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	01/08/2026

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure that Certified Nursing Assistant 1 (CNA 1), CNA 2, and Licensed Vocational Nurse 1 (LVN 1) responded in a timely manner to requests for assistance to the bathroom for one of one resident (Resident 4). This deficient practice resulted in Resident 4 having unmet needs. Findings: During a review of Resident 4' s admission Record (AR), the AR indicated the facility admitted Resident 4 on 11/6/2025, with diagnoses that included traumatic hemorrhage of the cerebrum (bleeding in the brain), muscle weakness, and lack of coordination. During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/13/2025, the MDS indicated Resident 4 had moderately impaired cognition (a level of cognitive decline). The MDS indicated Resident 4 was dependent with rolling left and right, chair/bed-to-chair transfer. During an observation on 1/8/2026 from 1:16 PM to 1:25 PM, Resident 4 was sitting in a wheelchair at the foot of the bed, facing away from the door, and was yelling repeatedly, Can I go to the bathroom, 16 times. During an observation on 1/8/2026 at 1:18 PM, CNA 1 entered Resident 4's room, looked around the room, while Resident 4 was yelling, Can I go to the bathroom, CNA 1 did not communicate with Resident 4 and left the room. During an observation on 1/8/2026 at 1:21 PM, CNA 2 entered Resident 4's room, but did not assist Resident 4 with toileting. CNA 2 did not communicate with Resident 4 and left the room. Resident 4 continued to repeatedly yell, Can I go to the bathroom. I just want to go to the bathroom. Resident 4 stated, I would make a mess and you going to be stuck with it. During an observation on 1/8/2026 at 1:24 PM, LVN 1 was standing in front of the medication cart located in the hallway close by Resident 4's room while Resident 4 continued to call out, Can I go to the bathroom. LVN 4 started to prepare medications and then entered Resident 4's room to administer medications. During an observation on 1/8/2026 at 1:27 PM, the Director of Nursing (DON) stated staff needed to assist Resident 4 once they heard him asking for assistance to the bathroom. The DON stated that they need to stop and notify the assigned CNA. The DON stated if the staff member who heard the resident calling was not the staff assigned to Resident 4, they needed to inform the assigned staff. During an observation on 1/8/2026 at 1:30 PM, the DON approached CNA 2, and CNA 2 went to Resident 4's room and asked Resident 4 what the resident needed. Resident 4 stated the resident needed to have a bowel movement. CNA 2 stated the CNA would help the resident and asked resident to wait a few minutes. During an observation on 1/8/2026 from 1:30 PM to 1:35 PM, Resident 4 was sitting in a wheelchair and was no longer yelling. During an interview on 1/8/2026 at 1:40 PM, LVN 1 stated that LVN 1 was preoccupied with the medication pass. LVN 1 stated that when a resident would call out to use the bathroom, LVN 1 needed to check on the resident and page the staff assigned to that resident. During an interview on 1/8/2026 at 2:06 PM, CNA 1 stated that at the time CNA 1 went to Resident 4's room, CNA 1 was taking out meal trays. CNA 1 stated that Resident 4 could get very persistent, and that there were not a lot of things that would keep Resident 4 happy. During a review of the facility's Policy and Procedure (P&P), titled (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 - Few	Resident Rights - Quality of Life, revised in March 2017, the P&P indicated demeaning practices and standards of care that compromise dignity are prohibited. Facility Staff promote dignity and assist residents as needed by:B. Promptly responding to the resident's request for toileting assistance.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure the call light system was functioning to allow one of one resident (Resident 4) to call for staff assistance. This deficient practice had the potential for Resident 4 to have unmet needs.Findings: During a review of Resident 4' s admission Record (AR), the AR indicated the facility admitted Resident 4 on 11/6/2025, with diagnoses that included traumatic hemorrhage of the cerebrum (bleeding in the brain), muscle weakness, and lack of coordination. During a review of Resident 4's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 11/13/2025, the MDS indicated Resident 4 had moderately impaired cognition (a level of cognitive decline). The MDS indicated Resident 4 was dependent with rolling left and right, chair/bed-to-chair transfer. During an observation on 1/8/2026 from 1:16 PM to 1:25 PM, Resident 4 was sitting in a wheelchair at the foot of the bed, facing away from the door, and was yelling repeatedly, Can I go to the bathroom, 16 times. The call light button was next to the resident, taped on top of the bottom rail. During an observation on 1/8/2026 at 1:20 PM, Resident 4 pressed the call light button placed near him; the call light bulb outside the door did not turn on and there was no audible sound outside the door. During an observation and interview on 1/8/2026 at 1:21 PM, CNA 2 confirmed that the call light outside Resident 4's room did not light up when Resident 4 pressed the call light button and that there were no audible sound and light outside the door. CNA 2 stated CNA 2 would call maintenance for the call light. During an observation on 1/8/2026 at 1:26 PM, the Maintenance Staff (MS) entered Resident 4's room to activate the call light. The MS stated the light bulb outside the door was not working. The MS stated MS did not receive a report Resident 4's call light needed to be checked until now. During an interview on 1/8/2026 at 1:59 PM, LVN 2 stated the call light needs to be working properly for residents to be able to reach staff when they need help. During a review of the facility's Policy and Procedure (P&P), titled Communication - Call System, dated 10/9/2024, the P&P indicated the facility will maintain a communication system to allow residents to call for staff assistance from their rooms and toileting/bathing facilities to ensure that residents have a means of contacting Facility staff for assistance. The P&P indicated if the call alert system is defective, it will be reported to maintenance for immediate repair.