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	12/17/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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
	055344	A. Building B. Wing	12/17/2025

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 0580 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 Licensed Vocational Nurse 4 (LVN 4) immediately notified the physician and the family for one of six sampled residents (Resident 2) after Resident 2's unwitnessed fall on 11/12/2025 at 6:30 pm. This failure had the potential for Resident 2 to receive inappropriate care and had the potential to delay the assessment and treatment of Resident 2. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 3/30/2018 with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), dementia (a progressive state of decline in mental abilities), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 2's History and Physical (H&P), dated 3/8/2025, 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 12/2/2025, the MDS indicated Resident 2's cognition (thinking, knowing, and being aware) was severely impaired. The MDS indicated Resident 2 had impaired movement of both upper and lower extremities and was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and to move around in bed. During a review of Resident 2's SBAR (situation, background, assessment, recommendation-a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 11/14/2025, the SBAR indicated while an unidentified staff provided care to Resident 2, Resident 2's right knee was observed to be swollen and Resident 2 did not complain of pain. The SBAR indicated Resident 2's physician was informed Resident 2's change in condition on 11/14/2025 at 4:13 am and Resident 2's family was informed on 11/14/2025 at 4:20 am. During a review of Resident 2's SBAR, dated 11/17/2025, the SBAR indicated Resident 2 had a discoloration behind both knees and back of thighs. The SBAR indicated Resident 2's family was informed on 11/17/2025 at 4 pm and Resident 2's physician was informed on 11/17/2025 at 5:30 am. During a review of Resident 2's SBAR, dated 11/20/2025, the SBAR indicated Resident 2 had a displaced (bone is out of alignment) comminuted (bone is broken into pieces) fracture (break in the bone) of the left thigh bone and an acute oblique fracture (sudden angled break) in the lower part of the right thigh bone. The SBAR indicated Resident 2's physician and family were notified on 11/20/2025 at 6 am. During a review of Resident 2's physician order (PO), dated 11/20/2025 and timed at 11:26 am, the PO indicated to send Resident 2 to General Acute Care Hospital 1 (GACH 1) for further evaluation and treatment of Resident 2's right and left thigh fractures. During a review of Resident 2's Discharge/Transfer Documentation (DTD) from GACH 1, dated 11/21/2025, the DTD indicated Resident 2 underwent surgical intervention that included intramedullary nailing (insertion of a metal rod to repair bone fractures) of Resident 2's left and right thigh bones fracture. During an interview on 12/16/2025 at 1:27 pm with the Director of Nursing (DON), the DON stated Resident 2 slid out of bed and was found on the floor during the 3 pm to 11 pm shift on 11/12/2025. Resident 2 was assessed and was not in pain. The DON stated Resident 2's family and physician were not informed on 11/12/2025 after Resident 2 was found on the floor. During a concurrent interview and record review on 12/16/2025 at 3:53 pm with the DON, the DON reviewed Resident 2's medical record and stated there was no SBAR or Change of Condition (COC) note in Resident 2's medical record regarding Resident 2's fall on 11/12/2025. The DON stated the DON did not know Resident 2 fell on [DATE] until LVN 3 told the DON on 11/20/2025. Resident 2's physician was informed on 11/20/2025 that Resident 2 fell on [DATE]. During a phone interview on 12/17/2025 at 11:46 am with LVN 3, LVN 3 stated LVN 3 did not take care of Resident 2 during the 3 pm to 11 pm shift on 11/12/2025. LVN 3 stated on 11/12/2025 at 6:30 pm, LVN 3 assisted LVN 4 and Certified Nursing Assistant 8 (CNA 8) to put Resident 2, who was sitting on the floor mat by Resident 2's bed, back to bed. During a concurrent interview and record review on 12/17/2025 at 3:02 pm with the DON, the facility's policy and procedure (P&P) titled Change of Condition Notification, dated 4/1/2025, was reviewed. 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/accident involving the resident. The DON stated the Change of Condition Notification policy applied to Resident 2's unwitnessed fall on 11/12/2025. The DON stated Resident 2's physician and family should have been notified on 11/12/2025 regarding Resident 2's fall. During a phone interview on 12/17/2025 at 3:12 pm with LVN 4, LVN 4 stated on 11/12/2025, while LVN 4

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	12/17/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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	12/17/2025

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 0600 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 provide a safe environment and protect one of six sampled residents (Resident 3) from physical abuse (aggressive or violent behavior with the intention to cause physical harm) and mistreatment when Certified Nursing Assistant 6 (CNA 6) roughly placed Resident 3 into a wheelchair, brushed Resident 2's hair roughly, and yelled at Resident 3 on 11/25/2025. This deficient practice had the potential to place Resident 3 at risk for physical and psychosocial harm.Findings: a. During a review of Resident 3's admission Record (AR), the AR indicated Resident 3 was readmitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/19/2025, 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 resident assessment tool), dated 11/19/2025, the MDS indicated Resident 3's cognition (thinking, knowing, and being aware) was severely impaired. The MDS indicated Resident 3 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). b. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). The AR indicated Resident 4 stayed in the same room as Resident 3. During a review of Resident 4's H&P, dated 6/4/2025, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of the facility's Interview Record (IR) with Resident 4, dated 11/25/2025, the IR indicated Resident 4 was interviewed by the facility regarding her observations made while CNA 6 was providing care to her roommate, Resident 3. The IR indicated Resident 4 stated that while CNA 6 was assisting Resident 3 with personal care, Resident 4 noticed that CNA 6 was speaking to Resident 3 in a loud and firm voice, repeatedly telling Resident 3 not to get up. Resident 4 stated that CNA 6 appeared to be holding Resident 3 tightly by the hands and guided Resident 3 to the wheelchair in a manner that Resident 4 described as fast and rough. Resident 4 further reported that while CNA 6 was combing Resident 3's hair, Resident 4 observed CNA 6 brushing Resident 3's hair hard enough that it seemed like it was pulling Resident 3's hair, which caused Resident 4 to become concerned for Resident 3's comfort. During a review of the facility's IR with the Director of Staff Development (DSD), dated 11/25/2025, the IR indicated that at approximately 3:25 pm while in the DSD's office, a CNA (unknown) came to report to the DSD that the CNA heard another CNA yelling at a resident (Resident 3). The IR indicated the CNA told the DSD to ask Resident 4 because Resident 4 heard it as well. The DSD spoke with Resident 4 who was under the care of CNA 6. The IR indicated Resident 4 told the DSD CNA 6 was rough with Resident 3 when CNA 6 grabbed Resident 3 by the arms and placed Resident 3 down (in the wheelchair). Resident 4 stated that when CNA 6 brushed Resident 3's hair CNA 6 was rough and yelled at Resident 3. During a review of the facility's IR with CNA 5, dated 11/26/2025, the IR indicated that CNA 5 stated that CNA 5 believed reporting the incident was the appropriate action. The IR indicated CNA 5 observed that Resident 3 appeared uncomfortable while CNA 6 was providing care and noted that CNA 6 spoke to Resident 3 in a loud tone of voice. CNA 5 stated that CNA 5 would not feel comfortable if CNA 5's own grandmother or family member were treated in that manner and this prompted CNA 5 to report the incident. During an interview on 12/15/2025 at 2:19 pm with Resident 3, Resident 3 stated Resident 3 did not remember the incident between Resident 3 and CNA 6. During an interview on 12/15/2025 at 2:25 pm with Resident 4, Resident 4 stated CNA 6 would practically throw Resident 3 into the (wheel)chair and would pull on Resident 3's hair while combing the knots out of Resident 3's hair. Resident 4 stated Resident 4 refused to have CNA 6 take care of Resident 4. During an interview on 12/16/2025 at 9:36 am with Social Worker Director (SWD), the SWD stated that on 11/25/2025 she went to speak to Resident 3 and Resident 3 stated the ugly and rude nurse (CNA 6) assisted Resident 3 to the restroom and yelled at Resident 3 not to get up, then CNA 6 got Resident 3 up and placed Resident 3 hard on the chair. Resident 3 stated Resident 3 did not like CNA 6. The SWD stated Resident 3's roommate, Resident 4, witnessed the incident and stated it happened between 3:30 pm and 4 pm on 11/25/2025. During an interview on 12/16/2025 at 11:39 am with the DSD, the DSD stated Resident 4 had requested not to have CNA 6 because CNA 6 has too much