STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056436	A. BUILDING _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICAL CENTER CONVALESCENT HOSPITAL	467 E GILBERT ST SAN BERNARDINO, CA 92404

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Facility reported incident number: CA00911513 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was issued for facility reported incident number : CA00911513.	F 000	[redacted] Received 09/30/24 Reviewd and approved 10/01/24	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on the observation, interview, and record review, the facility failed to meet the regulatory requirement to ensure the resident environment remains as free of accident hazards as possible when a resident (Resident 1) accidentally released a bear spray (a spray which is twice as concentrated as pepper spray, a chemical can cause burning pain, watery eyes, and coughing upon contact with skin or eyes) which affected five other residents (Residents 2 , 3, 4 ,5 and 6) on July 23, 2024.	F 689	F689 >How corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice: Resident's 2,3,4,5 and 6 on July 23 2024 were assessed by the Director of Nursing and RN supervisor all affected residents were moved to a place of safety, away from the harmful or abusive situation for their protection. Resident's 2,3,4,5 and 6 were body assessed and were immediately transferred to St. Bernadine's Hospital, due to inhalation/exposure to bear spray for medical evaluation and returned the following day and all residents felt better.	

[redacted] TIVE'S SIGNATURE [redacted] TITLE (X6) DATE 9/30/2024

[redacted] ciency which the institution may be excused [redacted] 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.

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F 689	Continued From page 1 This failure resulted in Residents 2 , 3, 4, 5 and 6 to experience red, watery eyes and coughing. Residents 2, 3, 5, and 6 required hospitalizations. Findings: 1. During a review of Resident 1's "Admission Record" (clinical record with demographic information), indicated Resident 1 was admitted to the facility on January 12, 2024, [redacted] A review of Resident 1's physician order dated on July 9, 2024, indicated, "Ativan (medication used for anxiety) ...as needed for m/b [manifested behavior] verbalization of feeling anxious related to anxiety disorder ... " A review of Resident 1's physician progress note dated July 19, 2024, indicated, " ... other: Plan ... Very aggressive foul language, though he followed me later to apologize. Will follow, will dismiss from care if not improved with psych following ... " A review of Resident 1's care plan indicated the following: a. Date-initiated January 30, 2024, indicated, "Focus. Increased aggressive behavior and outburst. Goal. The resident will effectively cope with his/her feelings of unhappiness and anger..." b. Date-initiated March 8, 2024, indicated,	F 689	Resident #1 was assessed on 7/23/2024 to ensure he was not affected from any toxic adverse reaction from the bear spray. No untoward reaction of the bear spray was experienced by the resident. Resident #1 was informed of the safety checks to be done by licensed nurses upon residents return from an out on pass and or going to doctors appointments to ensure safety. Licensed nurses were in serviced on 8/1/2024 and 8/9/2024 by the Director of nursing/MDS >How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken. DON,RN supervisors, MDS, I.P and case manager assessed all residents and no noted findings exhibited from all these residents in the building during this toxic inhalation incident. > What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur.	

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F 689	Continued From page 2 "Focus. Resident make threatening remarks, "that he will put a revolver to somebody's mouth if somebody disagree with him. Goal. Safety for the other resident and staff at all times... Target date: 10/09/2024 [October 9, 2024]. Intervention. 3/26/2024 [March 26, 2024] Discontinue hourly monitoring ... 3/8/2024 [March 8,2024] Hourly monitoring for safety..." c. Date-initiated July 15, 2024, indicated, "Focus. Increased verbal aggression behavior and outburst. Goal. The resident will effectively cope with his/her feelings of unhappiness and anger..." d. Date-initiated July 23, 2024, indicated, "Focus. Resident is at risk for threat to self, other resident, and staff...Spray bear spray in the hallway...Goal. Resident will be monitored by a 1:1 staff monitoring for resident's safety, other residents and staff..." During an interview on August 1, 2024, at 10:45 AM, with Resident 1, Resident 1 stated he usually kept his bear spray in his car at the facility's parking lot. Resident 1 stated that on July 23, 2024, he brought it with him to an appointment for safety reasons. He further added that normally, he would put it back in his car before entering the facility, however, he was upset that day because the transportation was two hours late. He stated he forgot to return the bear spray to his car, so he ended up keeping it in the basket of his walker. During further interview with Resident 1, Resident 1 stated when he was going into his room, he accidentally bumped into the door frame, removed the safety pin from the bear spray, and sprayed it toward the hallway. Furthermore, Resident 1 stated that the facility called the	F 689	1.Director of Nursing/MDS in serviced licensed nurses on 8/1/2024 and 8/9/2024 regarding safety checks to in coming resident from an out on pass. 2.QA log monitoring was put in place to ensure safety checks by RN supervisors, to be done weekly x 4, bi-weekly x 2 and then monthly x 3 months to monitor compliance. 3.All personal property inventory was update by SSD on 7/23/2024,8/1/2024 and 8/9/2024 4.All resident, whether LTC or new admits, are not allowed to have privately owned cars/SUV/van in the parking lot of Medical Center Convalescent to avoid any storage of non-disclosed toxic or harmful objects brought inside the facility. 4.A resident council meeting was held on 9/26/2024 by Activity Director. 5.DSD in serviced staff on neglect and abuse MGT on 8/30/2024 >How the facility plans to monitor its performance to make sure that solutions are sustained. A PIP-performance improvement plan was developed to monitor Compliance. Director of Nursing/Designee will report finding to The QAPI monthly for any recommendation and changes as indicated. >The corrective action compliance date 9/30/2024	

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F 689	Continued From page 3 police, who later helped him return the bear spray to his car. 2. During a review of Resident 2's "Admission Record", indicated Resident 2 was admitted to the facility on April 28, 2024, [redacted] A review of Resident 2's clinical record "nurses note" dated July 23, 2024, indicated "a body assessment done, noted eye redness accompanied by nonproductive cough secondary to exposure to bear spray ... MD (Medical Doctor) in the facility gave order may transfer to [Name of Hospital] for eval due to exposure of bear spray ... " During an interview on August 1, 2024, at 11:15 AM, with Resident 2, Resident 2 stated that his eyes burned during the incident but felt better after returning from the hospital. 3. During a review of Resident 3's "Admission Record", indicated Resident 3 was admitted to the facility on July 2, 2024, [redacted] A review of Resident 3's clinical record "nurses note" dated July 23, 2024, indicated, "Resident exposed to bear spray ... resident noted with redness to both eyes and nonproductive cough ... MD aware and gave order to send to ER [Emergency Room] for further evaluation r/t [related to] exposure to bear spray ... "	F 689		

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F 689	Continued From page 4 During an interview on August 1, 2024, at 11:30 AM, with Resident 3, Resident 3 stated that his eyes burned during the incident but felt better after returning from the hospital. 4. During a review of Resident 4's "Admission Record", indicated Resident 4 was admitted to the facility on July 18, 2023, [redacted] A review of Resident 4's clinical record "nurses note" dated July 23, 2024, indicated "Resident exposed to bear spray ... resident noted with redness to both eyes and nonproductive cough ... MD aware and gave order to send to ER [Emergency Room] for further evaluation r/t [related to] exposure to bear spray ... Resident declined to be transferred to the acute hospital. He claimed that he is alright, and when his eyes got washed out, he felt relief ... " During an interview on August 1, 2024, at 11:45 AM, with Resident 4, Resident 4 stated that his eyes burned during the incident but felt relief after the nursing staff washed his eyes. 5. During a review of Resident 5's "Admission Record", indicated Resident 5 was admitted to the facility on July 12, 2014, [redacted]	F 689		

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F 689	Continued From page 5 A review of Resident 5's clinical record "nurses note" dated July 23, 2024, indicated, "[Name of Private Ambulance Company] here to pick up the resident for medical evaluation, to [Name of Hospital] secondary to resident exposed to bear spray ... resident noted with redness to both eyes and nonproductive cough ... MD in facility gave order may transfer to [Name of Hospital] for further eval [read evaluation] due to inhalation/exposure of bear spray " During an interview on August 1, 2024, at 12:05 PM, with Resident 5, Resident 5 stated that his eyes burned during the incident but felt better after returning from the hospital. 6. During a review of Resident 6's "Admission Record", indicated Resident 6 was admitted to the facility on August 4, 2023 [redacted] A review of Resident 6's clinical record "nurses note " dated July 23, 2024, indicated, "Resident exposed to bear spray ... resident noted with redness to both eyes and nonproductive cough ... Dr [name of the Medical Doctor] was notified and ordered to send to [Name of Hospital] or medical evaluation d/t [due to] toxic spray exposure. " During an interview on August 1, 2024, at 12:20 PM, with Resident 6, Resident 6 stated that his eyes burned during the incident but felt better after returning from the hospital. Furthermore, Resident 6 stated more worried about his lung and breathing since he treated for pneumonia in the facility.	F 689		

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F 689	Continued From page 6 During an interview on August 1, 2024, at 12:35 PM, with the Director of Nurses (DON), the DON stated to ensure the safety of Resident 1, other residents, and facility staff, the facility continues to keep Resident 1 under one-to-one observation for close monitoring. During a concurrent interview and record review with the DON, on August 1, 2024, at 12:45 PM, the DON reviewed the facility's policy and procedure (P&P) titled, "Abuse and Neglect prevention management," revised December 2014, and stated that despite following all facility procedures and implementing interventions each time Resident 1 displayed behavior issues, the five residents affected by the bear spray should not have had to experience these situations. A review of the facility's P&P titled, "Abuse and Neglect prevention management," revised December 2014, indicated, "POLICY. It is the policy of the facility to ensure our residents safe ... DEFINITIONS ... Resident to resident altercations is an incident involving a resident who inflicts injury on another resident ... Everyone's Responsibility. It takes a team to keep our residents safe. The multidisciplinary team identifies risk and develops interventions to manage resident safety, evaluates the effectiveness of interventions ... INVESTIGATION .... C. Incidents and Accident reports and documentation will be reviewed by the multidisciplinary team, on the first business day after the occurrence, to identify events, patterns or trends ... D. All unusual occurrences need to be reported to immediate supervisor for an investigation. Additional investigation components will be completed ... PROTECTION.	F 689		

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F 689	Continued From page 7 A. The protection of the residents is our main concern. B. Residents will be protected from harm during an investigation. C. Residents will be separated or moved to a place of safety, away from a harmful or abusive situation, to prevent a reoccurrence and for their protection .... INCIDENT MANAGEMENT. The facility system to follow up on altercations will place an emphasis on preventing future altercations. This system includes but is not limited to: Care Plan updates to incorporate individualized recommendations from the formal incident review process, in addition to the immediate updates that may have occu1 at the time, prior to the altercation..."	F 689		