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	05/29/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained two of five sampled residents' (Resident 3's and Resident 4's) dignity when: 1. Certified Nursing Assistants (CNAs) (unidentified) on the night shift (11 pm to 7 am shift) would sometimes leave Resident 4 uncovered and with Resident 4's gown up to assist another resident (unidentified). 2. An unidentified male staff and CNA 4 only asked what Resident 5 (Resident 3's roommate) needed and not Resident 3, when the unidentified male staff and CNA 4 answered the call light (a device used by a resident to signal their need for assistance from staff) in Resident 3's and Resident 5's room on 5/29/2025. This failure caused Resident 4 to feel that Resident 4 was put aside and the CNAs did not concentrate on Resident 4's care. This failure caused Resident 3 to feel bad that the unidentified male staff and CNA 4 only checked on Resident 5 and not on Resident 3. Findings: 1. During a review of Resident 4's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 4 was readmitted to the facility on [DATE], with diagnoses which included functional quadriplegia (paralysis from the neck down, including legs, and arms, not due to a spinal cord injury), Stage 3 pressure ulcer (full-thickness loss of skin; dead and black tissue may be visible) of the right and left buttocks, and Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral region (the area at the base of the spine, located in the pelvic area). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 4's cognitive skills (functions that the brain uses to think, pay attention, process information, and remember things) were intact. The MDS indicated Resident 4 had an indwelling urinary catheter (a think, flexible tube inserted into the bladder to drain urine), was dependent (helper does all the effort) on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily), bed mobility, and transfers. The MDS indicated Resident 4 had two Stage 3 pressure ulcers (full thickness tissue loss) and one Stage 4 pressure ulcers (full thickness tissue loss with exposed bone, tendon, or muscle). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2025 at 11:20 am with Resident 4, Resident 4 stated occasionally when CNAs (unidentified) on the night shift took care of Resident 4, another resident (unidentified) would get up out of bed or his/her wheelchair unassisted and the CNA(s) who was/were taking care of Resident 4 would rush out to assist the other resident. Resident 4 stated the unidentified CNA(s) would then leave Resident 4 uncovered with Resident 4's gown up. Resident 4 stated Resident 4 would get upset because Resident 4 felt that the CNA(s) put Resident 4 aside and did not concentrate on Resident 4's care. 2. During a review of Resident 3's FS, the FS indicated Resident 3 was readmitted to the facility on [DATE], with diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dysphagia (difficulty swallowing). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills were intact. The MDS indicated Resident 3 had an indwelling urinary catheter, surgical wounds, and was dependent on staff for toileting hygiene, shower/bathing, dressing, putting on/taking off footwear, and bed mobility. The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort) for transfers. During a concurrent observation and interview on 5/29/2025 at 11:49 am with Resident 3 at Resident 3's bedside, Resident 3 stated the staff (in general) only answered Resident 5's call light and never answered Resident 3's call light. Resident 3 turned on Resident 3's call light. A male staff (unidentified) came into Resident 3's room and talked to Resident 5 (Resident 3's roommate whose bed was by the door) and turned the call light off. The male staff did not look behind the privacy curtain to ask Resident 3 if Resident 3 needed assistance. Resident 3 turned on Resident 3's call light again. CNA 4 came in, stood at the foot of Resident 3's bed and looked at Resident 3 but did not ask Resident 3 if Resident 3 needed assistance. CNA 4 spoke to Resident 5 and turned the call light off. Resident 3 turned on Resident 3's call light again and CNA 4 came back and asked Resident 3 if Resident 3 needed assistance. CNA 4 then assisted Resident 3. Resident 3 stated, It makes me feel bad when they ask (Resident 5) and (do not) check on me. During an interview on 5/29/2025 at 12:46 pm with CNA 4, CNA 4 stated when CNA 4 got inside Resident 3's and Resident 5's room, Resident 5 told CNA 4, Resident 5 accidentally turned on the call light. CNA 4 stated CNA 4 needed to ask both residents in the room if they needed assistance to make sure every resident's needs were met. During an interview on 5/29/2025 at 4:15 pm with the Director of Nursing (DON), the DON stated when answering call lights, staff (in general) needed to check on both residents in the room and ask if either resident needed something so both resident's needs would be met. A review of the facility's policy and procedure (P&P) titled, Resident Rights, revised 1/1/2012, the P&P indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of residents' rights .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policies and procedures (P&Ps) titled, Pressure Injury (PI- refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence) Prevention and Skin and Wound Management, for one of five sampled residents (Resident 1) when: 1. Resident 1 developed additional pressure injuries on the left buttocks/ischium (a paired bone forming the lower and back part of the hip bone) and on both heels 22 ½ hours after Resident 1 was admitted to the facility on [DATE]. 2. Resident 1's level of risk for development of pressure ulcers (PUs/PIs) was not accurately assessed upon admission on [DATE]. 3. Resident 1's care plan to address Resident 1's PIs on both heels did not include offloading (reducing or redistributing pressure on a specific area of the body, typically the foot or leg, to promote healing and/or development of wounds) pressure on the resident's bilateral (both sides) heels. These failures resulted in Resident 1 developing additional pressure injuries on Resident 2's left buttocks/ischium and had the potential for Resident 1 to develop further pressure injuries. Findings: During a review of Resident 1's Face Sheet (FS- front page of the chart that contains a summary of basic information about the resident), the FS indicated Resident 1 was admitted to the facility from the General Acute Care Hospital (GACH) 1 on 4/2/2025, with diagnoses which included congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and paraplegia (loss of movement and/or sensation, to some degree, of the legs). During a review of Resident 1's medical records from GACH 1, dated 3/15/2025 to 4/2/2025, the hospital records indicated Resident 1 had a sacral PI. The hospital records did not indicate Resident 1 had any other pressure injuries upon discharge from GACH 1 to the facility. During a review of Resident 1's Progress Note (PN) by Licensed Vocational Nurse (LVN) 4, dated 4/2/2025 and timed 4:22 pm, the PN indicated Resident 1 arrived at the facility on 4/2/2025 at 4 pm and was admitted with a wound on the right buttock. During a review of Resident 1's Braden Scale (BS - used to assess the resident's level of risk for development of pressure ulcers or pressure injuries), dated 4/2/2025 and timed 6:48 pm, the BS indicated Resident 1 had no impairment in sensory perception (ability to respond meaningfully to pressure-related discomfort), no limitation in mobility (ability to change and control body position), and only had a potential problem with friction and shear (forces acting on the skin during movement and repositioning) when being moved and/or lifted in bed/chair. The BS indicated Resident 1 scored a 17 and was at risk for pressure ulcer/injury development (total score of 12 or less represents high risk). (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Skin Check, dated 4/2/2025 and timed 7:05 pm, the Skin Check indicated LVN 1 completed a head-to-toe assessment and a foot evaluation of Resident 1. The Skin Check indicated Resident 1 had a Stage 4 PI (full-thickness skin and tissue loss) on the sacrum (the portion of the spine between the lower back and the tailbone) present on admission. During a review of Resident 1's History and Physical (H&P- physician's clinical evaluation and examination of the resident), dated 4/3/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Skin Issues assessment, dated 4/3/2025 and timed 2:27 pm, the assessment indicated Treatment Nurse (TN - a licensed nurse who is primarily involved in treating skin wounds and skin disorders) 1 completed a head-to-toe assessment of Resident 1 on 4/3/2025. The assessment indicated Resident 1's Stage 4 PI on the sacrum was healed. The assessment indicated Resident 1 had a Stage 4 PI (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the left ischium, a Stage 3 PI (full-thickness loss of skin. Dead and black tissue may be visible) on the right gluteus (right buttock), and a Deep Tissue Injury (DTI - a type of pressure injury where damage occurs beneath the skin's surface) on both heels. During a review of Resident 1's BS, dated 4/3/2025 and timed 2:28 pm, the BS indicated Resident 1 had no impairment in sensory perception, had very limited mobility, and had a problem with friction and shear when being moved and/or lifted in bed/chair. The BS indicated Resident 1 scored a 15 and was at risk for pressure ulcer development. During a review of Resident 1's untitled Care Plan (CP), initiated on 4/3/2025, the CP indicated Resident 1 was admitted with a Stage 4 pressure ulcer on the sacrum. The CP interventions included the following: administer medications and treatments as ordered and monitor/document for side effects and effectiveness; assess/record/monitor wound size, wound perimeter, wound bed, healing, progress, signs of infection, and report to the physician; avoid positioning the resident in the same position for prolonged periods of time; educate the resident/family/caregivers on causes of skin breakdown, importance of frequent repositioning, and good nutrition for prevention of pressure ulcers; and to provide staff assistance to turn and reposition Resident 1 at least every 2 hours. During a review of another Resident 1's untitled Care Plan (CP), initiated on 4/3/2025, the CP indicated Resident 1 had a DTI on both heels. The CP interventions did not include offloading pressure on Resident 1's heels. During a review of Resident 1's admission Minimum Data Set (MDS - a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 1 had decreased movement on both lower extremities (hips, knees, ankles, feet) and was dependent (helper does all the effort) on staff for toileting hygiene, showering/bathing, dressing, putting on/taking off footwear, rolling left and right (the ability to roll from lying on back to left and right side, and return to lying on back on the bed), and transfers. The MDS indicated Resident 1 was 68 inches tall and weighed 235 pounds. The MDS indicated Resident 1 was at risk of developing PIs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/28/2025 at 4:35 pm with LVN 1, Resident 1's Skin Check dated 4/2/2025 and timed at 7:05 pm and Resident 1's Skin Issues assessment dated [DATE] and timed at 2:27 pm were reviewed. LVN 1 compared Resident 1's Skin Check by LVN 1 with Resident 1's Skin Issues assessment by TN 1. LVN 1 stated, Maybe (Resident 1) had socks on (during admission skin check) and I (did not) remove them. LVN 1 stated LVN 1 relied on the treatment nurse's assessment too much. During a concurrent interview and record review on 5/29/2025 at 9:53 am with TN 1, Resident 1's Skin Check dated 4/2/2025 and timed at 7:05 pm and Resident 1's Skin Issues assessment dated [DATE] and timed at 2:27 pm were reviewed. TN 1 stated the nurse who admitted the resident (in general) needed to do the head-to-toe body check of the resident, write down what the nurse saw, and inform the resident's doctor. TN 2 stated, the following day after admission, the treatment nurses would assess the resident's (in general) skin again and would restage (wound staging is a system used to categorize wounds based on their depth and extent of tissue damage) any wounds. TN 1 compared Resident 1's Skin Check by LVN 1, dated 4/2/2025 and timed at 7:05 pm, to Resident 1's Skin Issues assessment by TN 1, dated 4/3/2025 and timed at 2:27 pm. TN 1 stated there was a big difference between the Skin Check by LVN and the Skin Issues assessment by TN 1. TN 1 stated TN 1 remembered Resident 1 only had a scar on the sacrum and Resident 1's skin on the sacrum was not open. TN 1 stated TN 1 identified a PI on Resident 1's left ischium, a PI on Resident 1's right ischium, and a DTI on Resident 1's bilateral heels when TN 1 assessed Resident 1's skin that day (4/3/2025). TN 1 stated because of the big difference between Resident 1's Skin Check and Resident 1's Skin Issues assessment, it would be difficult to determine which PIs were acquired from admission and which PIs were acquired in the facility. TN 1 stated it would only take one shift to not turn and reposition Resident 1 for Resident 1 to develop a PI. TN 1 verified the Skin Check done by LVN 1, dated 4/2/2025 and timed at 7:05 pm, only identified a PI on Resident 1's sacrum upon Resident 1's admission. TN 1 reviewed Resident 1's GACH 1 records, dated 3/15/2025 to 4/2/2025, and stated Resident 1's GACH 1 records indicated Resident 1 had a Stage 4 PI on the sacrum, but did not mention a DTI on both heels. During an interview on 5/29/2025 at 4:15 pm with the Director of Nursing (DON), the DON stated the nurse who admitted the resident (in general) would do a head-to-toe body check of the resident upon admission and write down whatever the admitting nurse found on the resident. The DON stated the treatment nurse would then do a thorough assessment the following day because we (the facility) needed to have an accurate description and staging of the wound by the treatment nurse. During a review of the facility's P&P titled, Skin and Wound Management, revised on 1/1/2013, the P&P indicated, a licensed nurse will perform a skin assessment upon admission for each resident as part of the Comprehensive Resident admission Assessment .the licensed nurse will also complete the Braden Scale upon admission/re-admission .and the licensed nurse will develop a care plan to identify interventions to prevent the development of pressure ulcers . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Pressure Injury Prevention, revised on 8/12/2016, the P&P indicated, A risk assessment (Braden Scale) for developing pressure injuries will be completed upon admission .and regardless of the risk score the licensed nurse will develop a care plan specific to the resident's risk factors .The Nursing Staff will implement interventions identified in the care plan based on the individual risk factors, which may include .pressure redistributing devices when in bed and chair, repositioning and turning, heel and elbow protectors, increasing mobility when appropriate through a RNA program or therapy programs, offloading pressure from heels, use of pillows and wedges for positioning and pressure relief, moisturizers and barrier creams to protect the skin, bowel and bladder training, scheduled toileting, incontinence management programs, devices to reduce friction and shear when repositioning such as bed trapeze, draw sheets, mechanical lifts and positioning aides .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed nurses and certified nursing assistants (CNAs) knew how to properly care for one of one sampled resident (Resident 2) with a nephrostomy tube (a tube used to drain urine directly from the kidney into a bag). Consequently, this failure resulted in Resident 2's nephrostomy tube to become dislodged and for Resident 2 to receive inappropriate care. Consequently, Resident 2 was transferred to the general acute care hospital (GACH) 2 's emergency department (ED) for evaluation and reinsertion of the nephrostomy tube on 5/17/2025 and on 5/20/2025. Findings: During a review of Resident 2's Face Sheet, the Face Sheet indicated Resident 2 was admitted to the facility on [DATE] with diagnoses that included urinary tract infection (UTI- an infection in the bladder/urinary tract) and hydronephrosis (when urine backs up into the kidneys due to a blockage in the urinary tract). During a review of the Resident 2's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 5/12/2025, the H&P indicated Resident 2 had the capacity to understand and make decisions. The H&P indicated Resident 2 had a right nephrostomy. During a review of Resident 2's admission Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 2 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, upper body dressing, and personal hygiene, and was dependent (helper does all the effort) on staff for showering/bathing, lower body dressing, and with putting on/taking off footwear. The MDS further indicated Resident 2 required substantial/maximal assistance (helper does more than half the effort) with moving around in bed and with transfers. During a review of the Change in Condition Evaluation (CIC), dated 5/17/2025 and timed 7:55 p.m., the CIC indicated, (Resident 2) was complaining of urine leaking, when inspected, back was wet with urine from the nephrostomy insertion site and nephrostomy tubing is almost completely out, nephrostomy bag also had no output. The CIC indicated Resident 2's physician was informed on 5/17/2025 at 8 p.m. and ordered to send Resident 2 to the hospital emergency department for further evaluation and reinsertion of the nephrostomy tube. During a review of a Progress Note (PN), dated 5/17/2025 and timed 9:30 p.m., the PN indicated Resident 2 was sent out to the general acute care hospital (GACH) 2 due to dislodgement of the nephrostomy tube. The PN indicated Resident 2 was transported to GACH 2 via an emergency medical services transportation. During a review of a PN, dated 5/19/2025, the PN indicated Resident 2 was readmitted to the facility with a nephrostomy tube. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the CIC, dated 5/20/2025 and timed 10:17 p.m., the CIC indicated Resident 2's nephrostomy was dislodged. The CIC indicated Resident 2's physician was informed on 5/20/2025 at 8 p.m. and ordered to send Resident 2 to the hospital emergency department for further evaluation and reinsertion of the nephrostomy tube. During a review of a PN, dated 5/20/2025 and timed 10:15 p.m., the PN indicated, Upon CNA doing rounds, the CNA noticed the nephrostomy was dislodged and tubing was on the floor. Upon assessment, the licensed nurse noticed leakage at the nephrostomy insertion site and (Resident 2's) back wet. Resident 2 is unsure how the tubing got dislodged. The Physician was aware and with orders to send out to the (ED) for reinsertion. During a review of a PN, dated 5/21/2025 and timed 7:39 p.m., the PN indicated Resident 2 returned from GACH 2 with the nephrostomy intact. During a concurrent observation and interview on 5/28/2025 at 11:53 a.m. with Resident 2, Resident 2 was observed resting in bed with clear amber urine in Resident 2's nephrostomy bag. Resident 2 stated Resident 2 did not know how the nephrostomy tube came out. Resident 2 stated the nurses (general) in the facility were terrific, they treat me well, and (are) doing their job. Resident 2 stated nurses (general) need to be more careful with turning Resident 2 side to side during care and when pulling Resident 2 up in bed. Resident 2 stated nurses (general) need to be more aware of the nephrostomy tube and bag. Resident 2 stated it was terrible in the (ED), (Resident 2) had to keep waiting to put (nephrostomy) tube in to drain my urine. During a phone interview on 5/28/2025 at 2:16 p.m. with Family Member (FM) 1, FM 1 stated Resident 2 has had a nephrostomy tube for about a year and had not had a problem with dislodgement at home. FM 1 stated the first time Resident 2's nephrostomy tube got dislodged was after Resident 2 was admitted to the facility. FM 1 stated Resident 2's nephrostomy tube might have gotten caught in the bed or in the blanket and got dislodged. During an interview on 5/28/2025 at 4:35 p.m. with licensed vocational nurse (LVN) 1, LVN 1 stated LVN 1 took care of Resident 2 on 5/20/2025. LVN 1 stated at the start of the 3 p.m. to 11 p.m. shift on 5/20/2025, Resident 2's nephrostomy tube was leaking and Resident 2's physician saw Resident 2 at the bedside and referred Resident 2 for an outside test to evaluate why Resident 2's nephrostomy was leaking. LVN 1 stated while LVN 1 was passing medications CNA 6 informed LVN 1 Resident 2's nephrostomy tube was on the floor and Resident 2's back was wet. LVN 1 stated Resident 2 did not know Resident 2's nephrostomy tube came out. LVN 1 stated there had been other residents in the facility with nephrostomy tube and LVN 1 remembered one male resident (unidentified) whose nephrostomy tube became dislodged. During an interview on 5/28/2025 at 5:02 p.m. with LVN 2, LVN 2 stated LVN 2 took care of Resident 2 on 5/17/2025 during the 3 pm to 11 pm shift. LVN 2 stated during the start of the shift on 5/17/2025, Resident 2's nephrostomy tube on the right side of Resident 2's back was draining with a dressing in place. LVN 2 stated later during LVN 2's shift on 5/17/2025, the CNA (unidentified) who took care of Resident 2 informed LVN 2 there was no urine in Resident 2's nephrostomy bag. LVN 2 checked on Resident 2 and the nephrostomy tube site dressing was a little peeled off on the corner. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 9:44 a.m. with the Director of Nursing (DON), the DON stated CNA 2 took care of Resident 2 on the 7 a.m. to 3 p.m. shift on 5/17/2025 and CNA 2 stated Resident 2's nephrostomy tube was leaking towards the end of CNA 2's shift and informed the LVN (unidentified). The DON stated CNA 6 took care of Resident 2 on the 3 p.m. to the 11 p.m. shift on 5/20/2025. The DON stated on 5/20/2025 when CNA 6 turned Resident 2 to get the resident ready for a shower, Resident 2's nephrostomy tube was already dislodged. During an interview on 5/29/2025 at 12:38 p.m. with CNA 5, CNA 5 stated CNA 5 had never had training on how to care for a resident with a nephrostomy tube and had not worked with Resident 2 before. During an interview on 5/29/2025 at 12:46 p.m. with CNA 4, CNA 4 stated CNA 4 was not trained on how to care for a resident with a nephrostomy tube. CNA 4 stated CNA 4 had not been assigned to care for Resident 2 but assisted with pulling Resident 2 up in bed before. During a concurrent interview and record review on 5/29/2025 at 3:31 p.m. with the Director of Staff Development (DSD), the DSD stated the DSD held an in-service about nephrostomy tube care on 5/23/2025 and did not go over nephrostomy tube and how to care for a resident with a nephrostomy tube when Resident 2 was admitted to the facility. The DSD stated the Assistant Director of Nursing (ADON) oversaw the licensed nurses' skills check and the DSD oversaw the CNAs skills check. The DSD reviewed the Skills Evaluation/Skills Check for the following: a. CNA 2's CNA Skills Evaluation/Orientation Checklist (SEOC), dated 4/17/2025. b. CNA 4's CNA SEOC, dated 4/12/2025. c. CNA 5's CNA SEOC, dated 4/10/2025. d. CNA 6's CNA SEOC, dated 4/10/2025. e. LVN 1's Licensed Nurse Orientation Skills Check and Annual Skills Check (OSCASC), dated 1/10/2025. f. LVN 2's Licensed Nurse OSCASC, dated 3/26/2025. The DSD stated all the above CNA SEOC and Licensed Nurse OSCASC indicated the CNAs' and the LVNs' skills on how to care for a resident with a nephrostomy tube was not assessed. The DSD stated the DSD checked with the ADON and the DON and they both stated there was no specific skills check regarding nephrostomy tube care. The DSD stated it was important to assess CNAs and LVNs skills to ensure they knew how to properly care for the resident. During an interview on 5/29/2025 at 4:15 p.m. with the DON, the DON stated an initial in-service about nephrotomy tube management was provided on 5/23/2025 but there has not been any skills check. The DON stated staff (general) knew prior to Resident 2's admission that Resident 2 had a nephrostomy. The DON stated it was important to evaluate competency and do a skills check to assess a CNA's and an LVN's knowledge on how to handle a nephrostomy tube, and how to take care of a resident with a nephrostomy tube. (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	05/29/2025

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 0726 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, Staff Competency or Skills Check, dated on 8/22/2019, the P&P indicated, The purpose of completing competency evaluations or skills checks is to determine knowledge and/or performance of assigned responsibilities based on standard or practice, policy and procedure .Competency evaluations or skills checks will be performed upon hire during the 90 day probation period, annually, anytime a new procedure is introduced and as needed .When a new product or equipment is introduced the employee will be provided education and skills check or competency evaluation if appropriate .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its Infection Prevention and Control Program for two of five sampled residents (Resident 3 and Resident 4) by failing to ensure: 1. Certified Nursing Assistant 1 (CNA 1) wore a protective gown when CNA 1 removed Resident 4's splints (devices used to immobilize a body part) while Resident 4 was in bed on 5/28/2025. Resident 4 had wounds and an indwelling urinary catheter (a flexible tube left inside the bladder and used to empty the bladder and collect urine in a drainage bag). 2. CNA 2 and CNA 3 wore a protective gown when they provided care to Resident 3 on 5/28/2025. Resident 3 had wounds and an indwelling urinary catheter. 3. CNA 2 and CNA 3 performed hand hygiene (cleaning hands by either washing them with soap and water, or by using an alcohol-based hand sanitizer) after they provided care to Resident 3 on 5/28/2025. These failures had the potential to spread infection to residents, staff, and visitors. Findings: 1. During a review of Resident 4's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Facesheet indicated Resident 4 was readmitted to the facility on [DATE] with diagnoses which included functional quadriplegia (paralysis from the neck down, including legs, and arms, not due to a spinal cord injury), Stage 3 pressure ulcer (full-thickness loss of skin; dead and black tissue may be visible) of the right and left buttocks, and Stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral region (the area at the base of the spine, located in the pelvic area). During a review of Resident 4's physician's order (PO), dated 8/1/2024, the PO indicated to place Resident 4 on Enhanced Barrier Precautions (EBP- gown and glove use when performing specific high-contact resident care activities for residents with wounds and/or indwelling medical device [inserted into the body and remain in place for an extended period]) due to Resident 4's pressure ulcers. A PO, dated 11/6/2024, indicated to place Resident 4 on EBP due to an indwelling urinary catheter. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 3/18/2025, the MDS indicated Resident 4's cognitive skills (functions that the brain uses to think, pay attention, process information, and remember things) are intact. The MDS indicated Resident 4 had an indwelling urinary catheter, was dependent (helper does all the effort) on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily), and was dependent on staff for bed mobility and transfers. The MDS also indicated Resident 4 had two Stage 3 pressure ulcers and one Stage 4 pressure ulcer. During a concurrent observation and interview on 5/28/2025 at 11:37 a.m., CNA 1 removed Resident 4's right arm, right leg, and left leg splints without a gown on. CNA 1 stated CNA 1 must use a gown when providing care to Resident 4 because Resident 4 had a catheter and wounds, but CNA 1 forgot to put a gown on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 3's FS, the FS indicated Resident 3 was readmitted to the facility on [DATE] with diagnoses which included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and dysphagia (difficulty swallowing). During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognitive skills are intact. The MDS indicated Resident 3 had an indwelling urinary catheter, surgical wounds, and was dependent on staff for toileting hygiene, shower/bathing, dressing, putting on/taking off footwear, and bed mobility. The MDS also indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort) for transfers. During a review of Resident 3's PO, dated 5/23/2025, the PO indicated to cleanse and apply hydrogel (a type of wound dressing) to Resident 3's left calf, left lower leg, left thigh, and sacral wounds. During an observation on 5/28/2025 at 12:26 p.m., CNA 2 and CNA 3 went inside Resident 3's room and dressed Resident 3. CNA 2 and CNA 3 did not have a gown on. After CNA 2 and CNA 3 dressed Resident 3, CNA 2 and CNA 3 removed their gloves and walked outside Resident 3's room without performing hand hygiene. During an interview on 5/28/2025 at 12:37 p.m. with CNA 2, CNA 2 stated EBP was when staff had to use gown and gloves for a resident with ostomy (surgical procedure to create an opening into a body organ), IV (intravenous catheter- a soft, flexible tube placed inside a vein, usually in the hand or arm, and used by health care providers to give a person medicine or fluids), catheter, and wounds. CNA 2 stated CNA2 and CNA 3 must gown up to provide care to Resident 3, but they did not put a gown on because they did not see the EBP sign by Resident 3's room door. CNA 2 stated they had to wear gown and gloves to protect themselves and Resident 3 from getting sick. CNA 2 stated they must wash hands or use hand sanitizer in between residents and when going in and out of a resident's room. During an interview on 5/28/2025 at 3:17 p.m., the Infection Prevention Nurse (IPN) stated EBP was when staff must don gloves, gown, and/or mask or face shield when providing care to a resident with wounds, catheter, or are immunocompromised. The IPN stated EBP was important to prevent cross contamination (transfer of harmful bacteria from one person, object, or place to another) and spreading infection to residents. The IPN stated hand hygiene must be performed before entering a resident room, before and after touching a resident, before exiting a resident room, and in between residents. During an interview on 5/29/2025 at 4:15 pm with the Director of Nursing (DON), the DON stated hand hygiene and EBP were important to mitigate (make less severe) infection. The DON stated staff (general) must wash their hands or use hand sanitizer and don (put on) personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) when performing high-risk activities for EBP. A review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, with an effective date 5/21/2025, indicated, For residents for whom EBP are indicated, EBP is employed when performing . dressing, bathing/showering, transferring within the resident room, providing hygiene, changing linens, changing briefs or assisting with toileting .After EBP required task and before exiting room, remove and place PPE in trash and perform hand hygiene . The P&P indicated EBP applies to all residents with wounds and/or indwelling medical devices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's P&P titled, Hand Hygiene, with a revision date of 9/1/2020, indicated hand hygiene must be performed before donning and after doffing PPE and immediately upon entering and exiting a resident room.