STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055344	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Heights Post Acute	590 S. Indian Hill Blvd. Claremont, CA 91711

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to ensure a safe and orderly discharge for one of six sampled residents (Resident 2) by failing to ensure: 1. Resident 2's skin assessment was done and documented upon Resident 2's discharge from the facility on 2/3/25. 2. Resident 2's skin condition was communicated to the receiving facility. These failures resulted in an incomplete and unsafe discharge of Resident 2 and had the potential to negatively impact Resident 2's health, safety, and well-being. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/16/25, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/25, the MDS indicated Resident 2 did not speak, rarely/never made Resident 2's ideas and wants understood, and rarely/never understood others. The MDS indicated Resident 2 had impaired movement of both upper extremities and was dependent on staff (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, moving, lying and sitting in bed, and transfer from chair/bed-to-chair/wheelchair. During a review of Resident 2's Change in Condition Evaluation (CIC), created by Licensed Vocational Nurse (LVN) 2 on 1/23/25 and timed 8:54 pm, the CIC indicated Resident 2 scratched Resident 2's calf while sitting in the wheelchair and sustained a wound on the right lower leg. The CIC did not indicate how Resident 2 scratched Resident 2's right leg while seated in the wheelchair. The CIC indicated Resident 2's physician was notified of the incident on 1/23/25 at 7:45 pm and ordered a treatment for the wound on Resident 2's right leg. (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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Claremont Heights Post Acute	590 S. Indian Hill Blvd. Claremont, CA 91711

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Order Summary Report (OSR), the OSR indicated Resident 2 had a physician's order (PO), dated 1/24/25, to clean Resident 2's right shin scratch, pat dry, and cover with dry dressing daily. There was no wound treatment order dated 1/23/25 found in Resident 2's clinical record. During a review of Resident 2's Medication Administration Record (MAR) for January 2025, the treatment order for Resident 2's right shin scratch was not transcribed in the MAR as ordered from 1/24/25 through 1/31/25. During a review of Resident 2's Treatment Administration Record (TAR) for January 2025, the treatment order for Resident 2's right shin scratch was not transcribed in the TAR as ordered from 1/24/25 through 1/31/25. During a review of Resident 2's clinical record, there was no documented evidence wound treatment was provided to Resident 2's right leg wound as ordered by the physician. During a review of Resident 2's Discharge Summary (DS) created by LVN 5, dated 2/4/25 and timed 1:06 am, the DS indicated Resident 2 was discharged to a group home on 2/3/25 at 6 pm. The DS indicated Resident 2 was picked up by a staff member of the group home where Resident 2 was discharged to. The DS indicated no documented assessment of Resident 2's skin condition upon discharge and no documented evidence Resident 2's skin condition was communicated to the group home staff member who picked up Resident 2. During an interview on 2/19/25 at 12:15 pm with LVN 4, LVN 4 stated licensed nurses must do a skin assessment upon resident's discharge and document the skin assessment in the resident's clinical record. During an interview and concurrent record review on 2/19/25 at 2:02 pm with the Director of Nursing (DON), the DON reviewed Resident 2's clinical record. The DON stated there was no documented skin assessment for Resident 2 upon Resident 2's discharge. During an interview on 2/19/25 at 3 pm with LVN 3, LVN 3 stated a body skin check must be done prior to resident's discharge just like on a resident's admission. During an interview on 2/19/25 at 5:57 pm with the DON, the DON stated a skin assessment must be done before a resident's discharge so a treatment order could be obtained from the physician prior to discharge and/or keep the resident in the facility if needed. During a review of the facility's policy and procedure (P&P) titled, Discharge and Transfer of Residents, dated 1/3/24, the P&P indicated, residents have rights that are intended to prevent inappropriate, unnecessary, and untimely transfers and discharges. The P&P indicated the purpose of the P&P was to ensure that discharge planning is complete and appropriate, and that necessary information is communicated to the continuing care provider.

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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 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** 34273 Based on interview and record review, the facility failed to provide needed care and services to 2 of 6 sampled residents (Residents 2 and 4) when: 1. Resident 2's clinical record did not indicate how Resident 2 scratched Resident 2's right leg and sustained a right leg wound on 1/23/25. 2. Resident 2's treatment order, dated 1/23/25, for Resident 2's right leg wound was not transcribed (to put in written or printed form) in Resident 2's clinical record until 1/24/25 and was not transcribed in Resident 2's Treatment Administration Record (TAR). There was no documented evidence wound treatment was provided to Resident 2's right leg wound according to the physician's order. 3. There was no documented evidence in Resident 4's clinical record to indicate Resident 4 had teeth extraction at the bedside on 1/23/25. 4. There was no documented evidence in Resident 4's clinical record to indicate Resident 4 was monitored each shift for 72 hours after teeth extraction and that Resident 4's family was informed Resident 4 had teeth extraction. 5. Resident 4's physician's order, dated 1/23/25, indicated a treatment order for an excoriation (a scrape or scratch to the skin) instead of for tooth/teeth extraction (a dental procedure that involves removing a tooth from its socket in the jawbone). There was no documented evidence in Resident 4's record that the physician's order was clarified with the physician or the registered nurse (RN) who took down the physician's order. These failures had the potential for Resident 2 and Resident 4 to receive inappropriate care and services. Cross reference F842 Findings: 1. During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/16/25, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/25, the MDS indicated Resident 2 did not speak, rarely/never made Resident 2's ideas and wants understood, and rarely/never understood others. The MDS indicated Resident 2 had impaired movement of both upper extremities and was dependent on others (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, moving, lying and sitting in bed, and transfer from chair/bed-to-chair/wheelchair. During a review of Resident 2's Change in Condition Evaluation (CIC), created by Licensed Vocational Nurse (LVN) 2 on 1/23/25 and timed 8:54 pm, the CIC indicated Resident 2 scratched Resident 2's calf while sitting in the wheelchair and sustained a wound on the right lower leg. The CIC did not indicate how Resident 2 scratched Resident 2's right leg while seated in the wheelchair. The CIC indicated Resident 2's physician was notified of the incident on 1/23/25 at 7:45 pm and ordered a treatment for the wound on Resident 2's right leg. During a review of Resident 2's Order Summary Report (OSR), the OSR indicated Resident 2 had a physician's order (PO), dated 1/24/25, to clean Resident 2's right shin scratch, pat dry, and cover with dry dressing daily. There was no wound treatment order dated 1/23/25 found in Resident 2's clinical record. During a review of Resident 2's Medication Administration Record (MAR) for January 2025, the treatment order for Resident 2's right shin scratch was not transcribed in the MAR as ordered from 1/24/25 through 1/31/25. During a review of Resident 2's Treatment Administration Record (TAR) for January 2025, the treatment order for Resident 2's right shin scratch was not transcribed in the TAR as ordered from 1/24/25 through 1/31/25. During a review of Resident 2's clinical record, there was no documented evidence wound treatment was provided to Resident 2's right leg wound as ordered by the physician. During a review of Resident 2's care plan, dated 1/27/25, the care plan indicated Resident 2 had limited range of motion of both shoulders and elbows. The care plan interventions indicated to position Resident 2 with pillows or splints to prevent further contractures, to assist Resident 2 with turning, repositioning, and with activities of daily living (ADLs). 2. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (damage to tissues in the brain which occurs because of disrupted blood flow to the brain). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 understood others and expressed Resident 4's ideas and wants. The MDS indicated Resident 4's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 4 required supervision or touching assistance with eating, required partial/moderate assistance with oral hygiene, required substantial/maximal assistance (helper does more than half the effort) with upper body dressing and personal hygiene, and was dependent on others for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 4's clinical record, there was no documented evidence Resident 4 had teeth extraction on 1/23/25. There was no documented evidence in Resident 4's clinical record to indicate Resident 4 was monitored each shift for 72 hours after teeth extraction and that Resident 4's family was informed Resident 4 had teeth extraction. The Dental Progress Notes was not found in the clinical record. During a review of Resident 4's physician's order (PO), transcribed by Registered Nurse (RN) 1, dated 1/23/25 and timed 10:40 am, the PO indicated, Apply excoriation site until bleeding stops. During a review of Resident 4's clinical record, there was no documented evidence in Resident 4's record that the physician's order was clarified with the physician or the registered nurse (RN) who took down the physician's order. During an interview on 2/19/25 at 11:23 am with LVN 3, LVN 3 stated LVN 3 mostly worked as the treatment nurse (nurse who assessed residents' skin and administered skin/wound treatments ordered). LVN 3 stated Resident 2 had a sporadic scab on the right lateral shin. LVN 3 stated LVN 3 only monitored Resident 2's right shin scratch and did not treat it because the dressing made the scratch humid and made the scab soft. LVN 3 stated licensed nurses must follow the physician's order including treatment orders. During an interview on 2/19/25 at 12:15 pm with LVN 4, LVN 4 stated licensed nurses must document everything the licensed nurses do for the resident in the resident's clinical record to communicate care provided to the resident to other care providers. During an interview on 2/19/25 at 2:02 pm with the Director of Nursing (DON), the DON reviewed Resident 2's clinical record and was unable to find documentation of how Resident 2 scratched Resident 2's right leg while seated in the wheelchair. The DON was unable to find the treatment order for Resident 2's right leg wound in Resident 2's TAR dated 1/1/25 to 1/31/25. The DON stated physician's orders must be transcribed in the resident's clinical record and transcribed in the MAR and/or the TAR. During an interview on 2/19/25 at 3 pm with LVN 3, LVN 3 stated LVN 2 received a treatment order for Resident 2's right shin scratch on 1/23/25 but LVN 2 did not transcribe the order in Resident 2's clinical record. LVN 3 stated LVN 3 wrote the treatment order in Resident 2's clinical record on 1/24/25 but did not transcribe the order in the TAR. LVN 3 stated there was no documented evidence in Resident 2's clinical record that treatment was provided to Resident 2's right leg shin scratch because treatment administration was usually documented in the TAR. LVN 3 stated the dentist usually saw residents at the bedside. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25 at 3:34 pm with Resident 4, Resident 4 stated the dentist came last month and extracted two of Resident 4's teeth at the bedside. During an interview on 2/19/25 at 3:38 pm with LVN 2, LVN 2 stated an activity staff (unknown) informed LVN 2 on 1/23/25 that Resident 2 was moving Resident 2's legs a lot and scratched Resident 2's right leg on the footrest of the wheelchair. LVN 2 stated when LVN 2 informed the physician about Resident 2's right leg wound, the physician ordered a wound treatment. LVN 2 did not transcribe the order in Resident 2's clinical record because LVN 2 thought all treatment orders had to go through the treatment nurse first. During an interview on 2/19/25 at 5:57 pm with the DON, the DON stated it was important to document details of what happened to the resident and what was done for the resident in the resident's clinical record because it provided the reader information regarding how incidents happened and how to prevent them. The DON stated documentation could also assist to develop the resident's care plan, to come up with the proper interventions, and to assess if staff training/education was needed. The DON stated licensed nurses must transcribe the physician's orders to the resident's clinical record and to the MAR and TAR, to show that the order(s) was/were implemented. During a telephone interview and concurrent record review on 2/21/25 at 11 am with the Medical Records Director (MRD), Resident 4's clinical record was reviewed. The MRD stated the MRD was unable to find any documentation that Resident 4 had teeth extracted on 1/23/25. On 2/21/25 at 11:23 am, the MRD provided a copy of Resident 4's Dental Progress Note (DPN), dated 1/23/25, via electronic mail (e-mail). The DPN indicated Resident 4's bottom left wisdom tooth and the tooth in front of Resident 4's bottom left wisdom tooth were extracted on 1/23/25. The DPN did not indicate where Resident 4's teeth extraction was performed. During a review of the facility's policy and procedure (P&P) titled, Completion & Correction, dated 1/1/12, the P&P indicated entries in the resident's medical record will be recorded promptly as the events or observations occur and will be complete, legible, descriptive, and accurate. The P&P also indicated, treatments, observations during treatments and effectiveness of treatments and the date and time noting physician orders must be documented in the resident's medical record. During a review of the facility's P&P titled, Change of Condition Notification, 4/1/15, the P&P indicated, a licensed nurse will notify the resident's attending physician and legal representative or an appropriate family member when there is an incident involving the resident. The P&P indicated, a licensed nurse will document the following: date, time and pertinent details of the incident and the subsequent assessment in the nursing notes; the time the attending physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received; the time the family/responsible person was contacted; update the care plan to reflect the resident's current status .a licensed nurse will document each shift for at least seventy-two hours (72) hours .

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on interview and record review, the facility failed to ensure the clinical record for 3 of 6 sampled residents (Residents 2, 3, and 4) was complete and accurate when: 1. Resident 2's clinical record did not indicate how Resident 2 scratched Resident 2's right leg and sustained a right leg wound on 1/23/25. 2. Resident 2's treatment order, dated 1/23/25, for Resident 2's right leg wound was not transcribed (put into written or printed form) in Resident 2's clinical record until 1/24/25 and was not transcribed in Resident 2's Treatment Administration Record (TAR). 3. Resident 3's clinical record did not indicate where Resident 3's tooth extraction was performed on 12/9/24. 4. There was no documented evidence in Resident 4's clinical record to indicate Resident 4 had teeth extraction at the bedside on 1/23/25. 5. There was no documented evidence in Resident 4's clinical record to indicate Resident 4 was monitored each shift for 72 hours after teeth extraction and that Resident 4's family was informed Resident 4 had teeth extraction. 6. Resident 4's physician's order, dated 1/23/25, indicated a treatment order for an excoriation (a scrape or scratch to the skin) instead of tooth/teeth extraction (a dental procedure that involves removing a tooth from its socket in the jawbone). These failures had the potential for Resident 2, Resident 3, and Resident 4 to receive inappropriate care, and for Resident 2's, Resident 3's, and Resident 4's care to not be accurately evaluated for procedural and guidelines compliance, and the need for staff education and training to be evaluated. Cross reference F684 Findings: 1. During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (brain disease, damage, or malfunction caused by an illness or organs that are not working as well as they should). During a review of Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/16/25, the H&P indicated Resident 2 did not have the capacity to understand and make decisions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 1/22/25, the MDS indicated Resident 2 did not speak, rarely/never made Resident 2's ideas and wants understood, and rarely/never understood others. The MDS indicated Resident 2 had impaired movement of both upper extremities and was dependent on staff (helper does all the effort) for eating, oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, personal hygiene, moving, lying and sitting in bed, and transfer from chair/bed-to-chair/wheelchair. During a review of Resident 2's Change in Condition Evaluation (CIC), created by Licensed Vocational Nurse (LVN) 2 on 1/23/25 and timed 8:54 pm, the CIC indicated Resident 2 scratched Resident 2's calf while sitting in the wheelchair and sustained a wound on the right lower leg. The CIC did not indicate how Resident 2 scratched Resident 2's right leg while seated in the wheelchair. The CIC indicated Resident 2's physician was notified of the incident on 1/23/25 at 7:45 pm and ordered a treatment for Resident 2's wound on Resident 2's right leg. During a review of Resident 2's Order Summary Report (OSR), the OSR indicated Resident 2 had a physician's order (PO), dated 1/24/25, to clean Resident 2's right shin scratch, pat dry, and cover with dry dressing daily. There was no wound treatment order dated 1/23/25 found in Resident 2's clinical record. During a review of Resident 2's Medication Administration Record (MAR) for January 2025, the treatment order for Resident 2's right shin scratch was not transcribed in the MAR as ordered from 1/24/25 through 1/31/25. During a review of Resident 2's Treatment Administration Record (TAR) for January 2025, the treatment order for Resident 2's right shin scratch was not transcribed in the TAR as ordered from 1/24/25 through 1/31/25. During a review of Resident 2's care plan, dated 1/27/25, the care plan indicated Resident 2 had limited range of motion of both shoulders and elbows. The care plan interventions indicated to position Resident 2 with pillows or splints to prevent further contractures, to assist Resident 2 with turning, repositioning, and with activities of daily living (ADLs). 2. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 3's H&P, dated 9/21/24, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Dental Progress Notes (DPN), dated 12/9/24, untimed, the DPN indicated Resident 3's bottom left wisdom tooth (tooth at the farthest back) was extracted (removed from the jawbone) on 12/9/24. The DPN did not indicate where Resident 3's tooth extraction was performed. During a review of Resident 3's progress notes (PN), the CIC, dated 12/9/24 and timed 1:26 pm, indicated Resident 3 had a tooth extraction by the in-house dentist. The CIC did not indicate where Resident 3's tooth extraction was performed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was independent with eating and oral hygiene, required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for personal hygiene, toileting hygiene and upper body dressing, and required partial/moderate assistance (helper does less than half the effort) with showering/bathing, putting on/taking off footwear, and with lower body dressing. 3. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (damage to tissues in the brain which occurs because of disrupted blood flow to the brain). During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 understood others and expressed Resident 4's ideas and wants. The MDS indicated Resident 4's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 4 required supervision or touching assistance with eating, required partial/moderate assistance with oral hygiene, required substantial/maximal assistance (helper does more than half the effort) with upper body dressing and personal hygiene, and was dependent on staff for toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. During a review of Resident 4's clinical record, there was no documented evidence Resident 4 had teeth extraction on 1/23/25. There was no documented evidence in Resident 4's clinical record to indicate Resident 4 was monitored each shift for 72 hours after teeth extraction and that Resident 4's family was informed Resident 4 had teeth extraction. The Dental Progress Notes was not found in the clinical record. During a review of Resident 4's physician's order (PO), transcribed by Registered Nurse (RN) 1, dated 1/23/25 and timed 10:40 am, the PO indicated, Apply excoriation site until bleeding stops. During a review of Resident 4's clinical record, there was no documented evidence in Resident 4's record that the physician's order was clarified with the physician or the registered nurse (RN) who took down the physician's order. During a review of Resident 4's clinical record, there was no documented evidence in Resident 4's clinical record to indicate Resident 4 was monitored each shift for 72 hours after teeth extraction and that Resident 4's family was informed Resident 4 had teeth extraction. During an interview on 2/19/25 at 11:23 am with LVN 3, LVN 3 stated LVN 3 mostly worked as the treatment nurse (nurse who assessed residents' skin and administered skin/wound treatments ordered). LVN 3 stated Resident 2 had a sporadic scab on the right lateral shin. LVN 3 stated LVN 3 only monitored Resident 2's right shin scratch and did not treat it because the dressing made the scratch humid and made the scab soft. LVN 3 stated licensed nurses must follow the physician's order including treatment orders. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/25 at 11:57 am with Certified Nursing Assistant (CNA) 6, CNA 6 stated usually when the dentist came in to see residents in the facility, the dentist saw residents in the beauty shop unless the resident was not up out of bed. During an interview on 2/19/25 at 12:15 pm with LVN 4, LVN 4 stated licensed nurses must document everything the licensed nurses do for the resident in the resident's clinical record to communicate care provided to the resident to other care providers. During an interview on 2/19/25 at 2:02 pm with the Director of Nursing (DON), the DON reviewed Resident 2's clinical record and was unable to find documentation of how Resident 2 scratched Resident 2's right leg while seated in the wheelchair. The DON was also unable to find the treatment order for Resident 2's right leg wound in Resident 2's TAR dated 1/1/25 to 1/31/25. The DON stated physician's orders must be transcribed in the resident's clinical record and transcribed in the MAR and/or the TAR. During an interview on 2/19/25 at 3 pm with LVN 3, LVN 3 stated LVN 2 received a treatment order for Resident 2's right shin scratch on 1/23/25 but LVN 2 did not transcribe the order in Resident 2's clinical record. LVN 3 stated LVN 3 transcribed the treatment order in Resident 2's clinical record on 1/24/25 but did not transcribe the order in Resident 2's TAR. LVN 3 stated there was no documented evidence in Resident 2's clinical record that treatment was provided to Resident 2's right leg shin scratch because treatment administration was usually documented in the TAR. LVN 3 stated the dentist usually saw residents at the bedside. During an interview on 2/19/25 at 3:34 pm with Resident 4, Resident 4 stated the dentist came last month and extracted two of Resident 4's teeth at the bedside. During an interview on 2/19/25 at 3:38 pm with LVN 2, LVN 2 stated an activity staff (unknown) informed LVN 2 on 1/23/25 that Resident 2 was moving Resident 2's legs a lot and scratched Resident 2's right leg on the footrest of the wheelchair. LVN 2 stated when LVN 2 informed the physician about Resident 2's right leg wound, the physician ordered a wound treatment. LVN 2 did not transcribe the treatment order in Resident 2's clinical record because LVN 2 thought all treatment orders had to go through the treatment nurse first. During an interview on 2/19/25 at 5:57 pm with the DON, the DON stated it was important to document details of what happened to the resident and what was done for the resident in the resident's clinical record because it provided the reader information regarding how incidents happened and how to prevent them. The DON stated documentation could also assist to develop the resident's care plan, to come up with the proper interventions, and to assess if staff training/education was needed. The DON stated licensed nurses must transcribe the physician's orders to the resident's clinical record and to the MAR and TAR, to show that the order(s) was/were implemented. During a telephone interview and concurrent record review on 2/21/25 at 11 am with the Medical Records Director (MRD), Resident 4's clinical record was reviewed. The MRD stated the MRD was unable to find any documentation that Resident 4 had teeth extracted on 1/23/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055344	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Heights Post Acute	590 S. Indian Hill Blvd. Claremont, CA 91711

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/21/25 at 11:23 am, the MRD provided a copy of Resident 4's Dental Progress Note (DPN), dated 1/23/25, via electronic mail (e-mail). The DPN indicated Resident 4's bottom left wisdom tooth and the tooth in front of Resident 4's bottom left wisdom tooth were extracted on 1/23/25. The DPN did not indicate where Resident 4's teeth extraction was performed. During a review of the facility's policy and procedure (P&P) titled, Completion & Correction, dated 1/1/12, the P&P indicated entries in the resident's medical record will be recorded promptly as the events or observations occur and will be complete, legible, descriptive, and accurate. The P&P also indicated, treatments, observations during treatments and effectiveness of treatments and the date and time noting physician orders must be documented in the resident's medical record. During a review of the facility's P&P titled, Change of Condition Notification, 4/1/15, the P&P indicated, a licensed nurse will notify the resident's attending physician and legal representative or an appropriate family member when there is an incident involving the resident. The P&P indicated, a licensed nurse will document the following: date, time and pertinent details of the incident and the subsequent assessment in the nursing notes; the time the attending physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received; the time the family/responsible person was contacted; update the care plan to reflect the resident's current status .a licensed nurse will document each shift for at least seventy-two hours (72) hours .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34273 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment to prevent the spread of infections to all 93 residents of the facility during the Coronavirus-19 (COVID-19 an illness caused by a virus that can spread from person to person) outbreak (OB-the occurrence of disease cases in excess of normal expectancy) in the facility by failing to ensure: 1. Activity Assistant (AA) 1 did not remove AA 1's N95 mask (a respiratory protective device designed to have a very close facial fit over the nose and the mouth, and filters airborne particles) while standing in the hallway in the resident care area where residents and other staff were. 2. Certified Nursing Assistant (CNA) 1 had CNA 1's N95 mask on correctly on 2/18/25 and was able to demonstrate how to properly don (put on) an N95 mask. 3. CNA 4 performed hand hygiene (cleaning hands by either washing them with soap and water, or by using an alcohol-based hand sanitizer) properly on 2/19/25. These failures had the potential to spread COVID-19 and or other infections to the residents, staff, and visitors that could lead to hospitalization and/or death. Findings: During an observation on 2/18/25 at 11:08 am, AA 1 pulled AA 1's N95 mask down to drink out of a bottle which was on top of the activity cart. AA 1 was standing in the hallway in front of room [ROOM NUMBER] and in front of the nurses' station. There were other staff and residents walking in the hallway around AA 1 and AA 1 was standing one room away from the COVID-19 isolation zone of the facility. The COVID-19 isolation rooms were from rooms 18 - 24. During an interview on 2/18/25 at 11:11 am with AA 1, AA 1 stated AA 1 was wearing an N95 mask so AA 1 will not get COVID-19. AA 1 stated AA 1 was not supposed to remove N95 mask in resident care areas. AA 1 stated AA 1 was trained to go to the break room when drinking, eating, and or when removing N95 mask. During an observation on 2/18/25 at 12:59 pm, CNA 1 was walking down the hall to the kitchen with the bottom strap of CNA 1's N95 mask hanging loosely under CNA 1's chin. The top strap of CNA 1's N95 mask was right above CNA 1's ears. During a concurrent observation and interview on 2/18/25 at 1:01 pm with CNA 1, CNA 1 stated CNA 1 was wearing an N95 mask to prevent from getting COVID-19. When asked if the bottom strap of the N95 mask was supposed to be hanging loosely under CNA 1's chin, CNA 1 moved the bottom strap above CNA 1's ears and stated the bottom strap had to be above the ears. CNA 1 stated the N95 straps hurt CNA 1. CNA 1 left the top and bottom straps of the N95 mask above CNA 1's ears. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/19/25 at 9:22 am, CNA 4 exited room [ROOM NUMBER], removed CNA 4's gloves and threw the gloves away. CNA 4 did not wash CNA 4's hands and or sanitized CNA 4's hands after removing CNA 4's gloves. CNA 4 walked towards Licensed Vocational Nurse (LVN) 4 and spoke to LVN 4. LVN 4 handed CNA 4 a piece of paper and CNA 4 started walking towards the kitchen. On the way to the kitchen, CNA 4 went inside room [ROOM NUMBER] to answer a call light. CNA 4 went inside room [ROOM NUMBER] without using hand sanitizer and or washing hands. CNA 4 then walked out of room [ROOM NUMBER] without performing hand hygiene and knocked on the kitchen door. During an interview on 2/19/25 at 9:26 am with CNA 4, CNA 4 stated CNA 4 must sanitize or wash hands when going in and out of resident rooms to prevent the spread of infection. During an interview on 2/19/25 at 5:57 pm with the Director of Nursing (DON), the DON stated staff (in general) must be educated on proper N95 donning procedure and proper fit to prevent the spread of infection and to control the COVID-19 OB. The DON stated hand hygiene must be done before and after resident care, and before and after glove use, to prevent the spread of infection and to control the COVID-19 OB. During a review of the facility's policy and procedure (P&P) titled, Respiratory Protection, dated 7/14/17, the P&P indicated employees must wear an N95 mask during any infectious respiratory disease emergency to prevent employee exposure to infectious agents in the workplace. The P&P indicated it is the employee's responsibility to know the respiratory protection requirements for their work areas and to wear the appropriate respiratory protective equipment according to proper instructions. During a review of the facility's P&P titled, Hand Hygiene, dated 9/1/20, the P&P indicated facility staff must perform hand hygiene before eating, after using the bathroom, after contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, wound drainage and soiled dressing, before and after food preparation, before and after assisting a resident with dining if direct contact with food is anticipated or occurs, before donning and after doffing personal protective equipment, and immediately upon entering and exiting a resident room.