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	04/09/2026

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 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 ensure safe infection control practices and sanitary environment were followed when: 1.physician's orders were not followed for Resident 53 and Resident 21, when the residents' oxygen nasal cannula tubing (device used to deliver oxygen into the nose via a tube) and humidifier (bottle filled with distilled water that attaches to an oxygen concentrator or tank to add moisture to the oxygen) were found unlabeled and undated2.Three Hoyer lift (a mechanical lift) slings (strong, fabric harnesses that securely hold a person with limited mobility while a mechanical lift moves them) were observed hanging from the exterior bars outside the laundry room windows.3.The facility failed to ensure staff adhered to required infection prevention and control practices, including appropriate PPE use during high-contact care for Resident 37 on Enhanced Barrier Precautions (EBP-an infection control guideline that requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading infectious diseases) placing Residents 37 at risk for potential transmission of infection.4.Two manual blood pressure cuffs (a tool used to measure blood pressure without electronics) were found visibly soiled with a white substance and lint in two of seven sampled Enhanced Barrier Precautions (EBP- an infection control guideline that requires staff to wear a gown and gloves while performing high-contact care activities with all residents who are at higher risk of acquiring or spreading infectious diseases) carts (mobile supply carts stocked with EPP- personal protective equipment such as gowns, gloves, and goggles.) located outside resident rooms.5. A staff member did not perform hand hygiene after removing gloves upon exiting a resident room on enhanced barrier precautions (EBP - an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of multidrug resistant organisms [MDRO - bacteria that have become resistant to certain antibiotics]).These failures had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi, or parasites) to 54 medically compromised residents and staff in the facility.Findings: 1.A. During a review of Resident 53's admission Record (contains medical and demographic information), the admission Record indicated Resident 53 was admitted to the facility on [DATE], with diagnoses which included Acute Respiratory Failure with hypoxia (the lungs cannot properly transfer oxygen into the blood, leading to dangerously low blood oxygen levels), Dependence on Supplemental Oxygen (the lungs or heart cannot get enough oxygen into the bloodstream from normal room air to keep the body functioning properly), and Cerebral Infarction (when a part of the brain dies because it is not getting enough blood and oxygen). During a review of Resident 53's Physician Order dated March 6, 2026, the Physician Order indicated, Oxygen @ 4 L/Min (Liter/Minute – unit of measurement) via nasal cannula or face mask continuously for SOB (Shortness of Breath). Monitor q (every) shift if oxygen is delivered at 3 L/min or above. Humidifier must be applied. (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
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 53's Physician Order dated March 6, 2026, the Physician Order indicated, Change nasal cannula or face mask and tubing q week on Sunday. Date nasal cannula or face mask and tubing when changed. Every night shift every Sunday. If oxygen is delivered at 3 L/min or above, humidifier must be changed weekly with nasal cannula or face mask. During an observation on April 6, 2026, at 10:57 AM, in Resident 53's room, Resident 53 was observed on oxygen 4 L/Min via nasal cannula tubing, and a humidifier was attached to an oxygen concentrator (device that provides supplemental oxygen). The nasal cannula tubing and humidifier were unlabeled and undated. During a concurrent observation and interview on April 6, 2026, at 11:13 AM, with Infection Preventionist (IP) in Resident 53's room, the IP inspected Resident 53's nasal cannula tubing and humidifier. The IP verified the nasal cannula tubing and humidifier were not labeled or dated. The IP stated both should have been labeled and dated to prevent infections. During a concurrent interview and record review on April 7, 2026, at 9:50 AM, with the Director of Nursing (DON), Resident 53's Physician Order dated March 06, 2026, indicated, Change nasal cannula or face mask and tubing q week on Sunday. Date nasal cannula or face mask and tubing when changed. Every night shift every Sunday. If oxygen is delivered at 3 L/min or above, humidifier must be changed weekly with nasal cannula or face mask. The DON stated the physician order was not followed. She further stated it is important to change the oxygen nasal cannulas and humidifier to prevent infections. B. During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD – a progressive, long-term lung disease that makes it hard to breathe), Nonrheumatic Aortic Valve Stenosis (the main valve controlling blood flow out of the heart becomes stiff, thick, and narrow, making it hard for blood to flow to the rest of the body), and Dependence on Supplemental Oxygen (the lungs or heart cannot get enough oxygen into the bloodstream from normal room air to keep the body functioning properly). During a review of Resident 21's Physician Order dated March 18, 2026, the Physician Order indicated, Oxygen @ 4 L/Min via nasal cannula or face mask continuously for COPD. Monitor q shift. If oxygen is delivered at 3 L/min or above, humidifier must be applied. During a review of Resident 21's Physician Order dated March 22, 2026, the Physician Order indicated, Change nasal cannula or face mask and tubing q week on Sunday. Date nasal cannula or face mask and tubing when changed. Every night shift every Sunday. If oxygen is delivered at 3 L/min or above, humidifier must be changed weekly with nasal cannula or face mask. During an observation on April 6, 2026, at 11:02 AM, in Resident 21's room, Resident 21 was observed on oxygen 4 L/Min via nasal cannula tubing, and a humidifier was attached to an oxygen concentrator. The nasal cannula tubing and humidifier were unlabeled and undated. During a concurrent observation and interview on April 6, 2026, at 11:17 AM, with Infection Preventionist (IP) in Resident 21's room, the IP verified the nasal cannula tubing and humidifier were not labeled or dated. The IP stated both should have been labeled and dated to prevent infections. During a concurrent interview and record review on April 7, 2026, at 9:56 AM, with DON, the Physician (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Order dated March 22, 2026, were reviewed. The physician order indicated, Change nasal cannula or face mask and tubing q week on Sunday. Date nasal cannula or face mask and tubing when changed. Every night shift every Sunday. If oxygen is delivered at 3 L/min or above, humidifier must be changed weekly with nasal cannula or face mask. The DON stated the physician order was not followed for this resident either. She further stated it should have been followed to help prevent infections. 2. During an observation and interview on April 6, 2026, at 8:23 AM, with Administrator, outside Administration building next to the laundry building, two Hoyer lift (a mechanical lift) slings (strong, fabric harnesses that securely hold a person with limited mobility while a mechanical lift moves them) were observed hanging from the bars on the laundry room window. The Administrator stated the sling should not be outside and should be laundered inside the laundry room because it an infection control and contamination concern. During an observation and interview on April 7, 2026, at 3:01 PM, with Housekeeping Supervisor (HS), outside laundry building, one Hoyer lift slings were observed hanging from the bar on the laundry room window. HS stated the sling should not be outside and there is a new employee that needs to be educated on the correct process to laundry slings. HS further states slings should be wiped down then hang in laundry room to dry. During an observation and interview on April 8, 2026, at 7:47 AM, with HS, at unit 1 linen closet, there was a Hoyer lift sling stored in clean linen closet. HS states once slings are laundered, they are stored in clean linen closet on units 1 and 2. During an interview and record review on April 8, 2026, at 3:50 PM, with the Administrator, the facility's P&P titled, Laundry, undated, was reviewed. The P&P indicated, . All linen will be handled in a manner to prevent contamination.1f.Linen should be stored in covered, clean storage carts or areas. The Administrator confirmed the P&P was not followed and stated that adherence is important due to the increased risk for infection within the resident population. 3. During a review of Resident 37 's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE], with the diagnoses which included, gastrostomy Status(G tube-surgically placed tube that provides direct access to the stomach for nutrition, fluids, and medications.), Acute Myocardial Infarction (MI-heart attack), Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 37's care plan titled, Resident requires Enchased barrier precautions due to Gastrostomy tube. History of ESBL (bacteria that is resistant to a wide range of antibiotics), MRSA(bacteria that is resistant to a wide range of antibiotics) dated February 13, 2026, the care plan indicated, PPE to be used for enhanced barrier precautions: 1. Gloves 2. Gown, when in direct contact with resident during care.Gloves and gown prior to the 6 moments of high-contact care activities (enhanced precautions (e.g., gloves and gowns) are specifically recommended to prevent MDRO; dressing, bathing or showering, transferring, providing hygiene, toileting). During an observation on April 8, 2026, at 6:22 AM, inside Resident 37's room, observed Resident 37's feeding tube discounted and draining on floor. Licensed Vocational Nurse 3 (LVN 3) and Certified Nursing Assistant 2 (CNA 2) responded to the situation. CNA 2 was observed cleaning the feeding solution from the floor and assisting LVN 3 with resident care, removing soiled towels and linens. LVN 3 was then observed flushing Resident 37's G-tube, assessing the site, and reconnecting the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	enteral feeding tube. Resident 37 was on EBP requiring the use of personal protective equipment (PPE), including a gown. LVN 3 and CNA 2 failed to wear the required gown during high-contact resident care. During an observation on April 8, 2026, at 6:31 AM, inside Resident 37's room, Resident 37's was observed again with the feeding tube disconnected, and feeding solution leaking. Registered Nurse Supervisor 2 (RNS 2) and CNA 3 responded and performed high-contact care activities, including removing and cleaning the feeding solution and providing G-tube care. RNS 2 was observed reconnecting the feeding tube. RNS 2 and CNA 3 failed to wear the required gown during high-contact resident care for Resident 37, who was on EBP. During an interview and observation on April 8, 2026, at 6:42 AM with LVN 3, outside Resident 37's room, observed signage posted outside the door indicating enhanced barrier precautions for resident 37. LVN 3 stated she should have been wearing a gown when she was providing care to Resident 37 due to G tube and increased risk for infection. During an interview on April 8, 2026, at 6:55 AM with Infection Preventionist (IP), outside resident 37's room. IP stated staff are expected to wear gloves, gowns and masks for residents on EBP when performing high contact care. She states the staff didn't follow the EBP guidelines. During an interview with the Administrator on April 9, 2026, at 12:32 PM, in the Administrator office, the Administrator stated the facility does not have a policy and procedure (P&P) on enhanced barrier precautions. The Administrator further stated the facility follows the CDC enhanced barrier precautions guidelines and the CDC guidelines signage is placed outside Resident's on enhanced barrier precaution rooms. The Administrator stated the staff did not follow the CDC guidelines line. 4. During an observation and interview on April 6, 2025, at 10:09 AM, with Certified Nursing Assistant 1 (CNA 1), in the hallway of unit 2, two manual blood pressure cuffs were found visibly soiled with white substance and lint inside top drawer of two EBP carts. CNA 1 acknowledged the blood pressure cuffs were dirty with white substances and lint. CNA 1 stated the facility's expectation is that resident care equipment must be cleaned after each use. During an observation and interview on April 6, 2025, at 10:15 AM, with Infection Preventionist (IP), in hallway of unit 2, the IP verified that two manual blood pressure cuffs were visibly soiled with white substance and lint and were stored inside the top drawers of two EBP carts. IP stated the facility's Policy and Procedure (P&P) require cleaning resident care equipment immediately after each resident use. The IP further stated EBP carts are used for residents at high risk of acquiring or spreading infectious diseases, and dirty equipment increases the infection risk for these and other residents. During a concurrent interview and record review on April 7, 2026, at 10:23 AM, with the Director of Nursing (DON), the facility's P&P titled, Cleaning & Disinfecting Blood Pressure Machine and Blood Pressure Cuff, undated, was reviewed. The P&P indicated, .It is our policy that the sphygmomanometer, used to measure blood pressure of residents, must be cleaned in between each resident's use.1. The blood pressure cuff and gauge will be cleaned after each use with a disinfectant wipe. Remove any visible soil first and then wipe with disinfectant wipe. The DON confirmed the P&P was not followed and stated that adherence is critical due to the increased infection risk within the resident population. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During an observation on April 6, 2026, at 10:25 AM, room [ROOM NUMBER] had a sign outside the doorway which indicated Enhanced Barrier Precautions.Everyone must: clean their hands, including before entering and when leaving the room. Housekeeper 1 (HK 1) was mopping the floor in the room and removed her disposable gloves and did not perform hand hygiene (hand washing or use of alcohol based hand sanitizer) after removing her gloves or upon exiting room [ROOM NUMBER]. Housekeeper 1 then continued mopping the hallway outside room [ROOM NUMBER]. During a concurrent observation and interview on April 6, 2026, at 10:29 AM, HK 1 was still mopping the hallway and had not yet performed hand hygiene after removing her disposable gloves or upon exiting room [ROOM NUMBER], when she agreed to be interviewed. HK 1 stated she removed her gloves and gown when leaving room [ROOM NUMBER] (on enhanced barrier precautions) but didn't perform hand hygiene because she was not done mopping so she continued to mop in the hallway. During an interview on April 6, 2026, at 10:36 AM, with the Director of Nursing (DON), the DON stated hand hygiene was supposed to be done every time before and after removing Personal Protective Equipment (PPE). The DON further stated hand hygiene was supposed to be done upon exiting a room on enhanced barrier precautions. The DON stated hand hygiene was important to prevent the spread of infection from one person to another person. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene Program, undated, the P&P indicated, Rationale for hand hygiene: Prevent transmission of infectious agents.indications for performing hand hygiene: -before and after glove use.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure five of five rooms (each with four resident beds 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 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 April 6, 2026, the document indicated there was a total of five rooms within the facility each with four beds and the ability to house 4 residents The rooms were: 102, 105, 106, 107 and 112.During a concurrent observation and interview on April 9, 2026, at 8:45 AM, with the Maintenance Supervisor (MS) and the Director of Nursing (DON), the MS measured Rooms 102, 105, 106, 107, and 112. All measurements were verified by both the MS, the DON 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 178.5 x width 238 = 42483 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 238 = 43792 sq in total room area. Within the room, there was one moveable wardrobe cabinet which measured 36 x 19 = 684.room [ROOM NUMBER]: Length 178 x 244 = 43432 sq in total room area. Within the room there was one moveable wardrobe cabinet which measured 33 x 18 = 594 and another moveable wardrobe cabinet which measured 33 x 19 = 627.room [ROOM NUMBER]: Length 184 x 239 = 43976 sq in total room area. Within the room, there was one moveable wardrobe cabinet which measured 23.5 x 40 = 940 and another moveable wardrobe cabinet which measured 39 x 24.5 = 955.5.During an interview on April 9, 2026, at 2:30 PM, with the Administrator (ADMIN), and the Assistant Director of Nursing (ADON), the ADMIN and ADON were 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 73.23 sq ft.room [ROOM NUMBER]: Length 178.5 x width 238 = 42483 sq in total room area. 42483 sq in divided by 144 (to convert to sq ft) = 295.02 sq ft total room area. Divided by 4 (number of residents in the room) = 73.75 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 71.25 sq ft.room [ROOM NUMBER]: Length 184 x width 238 = 43792 sq in total room area. 43792 sq in divided by 144 (to convert to sq ft) = 304.11 sq ft total room area. Divided by 4 (number of residents in the room) = 76.02 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 74.84 sq ft.room [ROOM NUMBER]: Length 178 x 244 = 43432 sq in total room area. 43432 sq in divided by 144 (to convert to sq ft) = 301.61 sq ft total room area. Divided (continued on next page)

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by 4 (number of residents in the room) = 75.40 sq ft per resident. However, within the room there was two moveable wardrobe cabinets. One measured 33 x 18 = 594 and the other measured 33 x 19 = 627. After subtracting the moveable wardrobe space, the total sq ft per resident was decreased to 73.28 sq ft.room [ROOM NUMBER]: Length 184 x 239 = 43976 sq in total room area. 43976 sq in divided by 144 (to convert to sq ft) = 305.38 sq ft total room area. Divided by 4 (number of residents in the room) = 76.34 sq ft per resident. However, within the room there was one moveable wardrobe cabinet which measured 23.5 x 40 = 940 and another moveable wardrobe cabinet which measured 39 x 24.5 = 955.5. After subtracting the moveable wardrobe space, the total sq ft per resident was decreased to 73.05 sq ft per resident.The Administrator (ADMIN) stated she agreed on the calculations and 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.During an interview on April 9, 2026, at 11:20 AM, 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, walker, Hoyer lift, and/or Geri chair (a large, padded chair that's designed to help people with limited mobility sit and stand comfortably).During a review of the facility's document titled, List of 5 rooms who Have 4 Residents, undated, the document indicated of the five rooms (Rooms 102, 105, 106, 107, and 112) four residents required use of Hoyer lift, nine residents had wheelchairs, five residents had Geri chairs, and two residents required walkers.The facility did not have a policy and procedure regarding minimum required room square footage required per resident

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dignity was maintained for one of 18 sampled residents (Resident 4) when Resident 4?s urinary collection bag (bag which collect and hold urine) was found not covered with a dignity bag (a drainage bag holder used to cover and hold the catheter drainage/collection bag, so it is not visible). This failure resulted in Resident 4's urine being visible to residents, staff, and visitors, which compromised his privacy and diminished his dignity, self-worth, and sense of respect.Findings: During a review of Resident 4's admission Record, (contains demographic and medical information), indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease (the final, permanent stage of chronic kidney disease where kidney function falls below 15% of normal), dependence on renal dialysis (a person's kidneys have failed [typically <15% function] and can no longer filter waste or manage fluids, making regular, life-sustaining dialysis treatments necessary to stay alive), obstructive uropathy (a blockage in the urinary system that prevents urine from flowing freely, causing it to back up into the kidneys) and reflux uropathy (a condition in which the kidneys become damaged or scarred due to the backward flow of urine from the bladder into the kidneys). During a concurrent observation and interview on April 6, 2026, at 11:26 AM in Resident 4's room, Resident 4 was observed resting in bed and had a suprapubic catheter (a thin, flexible tube inserted directly into the bladder through a small incision in the lower abdomen to drain urine). The urinary collection bag connected to the suprapubic catheter, was observed to contain urine, was not labeled with a date and was not concealed within a dignity bag, making it visible to anyone entering or passing by the room. Resident 4 stated the facility did not offer or provide him a cover (dignity bag) for his catheter drainage bag. During a concurrent observation and interview on April 6, 2026, at 11:35 AM, with the Infection Preventionist (IP) at Resident 4's room, IP acknowledged the urinary collection bag was not labeled with a date and the bag was not concealed within a dignity bag, resulting in its visibility to anyone entering or passing by the room. IP stated dignity bags are currently unavailable within the facility and reported that a request to reorder dignity bags had been made a while ago.During an interview on April 7, 2026, at 9:31 AM, with the Assistant Director of Nursing (ADON), the ADON stated all urinary collection bags should be covered with a dignity bag. The ADON further stated dignity bags were used for maintaining residents' privacy and dignity.During a concurrent interview and record review on April 9, 2026, at 10:37 AM with the Administrator (Admin) and the ADON, the facility's Policy and Procedure (P&P) titled, Foley Catheter, undated, was reviewed. The P&P stated . 3. Maintenance of foley catheter . g. Urinary drainage is kept inside a urinary drainage bag holder. The Admin stated all urinary collection bags should be covered with a dignity bag at all times to maintain resident's privacy and dignity. The Admin acknowledged the P&P was not followed when Resident 4's urinary collection bag was not concealed within a dignity bag, making it visible to anyone entering or passing by the room.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure nursing staff followed a physician's order for hypoglycemia (low blood sugar) management for one of one sampled residents (Resident 43) reviewed for insulin (medication used to help lower blood sugar levels), when on multiple occasions, staff did not document a required repeat blood sugar check after the Resident 43's initial blood sugar was below 70 milligrams per deciliter (mg/dl).This failure resulted in Resident 43 to not receive care and monitoring of blood sugar levels as ordered by the physician and for Resident 43 to experience hypoglycemia without staff knowledge or intervention.Findings: During a review of Resident 43's admission Record (contains medical and demographic information), the admission Record, indicated Resident 43 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (condition in which the body can't regulate blood sugar levels adequately, leading to high blood sugar levels), hemiplegia and hemiparesis (weakness and paralysis), and history of cerebral infarction (a specific type of stroke, referring to dead brain tissue caused by prolonged lack of blood flow).During an interview on April 6, 2026, at 10:09 AM, with Resident 43, Resident 43 stated her blood sugar levels had been low lately.During a review of Resident 43's care plan (an individualized plan for the medical care of a resident), titled, [Name of Resident 43] has diabetes mellitus.at risk for hypo/hyperglycemic episodes [episodes of low and high blood sugar levels].interventions.diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.Monitor blood sugar as ordered and provide insulin as ordered per sliding scale.During a review of Resident 43's physician's orders, dated June 1, 2024, indicated, Humalog solution [type of insulin] 100 unit/ml [units per milliliter - unit of measure].inject as per sliding scale: if 0-70 = 0 units give 4 oz [ounces] of juice Recheck BS [blood sugar] x 15 minutes. If results are below 60 notify MD or sent to ER [emergency room].During a review of Resident 43's Medication Administration Record (MAR - document used to record medications, treatments, and assessments), dated March 1, 2026, through March 31, 2026, the MAR indicated the following:1.On Sunday, March 1, 2026, at 6:30 AM, Resident 43's blood sugar was documented as 68 mg/dl. There was no documentation regarding a repeat blood sugar level.2.On Thursday, March 19, 2026, at 6:30 AM, Resident 43's blood sugar was documented as 67 mg/dl. There was no documentation regarding a repeat blood sugar level.3.On Wednesday, March 25, 2026, at 6:30 AM, Resident 43's blood sugar was documented as 69 mg/dl. There was no documentation regarding a repeat blood sugar level.During a concurrent interview and record review on April 9, 2026, at 10:05 AM, with the Director of Nursing (DON), Resident 43's MAR dated March 1, 2026, through March 31, 2026, was reviewed. The DON stated per the physician's orders, if Resident 43's blood sugar level was below 70 mg/dl, staff were supposed to give the resident four (4) ounces of juice (to attempt to raise the blood sugar), then recheck the blood sugar after 15 minutes and if it was below 60 mg/dl, staff were supposed to notify the physician and send the resident to the emergency room (ER). The DON acknowledged Resident 43's blood sugar levels were 68 mg/dl on March 1, 2026, at 6:30 AM, 67 mg/dl on March 19, 2026, at 6:30 AM, and 69 mg/dl on March 25, 2026, at 6:30 am. The DON further stated staff were supposed to recheck the residents blood sugar level after administering juice and the follow up blood sugar levels should have been documented as a progress note. The DON then reviewed Resident 43, progress notes, and the rest of the clinical record and stated she was unable to find documented evidence anywhere in the clinical record that Resident 43's blood sugar was rechecked on March 1, March 19, and March 25, of 2026 when the Resident 43's blood sugar was initially below 70 mg/dl.During a concurrent interview and record review on April 9, 2026, at 10:05 AM, with the Assistant Director of Nursing (ADON), Resident 43's clinical record was reviewed. The ADON stated she also was unable to find documented evidence that staff rechecked Resident 43's blood sugar level on on March 1, March 19, and March 25, of 2026 when Resident 43's blood sugar was initially below 70 mg/dl.During an interview on April 9, 2026, at 10:12 AM, with the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ADON, the ADON stated it was important to ensure Resident 43's blood sugar levels were rechecked and documented as ordered by the physician to ensure the juice that was given to the resident effectively raised the blood sugar level as expected and to ensure the facility informs the physician if it did not (raise the blood sugar level).During a review of the facility's policy and procedure (P&P) titled, Resident Assessment and Care Planning, dated January 2026, 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.

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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** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 6) reviewed for pressure ulcers (injury to skin and underlying tissues that develops as a result of prolonged pressure, shear, or friction) had a low air loss mattress (LAL mattress - a specialized mattress which is air filled and is designed to help prevent and treat pressure ulcers) programmed to the correct weight as ordered by the physician. This failure resulted in the low air loss mattress to not have the most therapeutic effect for the prevention and treatment of pressure ulcers and for Resident 6 to have increased risk for the development of new pressure ulcers and a delay in wound healingFindings: During a review of Resident 6's admission Record (contains medical and demographic information), the admission Record, indicated Resident 6 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (a condition where the heart is unable to pump blood effectively enough to meet the body's needs), type 2 diabetes mellitus (a condition which causes high blood sugar levels), age related osteoporosis (an age-related condition characterized by decreased bone density and structural deterioration, making bones fragile and more likely to fracture), muscle wasting and atrophy (loss of muscle mass and strength), and major depressive disorder (a mood disorder characterized by persistent depressed mood leading to significant functional impairment).During an observation on April 9, 2026, at 9:16 AM in Resident 6's room, Resident 6 was lying in bed turned to her left side while on a low air loss mattress. The low air loss mattress was programmed to 350 lbs.During a concurrent observation and interview on April 9, 2026, at 9:20 AM, with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the purpose of a low air loss mattress was to prevent pressure ulcers from forming and to ensure existing pressure ulcers did not worsen. LVN 1 further stated low air loss mattresses were supposed to be set per physician's orders. LVN 1 then observed resident 6 in bed and acknowledged Resident 6's low air loss mattress was programmed to 350 pounds and set to firm. LVN 1 then reviewed Resident 6's physician's orders and stated Resident 6's low air loss mattress was incorrectly set and should have been set to 70-80 pounds per the physicians orders but the mattress was instead set to 350 lbs. LVN 1 stated she did not know why the low air loss mattress was set to the incorrect weight.During an interview on April 9, 2026, at 10:18 AM, with the Director of Nursing (DON), the DON stated low air loss mattresses were supposed to be programmed for the correct weight as indicated in the physician's order and if it was not, it defeated the purpose of trying to reduce pressure and prevent pressure ulcers from developing or worsening.During a review of Resident 6's physicians orders, dated April 1, 2026, indicated, may use low air loss mattress at air pressure range of 70-80 lbs. [pounds] monitor mattress air pressure q shift [every shift]. If pressure is out of range, adjust bed and document variance and actions taken in progress note.During a review of Resident 6's Care Plan Report, a document which includes all of Resident 6's care plans (an individualized plan for the medical care of a resident), titled, Has new onset stage 2 pressure injury, risk for infection, worsening impairment, uncontrolled pain, dated March 27, 2026, the care plan indicated, Low air loss (LAL) mattress.provide tx [treatment] as ordered.During a review of the facility's policy and procedure (P&P) titled, Air Mattress, dated January 21, 2026, the P&P indicated, Purpose: To provide pressure reduction to residents at risk for skin breakdown. To distribute body weight relieving areas of pressure. Policy: It is the policy of this facility to utilize air mattress therapy under the direction of a physician's order or when the resident's clinical condition warrants pressure reducing devices.During a review of the facility's P&P titled, Pressure Injury Prevention and Management, dated January 21, 2026, the P&P indicated, Purpose: To provide a system of evaluation, assessment and monitoring of residents for prevention and/or management of pressure injuries.2. An assessment of care needs for pressure injury prevention and/or management will be made with emphasis on, but not limited to, prevention, pressure reducing devices.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) for one of 18 sampled Residents (Resident 4) when: 1.Urinary collection bag was not changed every Sunday and PRN (as needed) according to physician's orders. 2. Suprapubic catheter (a tube inserted into the bladder through a small abdominal incision, rather than the urethra, to drain urine) was not flushed with 60 cc (cubic centimeter: a unit of measurement) normal saline (a solution used for flushing suprapubic catheter) according to physician's orders This failure resulted in Resident 4's urinary drainage bag not being flushed and changed for several months, placing Resident 4 at risk for developing an urinary tract infections and causing discomfort and decline in Resident 4's health and well being.Findings:1.During a review of Resident 4's admission Record (contains demographic and medical information), indicated Resident 4 was readmitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease (the final, permanent stage of chronic kidney disease where kidney function falls below 15% of normal), dependence on renal dialysis (a person's kidneys have failed [typically <15% function] and can no longer filter waste or manage fluids, making regular, life-sustaining dialysis treatments necessary to stay alive), and obstructive uropathy (a blockage in the urinary system that prevents urine from flowing freely, causing it to back up into the kidneys) and reflux uropathy (a condition in which the kidneys become damaged or scarred due to the backward flow of urine from the bladder into the kidneys). During an observation on April 6, 2026, at 11:26 AM, in Resident 4's room, Resident 4 was observed resting in bed with a urinary collection bag positioned on the mattress between his legs. The urinary collection bag contained cloudy, concentrated urine, with significant sedimentation visible in the tubing and was emitting a foul odor. The urinary collection bag was not labeled with a date and was not properly positioned to allow for adequate drainage to prevent urine backflow into the Resident 4's bladder.During a concurrent observation and interview on April 6, 2026, at 11:35 AM, with the Infection Preventionist (IP) in Resident 4's room, the IP acknowledged the urinary collection bag was found laying on the mattress between the residents' legs. IP acknowledged the urinary bag contained cloudy, concentrated urine with significant sedimentation visible in the tubing and emanating a foul odor. IP acknowledged the urinary collection bag showed signs of long-term use, lacked any labeling indicating recent replacement and was not properly positioned to allow for adequate drainage to prevent urine backflow into Resident 4's bladder. IP was unable to state when the bag was changed and stated that for optimal urine drainage, the urinary collection bag should be properly secured to the bed's frame and kept below the level of the bladder. During a record review of Resident 4's Physician Orders dated January 4, 2026, the order stated, Suprapubic Catheter, change catheter bag Q [every] week on Sunday and PRN (as needed) if leakage, blockage or if soiled. During a record review of Resident 4's Treatment Administration Record (TAR) for January, February, March and April 2026 it was revealed there is no documentation indicating that the drainage bag had been changed since the order was received on January 4, 2026. During an interview with the Admin, on April 9, 2026, at 10:37 AM, the Admin confirmed there is no documentation indicating the urinary collection bag was changed since the order was received on January 4, 2026. The Admin explained that most likely staff were not aware of a weekly order for drainage bag change. The Admin acknowledged the physician orders to change catheter bag every week on Sunday and as needed if leakage, blockage or if soiled were not follow. During a concurrent interview and record review on April 9, 2026, at 10:37 AM with Admin and Assistant Director of Nursing (ADON), the facility's Policy and Procedure (P&P) titled, Close Drainage System Urinary Drainage Bags, revised January 21, 2026, was reviewed. The P&P stated, Purpose: To allow a system for the collection of urine from in [NAME] Foley catheters with infection control practices to prevent cross contamination. Policy: It is the policy of this facility that drainage system for indwelling foley (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheters are maintained as closed system to the extent possible. Urinary drainage bags are changed only when the catheter is changed or if it becomes cloudy, leaks or has an odor . F. Position drainage back below the level of the bladder and ensure it does not touch the floor. Admin and ADON acknowledge the P&P was not followed. 2. During an observation on April 6, 2026, at 11:26 AM in Resident 4's room, Resident 4 was observed resting in bed with a urinary collection bag positioned on the mattress between his legs. The urine collection bag contained cloudy, concentrated urine, with significant sedimentation visible in the tubing and was emitting a foul odor. The urinary collection bag was not labeled with a date and was not properly positioned to allow for adequate drainage to prevent urine backflow into Resident 4's bladder.During a concurrent observation and interview on April 6, 2026, at 11:35 AM, with the Infection Preventionist (IP) in Resident 4's room, the IP acknowledged the urinary collection bag was found laying on the mattress between Resident 4's legs. The IP acknowledged the urinary bag contained cloudy, concentrated urine with significant sedimentation visible in the tubing and emanating a foul odor. The IP acknowledged the urinary bag showed signs of long-term use, lacked any labeling indicating recent replacement and was not properly positioned to allow for adequate drainage to prevent urine backflow into Resident 4's bladder. The IP was unable to state how often and when the last time the suprapubic catheter was flushed.During a record review of Resident 4's Physician Orders dated January 4, 2026, the order stated, Suprapubic Catheter, irrigate PRN with 60 cc (cc - unit of measurement for fluids) normal saline to prevent blockage.During a concurrent interview and record review with the Administrator (Admin) and Assisted Director of Nurses (ADON) on April 9, 2026 at 10:37 AM, a review of Resident 4's Treatment Administration Record (TAR) for January, February, March and April 2026 was conducted. Resident 4's TAR revealed there was no documentation indicating the suprapubic catheter had been flushed since the order was received on January 4, 2026. The Admin and the ADON stated the expectations are that staff follow physicians' orders as written stating the physician orders to flush the suprapubic catheter PRN with 60 cc normal saline were not followed.During a concurrent interview and record review on April 9, 2026, at 10:37 AM with the Admin and the ADON, the facility's Policy and Procedure (P&P) titled, Close Drainage System Urinary Drainage Bags, revised January 21, 2026, was reviewed. The P&P stated Purpose: To allow a system for the collection of urine from in [NAME] Foley catheters with infection control practices to prevent cross contamination. Policy: It is the policy of this facility that drainage system for indwelling foley catheters are maintained as closed system to the extent possible. Urinary drainage bags are changed only when the catheter is changed or if it becomes cloudy, leaks or has an odor . F. Position drainage back below the level of the bladder and ensure it does not touch the floor. The Admin and ADON acknowledged the facility's P&P was not followed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff were competent in the monitoring of a dialysis access sites for one of one sampled resident (Resident 31) when multiple nursing staff were documenting Resident 31 had bruit (a whooshing or humming sound heard through a stethoscope placed over a fistula [surgically created connection between and artery and a vein], and thrill (a vibration or buzzing sensation felt under the skin when you lightly place your fingertips over a fistula. A normal continuous thrill indicates a functioning, patent fistula, confirming adequate blood flow) despite Resident 31 not having a fistula and instead had a Central Venous Catheter (CVC- a long, flexible tube inserted into a large vein which provides direct access to central circulation.) In addition, no nursing staff contacted the doctor for clarification of Resident 31's physician's order. This failure resulted in inaccurate documentation and demonstrated nursing staff confusion regarding monitoring of bruit and thrill on a fistula versus monitoring of complications with a central venous catheter. This poses a risk for missed, incorrect, or misleading clinical information regarding Resident 31's vascular access device.Findings: During a review of Resident 31's admission Record (contains medical and demographic information), the admission Record, indicated Resident 31 was admitted to the facility on [DATE], with diagnoses which included end stage renal disease (kidney failure), dependence on renal dialysis (a condition in which the kidneys cannot adequately filter waste or balance fluids, requiring the patient to rely on lifelong dialysis treatments [a medical treatment that filters waste, toxins, and excess fluid from the blood]), and legal blindness.During a concurrent observation and interview on April 7, 2026, at 9:51 AM, with Resident 31, Resident 31 stated he received dialysis three times a week. Resident 31 further stated his dialysis access site was a central venous catheter on his right chest as he pointed to his chest. A central venous catheter was observed with a dressing over the insertion site of the chest.During a review of Resident 31's physician's orders, dated March 24, 2026, indicated Resident 31 was to receive hemodialysis three times a week every Monday, Wednesday, and Friday.During a review of Resident 31's physician's orders, dated March 16, 2026, indicated, .Monitor shunt on right upper chest for Bruit q [every] shift and notify MD [medical doctor] if none is felt. Additionally, a physician's order dated March 16, 2026, indicated, .Monitor shunt on right upper chest for thrill q shift and notify MD if none is felt.During a review of Resident 31's Medication Administration Record (MAR - a document used to record the administration of medications, treatments, and assessments), dated March and April of 2026, the following was identified:1.For the physician's order monitor shunt on right upper chest for bruit q shift and notify MD if none is felt. the task was documented as completed on 70 different shifts amongst a total of six (6) different licensed nurses (which included Registered Nurse Supervisor [RNS] and Licensed Vocational Nurse 1 [LVN 1]).2.For the physician's order monitor shunt on right upper chest for thrill q shift and notify MD if none is felt. the task was documented as completed on 70 different shifts amongst a total of seven (7) different licensed nurses.During a concurrent interview and record review on April 8, 2026, at 2:08 PM, with the Director of Nursing (DON), the DON stated checking for bruit and thrill could only be done on a shunt/fistula and could not be done on a central venous catheter. The DON further stated the order to check bruit and thrill was inappropriate since the resident only had a central venous catheter. The DON then reviewed Resident 31's clinical record and stated the physician's order to check bruit and thrill was never clarified and no licensed nurse questioned the appropriateness of the order.During a concurrent interview and record review on April 8, 2026, at 2:15 PM, with the Assistant Director of Nursing (ADON), the ADON stated nursing staff input the physician's order to check bruit and thrill on a central venous catheter but they only check bruit and thrill on a fistula/shunt. Resident 31's MAR dated March and April 2026, were reviewed. The ADON acknowledged there were numerous nurses who were consistently documenting that they had (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	successfully checked Resident 31 for bruit and thrill despite having a central venous catheter. The ADON further stated staff would need to be in-serviced (trained) regarding dialysis assessment of bruit and thrill. During an interview on April 9, 2026, at 11:20 AM, with RNS, RNS acknowledged he documented in Resident 31's MAR as successfully checking for bruit and thrill despite Resident 31 only having a central venous catheter. RNS stated you can't check bruit and thrill on a central venous catheter.During an interview on April 9, 2026, at 11:25 AM, with LVN 1, LVN 1 acknowledged she documented in Resident 31's MAR for multiple days in March and April 2026 for checking resident 31 for bruit and thrill. LVN 1 further stated she checked for bruit by listening with a stethoscope to one of Resident 31's arms and checked for thrill by palpating (feeling) the arm where a shunt/fistula would usually be located. LVN 1 further stated she didn't realize the resident didn't have a shunt/fistula and thought she heard bruit and thrill even though the resident had a central venous catheter only. LVN 1 stated staff could benefit from re-education about assessing bruit and thrill.During a review of the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, dated May 2019, the P&P indicated, .Licensed nurses and nursing assistants employed (or contracted) by the facility will.b. Demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care.4. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: .f. basic nursing skills.l. identification of changes in condition.During a review of the facility's P&P titled, Documentation, dated January 21, 2026, the P&P indicated, Purpose: To provide guidelines to ensure documentation is completed which meets facility standards and regulations.c. Resident specific special needs will be assessed and findings documented. Special needs include, but is not limited to, the following: .vi. Dialysis.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 5 sampled residents (Resident 5) Metformin (a medication used for the treatment of high blood sugar) was administered as prescribed by the physician when the medication was administered without food. This failure had the potential for Resident 5 to have adverse side effects including gastrointestinal intolerance (the body's inability to properly digest or break down certain foods or substances, leading to uncomfortable digestive symptoms) and hypoglycemia (occurs when the blood sugar level drops below 70).Findings: During a review of Resident 5's admission Record (list of diagnoses and demographic information), the admission Record indicated, Resident 5 was admitted to the facility on [DATE], with the diagnoses which included Type 2 Diabetes Mellitus (a chronic condition where the body cannot effectively use insulin or produce enough of it, leading to high blood sugar levels) and Gastrostomy (a surgical procedure that creates an opening in the stomach wall through the abdomen to insert a feeding tube [G-tube]).During a medication administration observation on April 8, 2026, at 5:43 AM, Licensed Vocational Nurse 2 (LVN 2)was observed checking Resident 5's blood sugar level, it was 83. LVN 2 then removed one 500 mg (milligram - unit of weight in the metric system) tablet of Metformin from the medication bubble pack, placed it in a plastic cup, crushed the tablet, and delivered the medication via the resident's G-tube (GT - gastric tube - small tube surgically inserted through the abdomen directly into the stomach used for administration of nutrition, fluids, and medications), followed by a 30 ml (milliliter - unit of volume in the metric system) water flush. After completing the procedure, LVN 2 capped the G-tube and left the resident's room without providing Resident 5 with any food as prescribed by the physician.During an interview and record review with LVN 2 on April 8, 2026, at 5:55 AM, LVN 2 was prompted to read the yellow label on the Metformin bubble pack. LVN 2 read the instruction on the pharmacy-issued yellow label, which stated, Take this medication with a meal. LVN2 was prompted to read the pharmacy-issued white label on the bubble pack, which included the resident's name, medication name, dose, route, frequency and physician's instruction. LVN2 read aloud the instruction, .give with food. LVN 2 was asked what time breakfast will be served. LVN2 stated that breakfast will be served at around 7 AM. LVN 2 acknowledged she administered the Metformin to Resident 5 without food and not following physician's order.During a record review on April 8, 2026, at 6:03 AM, Resident 5's physicians orders were reviewed. The physician order dated March 17, 2023, stated Metformin HCL tablet 500 milligram give one tablet via G tube every morning and at bedtime related to type 2 diabetes mellitus with unspecified complication take with food or via by mouth. During a further review of Resident 5's physician orders, the physician order dated October 16, 2025, stated CCHO [Controlled carbohydrate Fortified diet], Soft and Bite sized texture, Regular consistency, With regular bread and may deviate from dietary restriction during special occasions.During an interview with the Assistant Director of Nursing (ADON) On April 8, 2026, at 7:48 AM, the ADON confirmed the physician's orders were not followed. The ADON stated Metformin should have been administered with food.During a concurrent interview and record review with the Administrator (Admin) on April 9, 2026, at 11:50 AM, the facility's Policy and Procedure (P&P) titled, Procedure: Administration of Doses, revised March 2026, was reviewed. The P&P stated, 1. Right resident - Each resident shall be appropriately identified prior to the administration of any medication by name and armband and or photograph. If applicable, vital signs or tests shall be done prior to the administration of a dose (ex. Pulse with digitalis preparations, periodic blood pressures with antihypertensive, and urine or blood sugar with insulin, ordered) by nurse before administering medication, 2. Right drug - compare physicians order with prescribed medication to ensure the correct medication is being administered, 3. Right dose - ensure prescription labeled dose is consistent with the prescriber's order, 4. Right route - follow the orders administration instructions. Adequate fluid (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be offered with oral medications, 5. Right time - administer the medication at the appropriate time as ordered by the prescriber. The Admin acknowledged the facility's P&P was not followed.

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	04/09/2026

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device that allows patients to communicate with nursing staff when they need assistance) was within residents' reach for two of six sampled residents (Resident 5 and 9) when: 1.For Resident 5, the call light was located on the floor on resident's right side of the bed and unreachable by the resident. 2.For Resident 9, the call light was wrapped around the feeding pump located on a pole away from resident's reach. This failure had the potential to placed Resident 5 and 9 at risk for their safety and well being.Findings: 1.During a review of Resident 5's admission Record (a document that gives a summary of resident information), the admission Record indicated, Resident 5 was admitted to the facility on [DATE], with the diagnoses which included Hemiplegia (a form of paralysis that causes severe or complete loss of movement on one side of the body) and Hemiparesis (weakness on one side of the body, affecting the arm, leg, and sometimes the face) following unspecified cerebrovascular disease (the group of conditions that interfere with blood flow to your brain, such as strokes) affecting left non dominant side.During an observation on April 8, 2026, at 5:43 AM, Resident 5 was laying in bed, awake. The call light was located on the floor on resident's right side of the bed and unreachable by the resident.During an observation and interview with Licensed Vocational Nurse 2 (LVN 2) on April 8, 2026, at 5:45 AM, LVN2 acknowledged the call light was on the floor and unreachable to resident. LVN2 stated the call light must have been fallen to the floor when I gave her the medication. LVN2 further stated the call light must be within resident's reach at all times.During an interview conducted with Resident 5 on April 8, 2026, at 5:52 AM, Resident 5 reported that she was unable to access the call light. She further indicated that, in the event she required assistance, she would likely need to yell for help, as the call light was not within her reach.During concurrent interview and record review on April 8, 2026, at 10:31 AM with the Administrator (Admin) and with the Assistant Director of Nursing (ADON), the facility policy and procedure (P&P) titled Answering the Call Light, revised October 2010 was reviewed. The P&P indicated, Purpose - The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines . 4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The ADON stated the call light should be within resident's reach at all times. The Admin acknowledged the P&P was no followed when Resident 5's call light was located on the floor on resident's right side of the bed and unreachable by the resident.2.During a review of Resident 9's admission Record (list of diagnoses and demographic information), the admission Record indicated Resident 9 was admitted to the facility on [DATE], with the diagnoses which included Paraplegia (the partial or complete paralysis of the lower half of the body, typically affecting both legs and sometimes the lower torso), acute and chronic respiratory failure (a life-threatening condition where there's not enough oxygen or too much carbon dioxide in your body), contracture of muscles (the permanent or long-lasting tightening, shortening, and hardening of muscles, tendons, or skin, which leads to rigid joints and a severe loss of movement) and dementia (a lasting decline in mental abilities, including memory, thinking, and reasoning, that is severe enough to interfere with daily life).During an observation on April 6, 2026, at 11:05 AM, Resident 9 was in laying in bed asleep, facing the wall and covered with blankets. The call light was wrapped around the feeding pump located on a pole away from residents' reach.During an observation and interview with Certified Nursing Assistant 1 (CNA 1) on April 6, 2026, at 11:08 AM, CNA1 acknowledged the call light was wrapped around the feeding pump located on a pole away from residents' reach. CNA1 states the call light should have been within resident's reach so she could call for assistance when needed. During an observation and Interview with MDS Coordinator (MDSC) on April 6, 2026, at 11:12 AM, The MDSC acknowledged the call light was wrapped around the feeding pump located on a pole away from residents' reach. The MDSC stated the call light should have not be hanging on the pole and should (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been clipped on the bed linens within resident's reach. During concurrent interview and record review on April 8, 2026, at 10:31 AM with the Admin and with ADON, the facility policy and procedure (P&P) titled, Answering the Call Light, revised October 2010, was reviewed. The P&P indicated, Purpose - The purpose of this procedure is to respond to the resident's requests and needs. General Guidelines . 4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. The ADON acknowledged the P&P was followed and stated the call light should be within resident's reach at all times. The Admin acknowledged the P&P was not followed when Resident 9's call light was wrapped around the feeding pump located on a pole away from residents' reach.