (an assessment of fall risk), dated November 8, 2024, the fall risk evaluation indicated Resident 37 was at High Risk for falls. During a review of Resident 37's nursing progress notes, a note dated June 10, 2024, indicated, .LVN noted [resident] lying on floor next to bed. No injuries noted. Resident assisted back to bed . During further review of Resident 37's nursing progress notes, a note dated July 5, 2024, indicated, Staff went to assist resident .as CNA (Certified Nursing Assistant) arrived resident was sitting on floor in room . During an interview on December 17, 2024, at 3:10 PM, with the Director of Nursing (DON), the DON stated Resident 37's care plan for risk for falls included the facility designated interventions to help prevent falls and/or lessen the extent of injuries sustained by a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 37's care plan (an individualized plan for the medical care of a resident), dated February 26, 2021, the care plan indicated, [name of Resident 37] is at risk for falls r/t [related to] confusion, gait [walking]/balance problems, deconditioning, poor safety awareness/judgement .incontinence, vision/hearing problems . Interventions listed for the care plan indicated, .Floor mat to assist resident with secured footing when getting out of bed. During a concurrent observation and interview on December 17, 2024, at 3:16 PM, with the DON, while in Resident 37's room, the DON observed Resident 37 in bed and acknowledged there was no fall mat next to or near the resident's bed. The DON further stated Resident 37 was supposed to have a fall mat by her bed and she was unsure of why there was not one. During a follow up interview on December 19, 2024, at 3:21 PM, with the DON, the DON stated the purpose of a fall mat was to minimize injury if an actual fall occurred. During a review of the facility's policy and procedure (P&P) titled, Prevention of Falls, Revised April 2024, the P&P indicated, It is the policy of this facility to assess residents for falls and to use appropriate measures to prevent falls .Every effort is utilized to prevent falls . During a review of the facility's P&P titled, Resident Assessment and Care Planning, revised May 2019, the P&P indicated, .the facility will develop and implement a comprehensive person-centered care plan consistent with resident rights and aimed to provide services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40171 Based on observation, interview, and record review, the facility failed to ensure daily staffing information was posted in a resident accessible area within the facility. This failure resulted in the inability of all 55 residents in the facility to have access to information regarding the staffing levels of licensed and unlicensed staff directly responsible for providing them care within the facility. Findings: During an observation on December 17, 2024, at 10:30 AM, near the facility's main entrance, the facility had posted staffing information which included Direct Care Service Hours Per Patient Day (DHPPD - the total number of actual direct care service hours performed by direct caregivers per patient day divided by the average patient census). This area was not accessible to residents within the facility. During a concurrent observation and interview on December 18, 2024, at 12:44 PM, with the Director of Staff Development (DSD), the DSD stated he was the individual responsible for posting the DHPPD staffing information. The DSD further stated the DHPPD staffing information was only posted at the front entrance of the facility. The DSD showed the front entrance which was only accessible through a door or by going behind the nurses station. The DSD stated the door remained locked so residents could not go through the door. The DSD further stated residents were also not allowed behind the nurses station to get to the front (where the DHPPD staffing information was posted). The DSD stated he was unaware the DHPPD staffing information needed to be posted in an area which was accessible to residents. During an interview on December 19, 2024, at 3:31 PM, with the Director of Nursing (DON), the DON stated the Direct Care Service Hours Per Patient Day (DHPPD - it is the total number of actual direct care service hours performed by direct caregivers per patient day divided by the average patient census) was supposed to be posted in an area within the facility which was accessible to residents and visitors. During a review of the facility's policy and procedure (P&P) titled, Nursing Shift Information Board, (undated), the P&P indicated, Policy - It is the policy of this facility to post the Daily Nursing Hours per patient day (PPD) by shift in a location visible to the residents and visitors .To ensure the visibility of the Daily Nursing Hours PPD the information will be posted on a bulletin board in an area frequented by the residents and visitors . Procedure: .1. The facility shall establish a bulletin board in a conspicuous place within easy visibility of the residents and visitors .4. The information shall include: a. The name of the facility. B. The date. C. The census total. D. The shift, including hours of the shift. E. The number of Registered Nurses per shift x [times] the hours worked = [equals] number of Registered Nursing Hours. F. The number of Licensed Vocational Nurses per shift x the hours worked = the number of Licensed Nursing Hours. G. The number of C.N.A.'s [Certified Nursing Assistants] per shift x the hours worked = the number of unlicensed hours .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46696 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when: a. Walk in refrigerator and freezer temperatures were not being monitored daily. b. A kitchen staff was observed working in the kitchen without a hair net. c. Shelves in the walk-in refrigerator had black residue on them where food was stored. These failures had the potential for bacteria to growth and cause foodborne illness in a highly susceptible population of 49 residents who received food and beverages from the kitchen. Findings: a. During a concurrent observation and interview on December 16, 2024, at 9:20 AM, in the kitchen with the Dietary Supervisor (DS), the walk-in refrigerator was observed not to contain a thermometer to monitor the temperatures inside, the logs identifying temperatures were being checked daily could also not be identified. The DS stated, those items need to be available, or we would not have record of if the temperature is safe. The DS further stated, they could not find the logs for the freezer either and these logs should be readily available if they are doing the checks every day. During a review of facility policy and procedure (P&P) titled, Cold Storage Temperature Monitoring and Record Keeping dated, 2023, the P&P indicated, 1. Food and Nutrition staff will check the inside temperature of refrigerators and freezers. 2. Food & Nutrition Service staff will record and initial the temperatures on the health care menus direct, LLC's Cold Storage temperature Log at the beginning of the AM and PM shifts. 3. If the temperatures are not within standards, Food and nutrition Services staff will notify the Food and nutrition services director. During a record review of the Federal FDA 2017 Food Code 3-501.16, the Federal FDA 2017 Food Code 3-501.16 indicated, Time/Temperature Control for Safety Food, Hot and Cold Holding. Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5 degree C to 57 degree C (41-degree F to 135-degree F) too long. Up to a point, the rate of growth increases with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth. b. During a concurrent observation and interview on December 17,2024, at 2:40 PM, in the Kitchen with the DS, the DS was observed working next to the kitchen stove containing food, with no hair net on and exposed hair. The DS stated, I should be wearing a hair net, I forgot I wasn't wearing one. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the Federal FDA 2017 Food Code 2-402.11 the Federal FDA 2017 Food Code 2-402.11 indicated, Hair Restraints 2-402.11 Effectiveness, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE SERVICE and SINGLE-USE ARTICLES. During an interview on December 19, 2024, at 3:53 PM, with the Infection Preventionist (IP- healthcare professionals who work to prevent and contain the spread of infectious diseases in healthcare settings), the IP stated, Working without hair nets is a concern for infection control related to food and drink contamination. c. During a concurrent observation and interview on December 17,2024 at 2:45 PM in the Kitchen with the DS, the walk-in refrigerator was observed, the top rack of the walk-in containing food items and drinks, was dirty with a black residue along the length of the shelves. The DS stated, Yes its dirty, we need to clean it. During a record review of the Federal FDA 2017 Food Code 4-601.11 the Federal FDA 2017 Food Code 4-601.11 indicated, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted. During an interview on December 19,2024 at 3:53 PM with IP, the IP stated, Residents consume the food in the kitchen, it is not okay to have dirty storage shelving it needs to be as clean as possible.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35183 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections, in a universe of 55 residents (Residents 1 to 55), when: 1. The facility did not conduct an annual review of its infection control program's policies and procedures (P&P) and update their program, as necessary. This failure had the potential to cause the facility to be out-of-date with current best practices and overlook potential gaps in their procedures. 2. Laundry staff (LS 1) did not follow the manufacturer's guidelines for the disinfectant used to disinfect laundry carts and dirty laundry barrels. Housekeeping staff (HS 1) did not follow the manufacturer's guidelines for the disinfectant used to disinfect resident rooms. This failure had the potential to cause the development and transmission of communicable diseases (an illness or infection that can spread from one person to another, or from a surface to a person) and infections to residents. 3. Housekeeping staff (HS 1) did not follow Enhanced Standard Precautions (ESP- a set of guidelines for preventing the transmission of Multidrug-Resistant Organisms (MDROs) in skilled nursing facilities) to prevent the spread of infection when HS 1 failed to don (to put on) a gown when cleaning and disinfecting an ESP room (ESP designated rooms require staff to don gloves and a gown when cleaning and disinfecting the environment). This failure had the potential to cause the transmission of MDROs to HS 1's clothing and then accidental transmission to other residents. Findings: 1. A review of the facility's policy and procedure (P&P) titled Infection Prevention and Control Program, dated revised June 2021, was conducted. The P&P indicated it had been reviewed and revised in June 2021. During an interview with the Administrator (Admin) on December 18, 2024, at 12:16 PM, the Admin stated the Infection Control Policies should be reviewed and updated as often as necessary but at least once per year. The Admin verified the Infection Control Policies the facility provided were reviewed and revised in June 2021. A review of the facility's P&P titled, Facility Policies and Procedures - Annual Reviews, dated revised April 2007, indicated, Policy Statement: Our facility reviews its operational policies and procedures and resident care policies as needed and at least annually. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2a. During a laundry services observation and interview on December 19, 2024, from 9:38 AM, to 10:30 AM, with a Laundry Staff (LS 1), Housekeeping Supervisor (H/Sup), and an Infection Preventionist (IP), LS 1 described the laundry process and stated the Certified Nursing Assistants (CNAs) brought the dirty laundry carts out of the facility and transferred the dirty laundry to the yellow barrels, LS 1 pointed to a row of yellow barrels lined up against an outside brick wall. LS 1 stated the yellow barrels were cleaned every weekend and more often if necessary. LS 1 explained how she would clean the yellow barrels by bringing them over to the outside hose, put a couple of drops of a multi-use cleaner in the barrel, spray water into the barrel, use a brush to clean the barrel and then rinse the barrel out with the hose. LS 1 stated she had been instructed to use a disinfectant on the yellow barrels, but she liked the multi-use cleaner better. In a continued observation and interview with LS 1, H/Sup and an IP, LS 1 demonstrated how she removed clean laundry from the dryer and placed it into a wire laundry basket on wheels, LS 1 stated she cleaned the clean laundry baskets with the disinfectant, by spraying the clean laundry basket with the disinfectant and then immediately wiping it off with a cloth. LS 1 stated she did not leave the basket's surface wet for any period of time. The IP stated the dirty laundry yellow barrels and clean laundry baskets were to be cleaned with the disinfectant and needed to stay wet with the disinfectant for 10 minutes, in order to kill or reduce bacteria and viruses. 2b. During a facility cleaning and disinfection observation and interview on December 19, 2024, from 9:49 AM, to 10:30 AM, with the H/Sup, a Housekeeping Staff (HS 1) and the IP, the H/Sup stated the disinfectant was used to clean the facility, such as, floors, rails, resident rooms, bathrooms, and floors. The H/Sup approached a resident's room which had the following postings at the rooms entrance: Notice of Room Deep Cleaning and Enhanced Standard Precautions (ESP) in effect. HS 1 was actively cleaning the room and was not wearing a gown, a form of Personal Protective Equipment (PPE). HS 1 explained a deep clean meant the room was cleaned top to bottom, the walls, all surfaces in the room, the bathroom and the floor was last. HS 1 stated she used the disinfectant for all the surfaces except the floor. HS 1 stated the surfaces needed to stay wet for 10 minutes except the walls and the floor. HS 1 stated she used a multi-use cleaner on the floor not the disinfectant. The IP stated she provided teaching on facility disinfection to the H/Sup who then instructed the housecleaning and laundry staff the proper way to disinfect. The IP stated for rooms under deep cleaning the staff needed to keep the walls wet with the disinfectant for 10 minutes and the disinfectant was supposed to be used on the room's floor and the floor was to be kept wet for 10 minutes, in order to kill or reduce bacteria and viruses. A review of the facility's multi-use cleaner titled, [Name of the disinfectant], undated, indicated, .cleans and deodorizes in one application. There was no documented evidence to show [Name of the disinfectant] disinfected surfaces. A review of the facility's disinfectant titled, [Name of the disinfectant], undated, indicated, . is a one step neutral disinfectant that is effective against a broad spectrum of bacteria, is virucidal [having the ability to destroy or inactivate viruses] . and inhibits the growth of mold and mildew . when used as directed. to disinfect inanimate [not alive], hard nonporous [does not allow air or liquid to pass through it] surfaces . Apply solution with a mop, cloth, sponge, hand pump trigger sprayer, or low-pressure coarse sprayer so as to wet all surfaces thoroughly. Allow to remain wet for 10 minutes, then remove excess liquid. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's P&P titled, Housekeeping - Cleaning Resident Rooms and Equipment, undated, indicated, PURPOSE: To maintain a clean and sanitary environment for residents. POLICY: Resident rooms and equipment shall be maintained in a clean and sanitary condition by appropriately trained and assigned staff. Cleaning products shall be reviewed by the Infection Preventionist and the housekeeping supervisor. The Infection Control Committee shall approve any change in housekeeping supplies. D. Environmental Rounds: 1. Safety Committee members including but not limited to the Infection Preventionist and housekeeping supervisor shall monitor the cleanliness of the facility and infection control practices on a regular basis to assure compliance with cleanliness and sanitation standards. 3. During a facility cleaning and disinfection observation and interview on December 19, 2024, from 9:49 AM, to 10:30 AM, with the H/Sup, HS 1 and the IP, the H/Sup approached a resident's room which had the following postings at the rooms entrance: Notice of Room Deep Cleaning and Enhanced Standard Precautions (ESP) in effect. HS 1 was actively cleaning the room and was not wearing a gown, a form of Personal Protective Equipment (PPE). HS 1 explained a deep clean meant the room was cleaned top to bottom, the walls, all surfaces in the room, the bathroom and the floor was last. HS 1 confirmed she was not wearing a gown and should be. She stated, I forgot. The H/Sup verified HS 1 was not wearing a gown and should be when cleaning an ESP room. The IP stated HS 1 was required to wear a gown when cleaning ESP designated rooms. A review of the facility's Enhanced Standard Precautions (ESP) posting, undated, indicated, For these six groups of care activities, use hand hygiene, gloves, and gowns, for residents who are on Enhanced Standard Precautions. cleaning and disinfecting the environment. A review of the facility's P&P for Personal Protective Equipment (PPE), undated, indicated, PPE is provided to our employees at no cost to them. Training in the use of appropriate PPE for specific tasks or procedures is provided by our Infection Preventionist and Director of Staff Development. The types of PPE available to our employees include Surgical masks, Gloves, Gowns, . PPE is located throughout the facility including nursing station(s), central supply, carts located directly outside a resident's room who is in need of Transmission Based Precautions [a set of infection control measures used for residents who may be infected with certain infectious agents]. All employees have immediate access to PPE. The Infection Preventionist will ensure that PPE is available for 'at will' use by the facility staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555896	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arrowhead Healthcare Center, LLC	4343 N. Sierra Way 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 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40171 Based on observation, interview, and record review, the facility failed to ensure five of five rooms (each occupied by four residents per room) had the minimum required square footage for each resident. This failure had had the potential for increased risk of accidents and injuries to occur within the room as a result of limited space for wheelchair and Hoyer lift access (a mechanical device that helps move people with limited mobility), limited space to accommodate resident care activities, increased risk for falls, and a potential delay in the evacuation of residents during an emergency. Findings: During an observation on December 16, 2024, at 9:59 AM, in room [ROOM NUMBER], there were four residents observed to occupy the room. During a review of the facility document titled, [name of facility] Census (a document which indicates the total number of residents within the facility and their room number) dated December 15, 2024, the document indicated there was a total of five rooms within the facility each of which were shared by four residents. The rooms were: 102, 105, 106, 107 and 112. During a concurrent observation and interview on December 19, 2024, at 8:45 AM, with the Maintenance Supervisor (MS), the MS measured Rooms 102, 105, 106, 107, and 112. All measurements were verified by both the MS and the surveyor using the facility's measuring tape and the following measurements were obtained: room [ROOM NUMBER]: Length (L) 185 (inches) x width (W) 237 = 43845 square inches (sq in) total room area. Within the room, there was one moveable wardrobe cabinet which measured 23 x 40 = 920 and one unmovable wardrobe cabinet which measured 39 x 19 = 741. room [ROOM NUMBER]: Length 184 x width 239 = 42542 sq in total room area. Within the room, there was one un-moveable wardrobe cabinet which measured 42 x 18 = 756 and a moveable wardrobe cabinet which measured 36 x 19 = 684. room [ROOM NUMBER]: Length 184 x width 240 = 44160 sq in total room area. Within the room, there was one moveable wardrobe cabinet which measured 36 x 19 = 684. room [ROOM NUMBER]: Length 177 x width 243 = 43011 sq in total room area. Within the room there was two moveable wardrobe cabinets which measured 33 x 18 = 594. room [ROOM NUMBER]: Length 184 x width 240 = 44160 sq in total room area. Within the room, there was one moveable wardrobe cabinet which measured 23 x 40 = 920 and another moveable wardrobe cabinet which measured 40 x 21.5 = 860. (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on December 19, 2024, at 10:40 AM, with the Administrator (ADMIN), and the MS, the ADMIN was shown the measured room sizes of rooms 102, 105, 106, 107, and 112. The measurements of the rooms were discussed and the following sq ft per resident were calculated: room [ROOM NUMBER]: Length (L) 185 (inches) x width (W) 237 = 43845 square inches (sq in) total room area. 43845 sq in divided by 144 (to convert to square feet) = 304.47 square feet (sq ft) total room area. Divided by 4 (number of residents in the room) = 76.11 sq ft per resident. However, within the room there was one moveable wardrobe cabinet which measured 23 x 40 = 920 and one unmovable wardrobe cabinet which measured 39 x 19 = 741. After subtracting the moveable wardrobe space (since it is not considered useable room space) the total sq ft per resident was decreased to 72.6 sq ft. room [ROOM NUMBER]: Length 184 x width 239 = 42542 sq in total room area. 42542 sq in divided by 144 (to convert to sq ft) = 295.43 sq ft total room area. Divided by 4 (number of residents in the room) = 73.85 sq ft per resident. However, within the room there was one un-moveable wardrobe cabinet which measured 42 x 18 = 756 and a moveable wardrobe cabinet which measured 36 x 19 = 684. After subtracting the moveable wardrobe space, the total sq ft per resident was decreased to 71.35 sq ft. room [ROOM NUMBER]: Length 184 x width 240 = 44160 sq in total room area. 44160 sq in divided by 144 (to convert to sq ft) = 306.66 sq ft total room area. Divided by 4 (number of residents in the room) = 76.66 sq ft per resident. However, within the room there was one moveable wardrobe cabinet which measured 36 x 19 = 684. After subtracting the moveable wardrobe space, the total sq ft per resident was decreased to 75.4 sq ft. room [ROOM NUMBER]: Length 177 x width 243 = 43011 sq in total room area. 43011 sq in divided by 144 (to convert to sq ft) = 298.68 sq ft total room area. Divided by 4 (number of residents in the room) = 74.67 sq ft per resident. However, within the room there was two moveable wardrobe cabinets which measured 33 x 18 = 1188. After subtracting the moveable wardrobe space, the total sq ft per resident was decreased to 72.6 sq ft. room [ROOM NUMBER]: Length 184 x width 240 = 44160 sq in total room area. 44160 sq in divided by 144 (to convert to sq ft) = 306.66 sq ft total room area. Divided by 4 (number of residents in the room) = 76.66 sq ft per resident. However, within the room there was one moveable wardrobe cabinet which measured 23 x 40 = 920 and another moveable wardrobe cabinet which measured 40 x 21.5 = 860. After subtracting the moveable wardrobe space, the total sq ft per resident was decreased to 73.57 sq ft per resident. The ADMIN stated she agreed that based on the measurements of rooms 102, 105, 106, 107, and 112; all five of the rooms were less than the required 80 sq ft per resident. The ADMIN further stated possible negative outcomes included falls and accidents if the rooms were too small. During an interview on December 19, 2024, at 2:40 PM, with the ADMIN, the ADMIN was asked for a list of residents who resided in Rooms 102, 105, 106, 107, and 112, and of those, which required the use of a wheelchair, Hoyer lift, and/or Geri chair (a large, padded chair that's designed to help people with limited mobility sit and stand comfortably). (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's document titled, List of Residents with Wheelchair/Hoyer's, undated, the document indicated of the five rooms which housed 20 total residents (Rooms 102, 105, 106, 107, and 112) 10 residents required use of Hoyer lift, nine residents had wheelchairs, and seven residents had Geri chairs. During an interview on December 19, 2024, at 12:07 PM, with the Administrator (ADMIN), the ADMIN stated the facility did not have a policy and procedure (P&P) regarding the minimum required square footage of resident's rooms.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 46696 Based on observation, interview, and record review, the facility failed to ensure the kitchen was free of pests, when a cockroach was observed on the wall behind the steam table (a type of food-holding equipment designed to keep hot foods at a safe holding temperature). This failure had the potential to cause contamination of food and beverage for 49 residents who receive food and beverage from the kitchen, potentially leading to a resident infection. Findings: During a concurrent observation and interview on December 16, 2024, at 8:48 AM, in the Kitchen, with the Dietary Supervisor (DS), a cockroach was observed on the wall behind the steam table in the kitchen. DS stated, There shouldn't be any bugs or cockroaches in the kitchen. During a concurrent interview and record review on December 19, 2024, at 3:34 PM, with Dietary Supervisor, the State Operations Manual S483.90(i)(4) was reviewed. The State Operations Manual S483.90(i)(4) indicated, Maintain an effective pest control program so that the facility is free of pests and rodents. Dietary Supervisor stated, we are out of compliance with this because of the cockroach. During an interview on December 19, 2024, at 3:53 PM, with the Infection Preventionist (IP-healthcare professionals who work to prevent and contain the spread of infectious diseases in healthcare settings), the IP stated, Cockroaches are a concern for infection control as they can spread disease. During a review of facility's policy and procedure (P&P) titled, Pest Control (undated), the P&P indicated, If pests are seen in the kitchen, the food services manager or appropriate staff shall be informed, describing where the pest was seen and when. Appropriate action will be taken to eliminate any reported pest situation in the department . 2. If a pest situation is reported, the contractor come sin to spray at appointed times. The contractor will document the visit along with actions taken. During a review of Service Inspection report dated December 12, 2024, the Service Inspection Report indicated, Service description: Pest control maintenance No other comments or explanation of the visit could be obtained.