STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555522	A. Building B. Wing	08/16/2024

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50631 Based on observation, interview, and record review, the facility failed to ensure resident's right were followed for one of four sample residents (Resident 81), when Resident 81 was placed on a left soft wrist restraint (device to prevent excessive movement of a body part to which they are attached) without an Informed Consent. This failure resulted in Resident 81 and Resident 81's Representative not being fully informed about the care and treatment provided. Findings: During a review of Resident 81's clinical record, the Record of Admission (contains demographic and medical information), indicated Resident 81 was admitted to the facility on [DATE]. A review of the Resident 81's History and Physical (H&P-contains information of health issues), dated July 28, 2024, indicated, admission diagnoses which include Cerebral Palsy (disorder that permanently affect a person's movement and muscle coordination), Tracheostomy status (an opening through the neck into the windpipe to allow air to fill the lungs and help a person breathe), and Gastrostomy status (a tube inserted through the abdomen to deliver fluids, nutrition, and medications directly to the stomach). During an observation on August 12, 2024, at 3:22 PM, in Resident 81's room, Resident 81 was resting in a bed with a soft wrist restraint on his left wrist, tied to the bed. During a concurrent interview and record review on August 15, 2024, at 2:18 PM, with the Neuro Care Unit Manager (NM), Resident 81's Order Summary Report, dated July 5, 2024, was reviewed. The Order Summary Report indicated, Left wrist restraint to prevent pulling at lines, tubes, and dressings. The NM acknowledged and stated there should have been a consent for the soft wrist restraint but could not find one. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on August 16, 2024, at 9:16 AM, with the NM, the facility's Policy and Procedure (P&P) titled, Restraints, Physical Guidelines for Use and Assessment, dated September 2001, was reviewed. The P&P indicated, .Complete the consent for use of the ordered physical restraint .the physician will discuss with the resident/representative the risk for injury based on individual resident factors and the potential risks and benefits of all options under consideration including using or not using a restraint. Additionally, the resident/representative will be informed of the right to refuse or revoke consent for the use of restraint. The physician will obtain informed consent from the resident/representative. The NM stated the policy was not followed and further stated the physician should have obtained informed consent prior to the application of the soft wrist restraint because it is our policy.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50631 Based on observation, interview and record review, the facility failed to ensure the enteral nutrition (liquid nutrition administered via feeding tube) was administered as ordered for one of 88 residents (Resident 60) when the feeding pump (a device used to deliver food to patient via feeding tube) was not stopped as ordered for Resident 60, causing Resident 60 to receive excessive feeding. This failure had the potential to increase the risk for aspiration (when food or liquids enter the lungs) and compromise the health of Resident 60. Findings: During a review of Resident 60's clinical record, the Record of Admission (contains demographic and medical information), the Record of Admission indicated, Resident 60 was admitted to the facility on [DATE]. A review of Resident 60's History and Physical (H&P-contain diagnoses information), dated November 26, 2023, indicated, the resident was admitted with diagnoses which included Gastrostomy status (a tube inserted through the abdomen that delivers nutrition and hydration directly to the stomach), Heart Failure (chronic condition in which the heart doesn't pump blood as well as it should), and Tracheostomy (an opening in the neck and into the windpipe to help someone breathe). During a review of Resident 60's Order Summary Report, dated August 7, 2024, the Order Summary Report indicated, The resident is to receive [Name of tube feeding] at 52 ml (milliliter- a unit of measurement) per hour or until 1040ml/1560 kcal (kilocalorie - the amount of energy in food) is infused via pump daily; feeding to start at noon (12:00 PM). During a concurrent observation and interview on [DATE], at 10:01 AM, with Licensed Vocational Nurse (LVN 4), in Resident 60's room, Resident 60 was resting in bed with the feeding pump infusing [Name of tube feeding] at a rate of 52 ml per hour. The total amount infused noted on the pump screen indicated 1512ml. LVN 4 confirmed and stated the feeding pump should not be running at this time and should have been stopped when the 1040ml (an excess of 472ml) infusion was completed, per the physician order. During a concurrent interview and record review on August 15, 2024, at 9:33 AM, with the Neuro Care Unit Manager (NM), the facility's Policy and Procedure (P&P) titled Closed System Ready-to-hang Containers of formula Procedure for dated April 1994, was reviewed. The P&P indicated, .to accurately administer the amount of formula ordered by the physician . The NM acknowledged and stated the policy was not followed. The NM further stated it is important to follow the policy because the amount of feeding ordered is calculated by the nutritionist based on the calorie needs for each resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50631 Based on observations, interviews, and record review, the facility failed to ensure secure storage of medications for one of 15 medication carts (a mobile cart used by licensed nurses to store and transport medication to resident rooms) when Medication Cart #1 was left unlocked and unattended by a licensed nurse in North wing. This failure had the potential to cause unsafe access from unauthorized personnel to medications which could potentially cause harms and injuries from misuse of medication. Findings: During an observation on August 15, 2024, at 5:33 AM, Licensed Vocation Nurse (LVN 6) was observed utilizing Medication Cart #1 prior to entering inside room [ROOM NUMBER] and closed the door without locking the cart. Medication Cart #1 was parked in the hallway, by room [ROOM NUMBER] in the North wing, and was left unlocked and unattended by LVN 6. During an interview on August 15, 2024, at 5:40 AM, LVN 6 acknowledged and stated she did not lock the medication cart and should have locked it after she removed the medication. LVN 6 further stated it is important to lock the medication cart to keep the medication safe and to follow facility's policy. During a concurrent interview and record review on August 15, 2024, at 9:22 AM, with the NeuroCare Unit Manager (NM), the facility's Policy and Procedure (P&P) titled Safe Storage of Medication dated June 1974, was reviewed. The P&P indicated, .Medication carts and treatment carts containing medications must be locked unless under the direct supervision of the nurse or other licensed/registered personnel . The NM stated the policy was not followed and the nurse should have locked the medication cart before entering the room. The NCUM further stated it is important to keep all medications locked to make sure the medications are kept safe and only licensed and authorized personnel have access to the medications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110 Based on observation, interview, and record review, the facility failed to maintain infection control practices for four (4) of seven (7) sampled residents (Resident 51, Resident 69, Resident 57, and Resident 85) when: 1. Resident 51, who was not on transmission-based precaution (methods that are used to help stop the spread of germs from person to another), was observed less than three (3) feet (unit of measurement) apart from Resident 69 who was on transmission-based precautions. 2. The visitor of Resident 85, who was on droplet isolation (an infection control practice uses to prevent the spread of infection that are transmitted through respiratory droplets), was not educated about the proper use of Personal Protective Equipment (PPE-such as mask, gown and gloves worn to minimize exposure to illnesses) and was seen walking out of the isolation room without taking off the PPE. 3. Resident 57, who was not on transmission-based precautions was observed in the same room with Resident 85, who was on transmission-based precautions, with the ceiling suspended curtains drawn opened between the residents. These failures had the potential to put all residents, visitors, and staff at risk to be exposed to a contagious disease (illness caused by spread of germs) that could compromise residents' health and may lead to actual harm from preventable diseases. Findings: 1. A review of Resident 69's History and Physical (H&P-contains the overall condition of the resident), indicated, Resident 69 was admitted to the facility on [DATE], with diagnoses which included respiratory failure encephalopathy (a condition when lungs cannot get enough oxygen into the blood which cause disturbance of brain function) with tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck), and subarachnoid hemorrhage (bleeding in the brain and surrounding tissues) from ruptured aneurysm (when a weakened area in a blood vessel wall burst, leading to bleeding). A review of Resident 69's Order Sheet, dated August 19, 2024, indicated, Resident 69 was ordered to be on droplet and contact isolation (a type of transmission-based precaution that is used to prevent the spread of diseases that can be transmitted through direct or indirect contact with an infected person or contaminated surfaces) for Extended-Spectrum Beta-Lactamase (ESBL-a type of infection that is difficult to be treated). A review of Resident 51's H&P, indicated, Resident 51 was admitted on [DATE], with diagnoses which included chronic respiratory failure (long term condition when lungs can't get enough oxygen into the blood) with tracheostomy, and diabetes (disorder characterized by high blood sugar). There was no indication that Resident 51 was on any transmission-based precaution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on August 12, 2024, at 10:15 AM, with License Vocational Nurse 1 (LVN1), Resident 51 and Resident 69 were observed in room [ROOM NUMBER]. room [ROOM NUMBER]'s door was open, with a sign taped to it, which stated, stop and report to nurse's station before entering room. The back of the sign stated, Droplet and Contact Precaution Isolation, and indicated that an isolation mask, gown, and gloves were the required PPE that needed to be worn by any person when entering the room. Resident 51 was seen on a geriatric chair (a specialized recliner-like chair designed to provide comfort and support for elderly or disabled individuals who may have limited mobility) and Resident 69, who was seen in his bed. There was no cubicle curtain drawn between Resident 51 and Resident 69. LVN 1 stated that Resident 51 and Resident 69 should be kept at least three (3) feet apart. LVN 1 verified and confirmed Resident 51 and Resident 69 were separated only one and a half (1.5) feet apart. During a concurrent interview, on August 12, 2024, at 10:25 AM, with the Infection Preventionist (IP) and LVN 1, IP stated that the facility's policy and procedure (P&P) indicated, it is feasible, residents with and without transmission-based precaution can be in the same room. IP further explained Resident 51, who was not on transmission-based precaution, could share room with Resident 69, who was on droplet and contact isolation, but they must be at least three (3) feet apart. LVN 1 confirmed and stated, Resident 51 and Resident 69 were seen only 1.5 feet apart. IP responded by saying, Since they are not 3 feet apart, they are not following the policy. A review of facility's P&P titled, Transmission-based precaution, dated May 1997, indicated, . 2.2.1 If a private room is not available and cohorting [divide people into groups] with a like illness is not feasible, the patient shall be separated at all times by at least three feet from other patient .3.2.2 Ensure that patients are physically separated from each other by at least 3 feet. Draw the cubicle curtain closed between beds to minimize opportunity for direct contact . 2. A review of Resident 85's H&P, indicated, Resident 85 was admitted on [DATE], with diagnoses which included respiratory failure (ability to maintain adequate gas exchange in the lung) with tracheostomy, cerebellar hemorrhage (bleeding in the small space in brain), hypertension (high blood pressure), and diabetes mellitus. A review of Resident 85's Order Sheet, dated August 14, 2024, indicated, resident was ordered to be on droplet isolation for ESBL. During a concurrent observation and interview on August 15, 2024, at 1:52 PM, Resident 85 was observed in room [ROOM NUMBER]. room [ROOM NUMBER]'s door was open, with a sign taped to it, which stated, stop and report to nurse's station before entering room. The back of the sign stated, Droplet Precaution Isolation, and indicated that an isolation mask, gown, and gloves were the required PPE that needed to be worn by any person when entering the room. One visitor was seen inside the room, with PPE on. The visitor was observed walking out of the room wearing PPE. The visitor stated he visited Resident 85 and had never been informed by staff that he needed to remove the PPE before leaving the room. During an interview on August 15, 2024, at 1:57 PM, with LVN 2, LVN 2 stated she has not educated Resident 85's visitor to remove PPE before leaving isolation room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [NAME] 15, 2024, at 2:09 PM, with Registered Nurse 1 (RN 1), RN 1 stated that she educated family members to wear PPE when entering isolation room but did not educate the family members to remove the PPE before leaving the room. RN 1 further stated, according to the facility's P&P, the family members should remove PPE before leaving the isolation room. During an interview on August 15, 2024, at 2:14 PM, with the Director of Nursing (DON), the DON stated, per policy, staff and resident's family should wear PPE when entering isolation room and should remove PPE when leaving the isolation room. A review of facility policy and procedure (P&P) titled, Transmission-based precaution, dated May 1997, indicated, .The gown will be removed before leaving the room and discarded into the regular trash unless it heavily soiled with blood, body fluids, or other potentially infectious materials . 50575 3. During a review of Resident 85's H&P, indicated, Resident 85 was admitted on [DATE], with diagnoses which included respiratory failure with tracheostomy, cerebellar hemorrhage, hypertension, and diabetes mellitus. A review of Resident 85's Order Sheet, dated August 14, 2024, indicated, resident was ordered to be on droplet isolation for ESBL. During a review of Resident 57's H&P, H&P indicated, Resident 57 was admitted to the facility on [DATE], with diagnoses which included anoxic encephalopathy (when your brain loses oxygen supply), cardiac arrest (when the heart suddenly and unexpectedly stops pumping), seizure (a sudden, uncontrolled burst of electrical activity in the brain), chronic hypoxemic respiratory failure and diabetes (a chronic disease that affects how your body turns food into energy). There was no indication that Resident 57 was on any transmission-based precautions. During a concurrent observation and interview on August 16,2024, at 8:15 AM, with the Infection Preventionist (IP) in Resident 85 and 57's shared room, a droplet precaution sign was on the wall outside the room. Residents 85 and 57 were lying in bed with the ceiling suspended curtains, between the two residents, drawn open. The IP stated Resident 57 is not on isolation but Resident 85 was on droplet precautions. During a concurrent interview and record review on August 16, 2024, at 9:17 AM, with the IP, the federal regulations for droplet precautions was reviewed. The federal regulations for droplet precautions indicated, .If it becomes necessary for a resident who requires droplet precaution to share a room with resident who does not have the same infection, the facility should make decisions regarding resident placement on a case-by-case basis after considering infection risks to other resident in the room and available alternatives. Spatial separation and drawing curtain between resident bed is especially important in multi-bedrooms with infections transmitted by the droplet route . The IP acknowledged and stated the federal regulation for droplet precautions were not followed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a subsequent concurrent interview and record review on August 16, 2024, at 9:20 AM, with the Neuro Care Unit Manager (NM), the federal regulations and the CDC guidelines for droplet precautions were reviewed. The CDC guidelines for droplet precautions indicated, .Spatial separation of greater than or equal to 3 feet and drawing the curtain between patient beds is especially important for patients in multi-bedrooms with infections transmitted by the droplet route . The NM acknowledged the federal regulations, and the CDC guidelines were not followed and further stated that those were important to follow for the protection of the other residents from being exposed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50575 Based on observation, interview, and record review, the facility failed to ensure the Centers for Disease Control and Prevention (CDC-a service organization that protects the public's health's) guideline was followed appropriately for two (2) of four sampled residents (Resident 57 and Resident 85) when the Infection Preventionist (IP) did not assess, monitor, and manage the transmission-based precaution (methods that are used to help stop the spread of germs from person to another) appropriately. This failure had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi, or parasite) to all residents and staff in the facility. Findings: During a review of Resident 85's History and Physical (H&P-contain diagnoses information), indicated, Resident 85 was admitted on [DATE], with diagnoses which included respiratory failure (a condition when lungs cannot get enough oxygen into the blood) with tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the windpipe from outside the neck), cerebellar hemorrhage (bleeding in the small space in the brain), hypertension (high blood pressure), and diabetes mellitus (characterized by high blood sugar). A review of Resident 85's Order Sheet, dated August 14, 2024, indicated, resident was ordered to be on droplet isolation (an infection control practice used to prevent the spread of infection that are transmitted through respiratory droplets), for Extended-Spectrum Beta-Lactamase (ESBL-a type of infection that is difficult to be treated). During a review of Resident 57's H&P, H&P indicated, Resident 57 was admitted to the facility on [DATE], with diagnosis which included anoxic encephalopathy (when the brain loses oxygen supply), cardiac arrest (when the heart suddenly and unexpectedly stops pumping), seizure (a sudden, uncontrolled burst of electrical activity in the brain), chronic hypoxemic respiratory failure (prolong lack of oxygen in the blood)and diabetes (a chronic disease that affects how your body turns food into energy). There was no indication that Resident 57 was on any transmission-based precaution. During a concurrent observation and interview on August 16,2024, at 8:15 AM, with the Infection Preventionist (IP), in Resident 85 and 57's shared room, a droplet precaution sign was on the wall outside the room. Residents 85 and 57 were lying in bed with the ceiling suspended; curtain between the two residents, were drawn open. The IP confirmed and stated Resident 57 is not on isolation (needs to be separated from others), but Resident 85 was on droplet precautions. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on August 16, 2024, at 9:17 AM, with the IP, the facility's policy and procedure (P&P) titled, Transmission-Based Precautions, dated May 1997, and the federal regulations for cohorting [placing together] isolation and non-isolated patients regarding droplet precautions, were reviewed. The P&P indicated, .If a private room is not available and cohorting with a like illness is not feasible, the patient shall be separated at all times by at least three feet from other patients . The federal regulations for cohorting isolation and non-isolated patients regarding droplet precautions indicated, .if it becomes necessary for a resident who requires droplet precaution to share a room with resident who does not have the same infection, the facility should make decisions regarding resident placement on a case-by-case basis after considering infection risks to other resident in the room and available alternatives. Spatial separation and drawing curtain between resident bed is especially important for residents in multi-bedrooms with infections transmitted by the droplet route . The IP acknowledged and stated the facility's policy was missing the drawing of the curtain between resident beds and further stated it should have been in their policy. The IP further stated, she did not know the curtains should be pulled forward when cohorting with a droplet precaution resident. During a concurrent interview and record review on August 16, 2024, at 9:19 AM, with the Neuro Care Unit Manager (NM), the facility's P&P titled, Transmission-Based Precautions, dated May 1997, was reviewed. The P&P indicated, .If a private room is not available and cohorting with a like illness is not feasible, the patient shall be separated at all times by at least three feet from other patients . During a follow-up interview and record review on August 16, 2024, at 9:20 AM, with the NM, the federal regulations and the CDC guidelines for droplet precautions, were reviewed. The CDC guidelines for droplet precautions indicated, .Spatial separation of greater than or equal to 3 feet and drawing the curtain between patient beds is especially important for patients in multi-bedrooms with infections transmitted by the droplet route . The NM acknowledged the federal regulations and the CDC guidelines for the drawing of the curtains for droplet precautions were not accurately reflected in the facility's policy. The NM stated it is important for the policy to reflect the standard of practices for the protection of residents from being exposed to infections. During a review of the facility's job description titled, Infection Preventionist, dated November 30, 2021, indicated, .responsibilities, Job details 1.1 Responsible for assisting the department to ensure compliance program in sub-acute services, State and CMS regulations.