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	04/28/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44027 Based on interview and record review, the facility failed to notify one of five sampled resident ' s (Resident 9) physician of Resident 9 ' s refusal of blood tests. This failure had the potential for Resident 9 to experience a decline in health and well-being. (Cross Reference F656) Findings: During a review of Resident 9's Admission Record (AR), the AR indicated the facility admitted Resident 9 on 8/28/2019 and readmitted Resident 9 on 10/11/2024 with diagnoses including metabolic encephalopathy (brain disease that alters brain function or structure), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and Alzheimer ' s disease (a progressive disease that destroys memory and other important mental functions). During a review of Resident 9 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/30/2025, the MDS indicated Resident 9 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 9 required partial/moderate (helper does less than half the effort) from staff for bathing and toileting hygiene. The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) assistance from staff for lower body dressing. The MDS indicated Resident 9 received psychotropic medications. During a review of Resident 9 ' s Order Summary Report (OSR), dated 4/28/2025, the OSR indicated Resident 9 had physician orders for: 1. Complete blood count (CBC, a group of blood tests that measure the number and size of the different cells in your blood) every Monday due to (d/t) Clozapine (a psychotropic medication used to treat Schizophrenia) use every Monday. The order date was 12/31/2024. 2. Valproic acid (a psychotropic medication used to treat mood swings) level on every Wednesday. The order date was 3/26/2025. (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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review on 4/28/2025 at 1:30 p.m. with the Director of Nursing (DON), Resident 9 ' s Requisition, dated 1/31/2025, and the facility ' s Patient Service Log, dated 2/3/2025, were reviewed. The Requisition indicated Resident 9 refused to have Resident 9's blood drawn on 1/31/2025 and 2/3/2025. The Patient Service Log indicated Resident 9 refused to have Resident 9's blood drawn on 2/3/2025. The DON stated Resident 9 had a behavior of refusing to have Resident 9's blood drawn. The DON verified Resident 9 ' s medical record did not indicate Resident 9 ' s physician was notified of Resident 9 ' s refusals for dates 1/31/2025 and 2/3/2025. The DON verified Resident 9 ' s doctor was not notified each time Resident 9 refused the blood draws. The DON stated the CBC test was needed because the valproic acid medication could negatively affect Resident 9 ' s infection fighting blood cells. The DON stated the valproic acid level test was needed to ensure Resident 9 was getting the right amount of the valproic acid medication. The DON stated the doctor should be notified of Resident 9 ' s refusals. During a review of the facility's P&P titled, Change of Condition Notification, revised 4/1/2015, the P&P indicated, To ensure residents, family, legal representatives, and physicians are informed of changes in the resident's condition in a timely manner. The P&P indicated, Update the Care Plan to reflect the resident's current status.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 44027 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of five sampled residents (Residents 9) by failing to: a. Ensure the facility included in Resident 9's care plan interventions addressing Resident 9 ' s behavior of refusing the ordered weekly blood tests. b. Ensure the facility included Resident 9's ordered blood tests in the interventions of the untitled care plan, initiated on 2/29/2025. These failures had the potential for Residents 9 not to receive interventions to address the Resident 9's specific needs and experiencing harm. (Cross Reference F580) Findings: During a review of Resident 9's Admission Record (AR), the AR indicated the facility admitted Resident 9 on 8/28/2019 and readmitted Resident 9 on 10/11/2024 with diagnoses including metabolic encephalopathy (brain disease that alters brain function or structure), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), and Alzheimer ' s disease (a progressive disease that destroys memory and other important mental functions). During a review of Resident 9 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/30/2025, the MDS indicated Resident 9 was severely impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 9 required partial/moderate (helper does less than half the effort) from staff for bathing and toileting hygiene. The MDS indicated Resident 9 required substantial/maximal assistance (helper does more than half the effort) assistance from staff for lower body dressing. The MDS indicated Resident 9 received psychotropic medications. During a review of Resident 9 ' s Order Summary Report (OSR), dated 4/28/2025, the OSR indicated Resident 9 had physician orders for: 1. Complete blood count (CBC, a group of blood tests that measure the number and size of the different cells in your blood) every Monday due to (d/t) Clozapine (a psychotropic medication used to treat Schizophrenia) use every Monday. The order date was 12/31/2024. 2. Valproic acid (a psychotropic medication used to treat mood swings) level on every Wednesday. The order date was 3/26/2025. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/28/2025 at 1:30 p.m. with the Director of Nursing (DON), Resident 9 ' s untitled care plan, initiated on 2/29/2025, was reviewed. The care plan indicated resident 9 was on Clozapine and Depakote (valproic acid, a psychotropic medication used to treat mood swings). The care plan failed to indicate the intervention of drawing the weekly labs as ordered. The DON stated Resident 9 ' s care plan should also include interventions for the behavior of refusing the weekly labs (blood tests). During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, revised 8/24/2023, the P&P indicated, the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental, and psychosocial well- being.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44027 Based on interview and record review, the facility failed to ensure three of three sampled residents (Residents 10, 11, and 12), were assessed before, during, and after dialysis (the process of removing excess water and toxins from the blood in people whose kidneys can no longer perform these functions naturally) and/or assessment documentation was placed in the residents ' medical records according to the facility ' s policy and procedure (P&P), titled, Dialysis Management, revised 1/25/2024. These failures had the potential for Residents 10, 11, and 12 to experience complications associated with dialysis and for the facility staff to not provide lifesaving interventions. Findings: During a review of Resident 10's Admission Record (AR), the AR indicated the facility admitted Resident 10 on 1/11/2025 and readmitted Resident 10 on 2/4/2025 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), respiratory failure (when the lungs can't get enough oxygen into the blood), and dependence on renal dialysis (a person relying on artificial kidney machines, or dialysis, to perform the functions of their kidneys, which have been damaged or are no longer functioning adequately). During a review of Resident 10 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2025, the MDS indicated Resident 10 had no impairment in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 10 required substantial/maximal assistance (helper does more than half the effort) assistance from staff for lower body dressing and toileting hygiene. The MDS indicated Resident 10 required partial/moderate (helper does less than half the effort) from staff for bathing and personal hygiene. The MDS indicated Resident 10 was receiving dialysis. During a review of Resident 10 ' s untitled care plan, initiated on 2/5/2025, the care plan indicated Resident 10 was transported every Monday, Wednesday, and Friday to a dialysis center to receive dialysis. The care plan indicated interventions included, prior to dialysis nurses would document time, date, general condition of resident when taken to dialysis, and post dialysis, nurses would document date, time and condition of resident when he/she comes back. During a review of Resident 11's AR, the AR indicated the facility admitted Resident 11 on 10/16/2024 and readmitted Resident 11 on 12/9/2024 with diagnoses including type 2 diabetes mellitus, end stage renal disease (ESRD, a condition in which a person's kidneys cease functioning), and dependence on renal dialysis. During a review of Resident 11 ' s MDS, dated [DATE], the MDS indicated Resident 11 was severely impaired in cognitive skills. The MDS indicated Resident 11 was dependent on staff for lower body dressing, bathing, and toileting hygiene. The MDS indicated Resident 11 was receiving dialysis. During a review of Resident 11 ' s untitled care plan, initiated on 10/28/2024, the care plan indicated Resident 11 was scheduled to be transported every Monday, Wednesday, and Friday to a dialysis center to receive dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 12's AR, the AR indicated the facility admitted Resident 12 on 4/16/2025 with diagnoses including type 2 diabetes mellitus, end stage renal disease, and muscle weakness. During a review of Resident 12 ' s MDS, dated [DATE], the MDS indicated Resident 12 had no impairments in cognitive skills. The MDS indicated Resident 12 was dependent on staff for lower body dressing and toileting hygiene. The MDS indicated Resident 12 required substantial/maximal assistance from staff for bathing and upper body dressing. The MDS indicated Resident 12 was receiving dialysis on admission and while a resident of the facility. During a review of Resident 12 ' s untitled care plan, initiated on 4/17/2024, the care plan indicated Resident 12 was transported every Tuesday, Thursday, and Saturday to a dialysis center to receive dialysis. During an interview on 4/25/2025 at 10:12 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated for residents (in general) who receive dialysis, the nurse was responsible to do a pre-dialysis assessment and a post-dialysis assessment. LVN 1 stated the assessments were documented in residents ' (in general) medical record. LVN 1 stated that the resident ' s (in general) pre-dialysis assessment was printed and sent with the resident to the dialysis center. LVN 1 stated the nurse at the dialysis center would document the treatment the resident received and return the documentation with the resident when the resident returned to the facility. LVN 1 stated upon resident return, the dialysis center documentation was placed in the resident ' s medical record. During a concurrent interview and record review on 4/25/2025 at 2:39 p.m. with the Assistant Director of Nursing (ADON), Resident 11 ' s Pre-Dialysis Evaluations (PDE), dated 4/11/2025 and 4/14/25 were reviewed. The section of the PDEs, titled, Dialysis Unit to Complete were both blank (incomplete documentation). The ADON confirmed the nurse from the dialysis center should have completed the section when Resident 11 was at the dialysis center. The ADON also verified Resident 11 ' s Medical Record was missing the Post Dialysis Evaluations for 4/7, 4/11, and 4/14/2025. During a concurrent interview and record review on 4/25/2025 at 2:45 p.m. with the ADON, Resident 12 ' s medical record was reviewed. The ADON confirmed Resident 12 ' s medical record did not include any documentation from the dialysis center on treatment Resident 12 received on 4/19/2025 and 4/22/2025. During a concurrent interview and record review on 4/25/2025 at 2:50 p.m. with the ADON, Resident 10 ' s PDE, dated 4/11/2025 was reviewed. The ADON indicated, the section of the PDEs, titled, Dialysis Unit to Complete was left blank. The ADON confirmed the nurse from the dialysis center should have completed the section when Resident 10 was at the dialysis center. During a review of the facility's P&P titled, Dialysis Management, revised 1/25/2024, the P&P indicated, A pre and post dialysis evaluation will be completed by the licensed nurse. The P&P indicated, all documentation concerning dialysis services and care of the dialysis resident will be maintained in the resident's medical record [.]. The P&P indicated the Nursing Staff will send a dialysis communication form to the dialysis center every time a resident is scheduled for off-site dialysis[.]. The P&P indicated the dialysis provider's nurse will be responsible for documentation of dialysis treatment and providing the resident's post dialysis weight.

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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. 44027 Based on interview and record review, the facility failed to ensure one of two sample resident ' s (Resident 5) controlled medication (a drug that is tightly controlled by the government), morphine sulfate (used to treat moderate to severe pain), was accurately inventoried and reconciled to Resident 5 ' s Medication Administration Record (MAR). This failure had the potential for the diversion of Resident 5 ' s morphine sulphate. Findings: During a review of Resident 5's Admission Record (AR), the AR indicated the facility admitted Resident 5 on 1/3/2023 with diagnoses including type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), dementia (a group of thinking and social symptoms that interferes with daily functioning), and encounter for palliative care (specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness). During a review of Resident 5 ' s Minimum Data Set (MDS, a resident assessment tool), dated 2/7/2025, the MDS indicated Resident 5 was severely impaired in cognitive skills (the ability to make daily decisions). The MDS indicated Resident 5 was dependent (helper does all the effort) on staff for dressing, bathing, and oral and toileting hygiene. The MDS indicated Resident 5 received scheduled pain medication regimen. During a review of Resident 5 ' s Order Summary Report (OSR), dated 4/25/2025, the OSR indicated Resident 5 had a physician ' s order for morphine sulfate oral solution 100 milligram (mg, a unit of measurement)/5 milliliter (ml, a unit of measurement) - give 0.5 ml orally (by mouth) every 12 hours for for pain management. During a concurrent interview and record review on 4/24/2025 at 6:43 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 5 ' s Individual Narcotic Record (INR), dated 4/12/2025 was reviewed. The INR indicated Resident 5 had a supply of morphine sulfate. LVN 2 stated the facility kept track of Resident 5 ' s morphine sulfate by measuring the amount of liquid morphine sulphate used and how much was remaining, and documenting each time nurses used the morphine sulfate. During a concurrent interview and record review on 4/25/2025 at 2:15 p.m. with the Assistant Director of Nursing (ADON), Resident 5 ' s Medication Administration Record (MAR), for April 2025, and Resident 5 ' s INR, dated 4/12/2025 were reviewed. The MAR indicated nurses (in general) gave Morphine Sulfate to Resident 5 daily at 6:00 p.m. including on 4/14, 4/15, 4/20, 4/22, and 4/23/2025. The ADON confirmed the INR was missing entries from the nurses (in general) for the 6:00 p.m. doses, indicating the use and removal of the morphine sulphate on 4/14, 4/15, 4/20, 4/22, and 4/23/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, revised January 2018, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and recordkeeping in the facility [.]. The P&P indicated, [.] Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR)[.]. The P&P indicated Current controlled substance accountability records are kept in the MAR, or designated book.