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	06/26/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the residents' right for dignity for two of five sampled residents (Residents 3 and 4) when:A. Resident 3 was observed with a large wet stain in the inner and middle area of Resident 3's pants.B. Resident 4 was observed sitting in Resident 4's wheelchair in the facility dining room with a large wet stain on both sides and the middle area of Resident 4's shorts.These failures had the potential to result in low self-esteem and humiliation for Residents 3 and 4.Findings:A. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses that included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), hepatic encephalopathy (loss of brain function when a damaged liver doesn't remove toxins from the blood), and depression (persistent low mood affecting daily living).During a review of Resident 3's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 9/18/24, the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 6/2/25, the MDS indicated Resident 3's cognitive (process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 3 was dependent on staff for toileting hygiene, bathing and upper/lower body dressing.B. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included Type 2 diabetes mellitus (body has trouble controlling blood sugar), acquired absence of right and left leg below the knee (loss of leg at or below the knee), and a cognitive communication deficit (difficulties in communication).During a review of Resident 4's H&P dated 3/18/25, the H&P indicated Resident 4 did not have the capacity to understand and make decisions.During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had severely impaired cognitive skills, impairment on both sides in the lower extremities and used a wheelchair for mobility. The MDS indicated Resident 4 was dependent on staff for toileting hygiene.During an observation in the dining room on 6/26/25, at 5:10 p.m., Resident 3's pants had a large wet stain in the inner and middle area of Resident 3's pants. During an interview on 6/26/25 at 5:13 p.m. with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated some residents wore double diapers or a towel was placed in place between the residents' legs so it cannot be seen when residents got wet.During a concurrent observation and interview on 6/26/25 at 5:21 p.m., with Resident 4 in the dining room, Resident 4's green colored shorts had a large wet stain on both sides and the middle area. Resident 4 stated Resident 4 did not spill anything on himself, and stated Resident 4 was wet from urine. Resident 4 stated Resident 4 told the nurse Resident 4 was wet, and that Resident 4 had been wet for two hours. Resident 4 stated the nurse (unidentified) told Resident 4 a nurse would take care of it but Resident 4 remained wet.During an interview on 6/26/25 at 5:25 p.m. with CNA 2, CNA 2 stated CNA 2 was assigned to Resident 3. CNA 2 stated, CNA 2 started work today, 6/26/25 at 3:00 p.m. and showered another resident. CNA 2 stated CNA 2 would change Resident 3 as soon as CNA 2 got a chance. CNA 2 stated CNA 2 did not check Resident 3 today (6/26/25) when CNA 2 came in for work because CNA 2 started passing coffee. CNA 2 stated it was important to check the residents to prevent pressure ulcers (PU-lesion/wound caused by unrelieved pressure that results in damage of underlying tissue) or rashes and to keep the residents clean.During a concurrent observation of Resident 3 and interview on 6/26/25 at 5:35 p. m. with CNA 2, CNA 2 stated Resident 3 was wet, and CNA 2 needed to change Resident 3. CNA 2 stated this was the first time today CNA 2 had a chance to change Resident 3's clothes.During an interview on 6/26/25, at 5:41 p.m. with Licensed Vocational Nurse 4(LVN 4), LVN 4 stated it was important to keep residents dry for comfort and it was the residents' right to be changed when wet. LVN 4 stated it was important for residents not to sit wet for extended period of time to prevent the development of PU.During an interview on 6/26/25 at 5:56 p.m. with the Director of Nurses (DON), the DON denied the facility had an issue with staffing.During an interview on 6/26/25, at 6:54 p.m. with CNA 3, CNA 3 stated CNA 3 was assigned to Resident 4. CNA 3 stated CNA 3 needed to check the residents assigned to CNA 3, 30 minutes to one hour of starting work. CNA 3 stated the residents (in general) were supposed to be checked before they went to the dining room and sometimes on 3:00 p.m.- 11:00 p.m. shift the residents were already in the dining room, and CNAs go to the dining room to check the residents. CNA 3 stated CNA 3's run (assignment) was switched by the Director of Staff Development (DSD) 45 minutes into CNA 3's shift. CNA 3 stated when CNA

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 2) received adequate supervision to prevent an elopement (when a patient leaves a healthcare facility without authorization or proper discharge).On 6/23/25, Resident 2 was found on the ground outside the facility with a bleeding laceration (type of open wound) on Resident 2's left eyebrow area.This failure resulted in Resident 2 sustaining bruising around the left eye and a laceration on Resident 2's left eyebrow which required 3 stitches. Resident 2 was transferred to General Acute Care Hospital (GACH) 1 for evaluation and for stitches to left eyebrow laceration after Resident 2 fell on 6/23/25.Findings:A review of Resident 2's admission Record indicated the resident was readmitted to the facility on [DATE] with diagnoses that included Parkinsonism (refers to brain conditions that cause slowed movements, rigidity (stiffness), and tremors (involuntary, rhythmic shaking movements in various parts of the body), abnormalities of gait and mobility (a range of walking or movement patterns that deviate from the typical), and unspecified macular degeneration (eye disease causing vision loss), and unspecified dementia (thinking and social symptoms that interferes with daily functioning).A review of Resident 2's History and Physical (H&P- a term used to describe a physician's examination of a resident) dated 11/25/24, indicated that Resident 2 did not have the capacity to understand and make decisions due to (d/t) dementia (thinking and social symptoms that interferes with daily functioning). Resident 2's H&P indicated Resident 2 had an unsteady gait (abnormal walking pattern characterized by a lack of coordination, balance, or stability, increasing the risk of falls).A review of Resident 2's Minimum Data Set (MDS, a standardized resident assessment and care screening tool) dated 4/11/25, indicated that Resident 2's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses) was severely impaired. The MDS indicated that Resident 2 used a manual wheelchair and walker as mobility devices and required supervision/touch assistance with sit to stand.A review of Resident 2's Physician's Order, dated 6/23/25, indicated that Resident 2 may be sent out to General Acute Care Hospital (GACH) 1 for further evaluation status post (s/p) an unwitnessed fall.A review of Resident 2's Situation, Background, Assessment, and Recommendation (SBAR - used to convey information clearly and concisely to ensure that important information is shared effectively between healthcare professionals) Form dated 6/23/25 at 5:37 p.m., indicated Resident 2 had a skin tear noted above left eyebrow 3.5 centimeters (cm) x 1 cm and bleeding was noted. The SBAR indicated that Resident 2 was transferred to GACH 1.A review of Resident 2's Elopement Evaluation, dated 4/11/25, indicated Resident 2 was at risk for elopement due to a history of elopement or behavior of attempting to leave the facility without informing staff, due to verbally expressing the desire to go home, and due to wandering behavior.A review of the emergency room Discharge Summary (ERDS), dated 6/23/25, indicated that Resident 2 was admitted to GACH 1 with a facial laceration. The ERDS indicated Resident 2 had left periorbital (around the eye) bruising and three stitches.A review of Resident 2's At Risk for Falls Care Plan, revised 4/18/25, indicated to anticipate and meet the needs of the patient and to assist Resident 2 with locomotion (movement or the ability to move from one place to another) on and off the unit.A review of Resident 2's Quarterly Fall Risk Evaluation (FRE- process used to identify individuals who are at higher risk of falling) Form, dated 10/25/24 and 4/11/25, indicated Resident 2 was at risk for falls. Resident 2's admission FRE, dated 5/21/25, indicated Resident 2 was at risk for falls. The FRE indicated that Resident 2 fell on [DATE], 11/28/24, 1/22/25, 5/21/25, and 6/23/25.During a phone interview, on 6/26/25, at 1:08 p.m., with Family (FAM 1), FAM 1 stated Resident 2 frequently goes around the facility in Resident 2's wheelchair. There are double doors that lead to the lobby and out the front door and to a driveway and to the street. FAM 1 stated nobody/no staff are ever at the front desk or in the front lobby area because they all leave at 5 p.m. FAM 1 stated FAM 1 has witnessed several times there were no staff in Nurse Station 1 near an exit. FAM 1 stated Resident 2 went outside of the facility through the front doors (second set of double doors). FAM 1 stated Resident 2 was found sitting on the concrete outside in the front of the facility where there are rocks and bushes. FAM 1 stated Resident 2 sustained an injury that required sutures (threads used to close wounds) on Resident 2's left eyebrow, around temporal (lateral portion located toward the temples) and orbital (bony cavity in the skull that houses eyeball/eye socket) eye area. FAM 1 stated there was inconsistent administration and high turnover so, they don't get to know the residents well enough to anticipate certain behavior of residents.During an interview, on 6/26/25, at 2:12 p.m., with the Rehabilitation

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of five sampled residents (Resident 1), who had diagnosis of dementia (loss of memory and other mental abilities severe enough to interfere with daily life), had a history of fall (unintentionally coming to rest on a lower-level surface) on 6/1/25, and was assessed at a high fall risk on 6/1/25, received care needs and services to prevent a fall on 6/19/25 by failing to ensure:Licensed Vocational Nurse (LVN) 2 monitored (observed and checked) and promptly (quickly/rapidly/immediately) redirected Resident 1 (direct Resident 1 to a new or different place or purpose) when Resident 1 got up from Resident 1's wheelchair unassisted while Resident 1 was at Nurses' Station 1 on 6/19/25 [at around 10 am].As a result, on 6/19/25, at approximately 10 am, Resident 1 fell out of Resident 1's wheelchair, in front of Nurses' Station 1. Resident 1 sustained fractures (break in the bones) of the left 8th, 9th, and 10th ribs (are commonly referred to as false ribs [12 paired bones which form a cage to protect the lungs and the heart]. Unlike the first seven ribs, which directly connect to the sternum [breastbone]). Findings:During a review of Resident 1's admission Record (AR), the AR indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses that included dementia, a history of falling, cognitive (ability to think and understand information) communication deficit (communication difficulties stemming from impaired cognitive functions rather than direct speech or language problems), difficulty in walking and impulse disorder (inability to resist urges and impulses [acting without forethought]).During a review of Resident 1's untitled Care Plan (CP), dated 8/8/24, revised 5/9/25, the CP indicated Resident 1 was at risk for falls related to dementia, the aging process, poor safety awareness, and a history of falls. The CP interventions included anticipating and meeting Resident 1's needs, promptly response to all of Resident 1's requests for assistance and removing any potential causes of falls if possible.During a review of Resident 1's History and Physical (H&P, physician examination of a resident), dated 1/27/25, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated Resident 1 had an unstable gait (abnormal walking pattern characterized by a lack of coordination [the ability to use different parts of the body together smoothly and efficiently]), balance, or stability, and increasing the risk of falls. During a review of Resident 1's Minimum Data Set (MDS, resident assessment tool), dated 3/25/25, the MDS indicated Resident 1's cognitive skills (ability to make daily decisions) was severely impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) from staff for transfers (moving from bed to chair or wheelchair), and walking.During a review of Resident 1's Fall Risk Evaluation (FRE), dated 6/1/25, the FRE indicated Resident 1's fall risk score was 15 due to Resident 1 required the use of assistive devices (cane, wheelchair, walker, furniture) while standing and walking, and had one to two falls in the past 3 months. The FRE indicated a score of 10 or higher, placed Resident 1 at high risk for fall. The FRE indicated Resident 1 was considered at high risk for potential falls (an increased likelihood of a person experiencing a fall, which can lead to injuries) when Resident 1's fall risk score was 10 or greater. The FRE indicated for nursing staff (in general) to focus on Resident 1's risk for falls with a goal for Resident 1 to be free of falls, and interventions to assist Resident 1 with ambulation (the ability to walk from place to place) and transfers.During a review of Resident 1's Situation, Background, Assessment, and Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among the residents) Form, dated 6/1/25 and timed at 11:50 pm, the SBAR indicated Resident 1 had a fall, was unresponsive to verbal questions, and sustained an open skin tear to the left side of Resident 1's face due to the fall. During a review of Resident 1's Risk for Falls Care Plan (CP), dated 6/1/25, indicated Resident 1 was transferred to General Acute Care Hospital (GACH) 2 Emergency Department (ED) (on 6/1/25) due to a fall on 6/1/25. The CP interventions included assisting Resident 1 with walking, transferring, and placing Resident 1 in front of the Nurses' Station for monitoring (observing and checking) [Resident 1's behavior to prevent falls].During a review of Resident 1's Fall Investigation Report (IR), dated 6/19/25 and timed 10:16 am, the IR indicated on 6/19/25 at 10 am, Resident 1 got up from Resident 1's wheelchair and fell on the floor in front of Nurses' Station 1. The IR indicated LVN 2 was on the computer with the Activities Director (AD) in Nurses' Station 1 on 6/19/25 [at 10 am]. The IR indicated LVN 2, and the AD saw Resident 1 walking towards Nurses' Station 1 unassisted, but LVN 2 and the AD were not able to get to Resident 1 in time due to the incident happened too fast. During a review of Resident 1's SBAR Form, dated 6/19/25 and timed at 10:25 am, The SBAR indicated [on 6/19/25, at 10 am], Resident 1 got up from Resident 1's