

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/27/2026
NAME OF PROVIDER OR SUPPLIER  Claremont Heights Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observation, interview, and record review, the facility failed to implement a care plan's (CP) interventions to keep bilateral (both sides) floor mats next to the bed for one of two sampled residents (Resident 2). This deficient practice had the potential to result in unmet individualized needs for Resident 2 and the potential to affect the resident's physical well-being. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 8/11/2020, with diagnoses that included dementia (a progressive state of decline in mental abilities) and lack of coordination. During a review of Resident 2's Minimum Data Set (MDS- a resident assessment tool), dated 10/22/2025, the MDS indicated Resident 2 had severe cognitive (the ability to think and process information) deficit. The MDS indicated Resident 2 required maximal assistance (Helper lifts or hold trunk or limbs and provides more than half the effort) with walking 10 feet, sitting to standing, chair/bed-to- chair transfers, and with toilet transfers. During a review of Resident 2's CP titled risk for falls related to impaired mobility, initiated 10/26/2025, the CP indicated Resident 2 may have the bed in the lowest position with bilateral floor mats while in bed due to getting up unassisted. During a review of Resident 2's CP titled risk for falls related to impaired mobility and weakness, initiated 10/26/2025, the CP's interventions indicated to apply floor mats next to [Resident 2's bed] as appropriate. During a review of Resident 2's Fall Risk Evaluation, dated 12/10/2025, the evaluation indicated Resident 2 's score was 16 (a total score of 10 or greater is considered a high risk for potential falls) and Resident 2 was at high risk for falls. During an observation on 1/23/2026 at 4:36 PM, Resident 2 was lying in bed, and the bed was in a low position. A bed alarm was in place, and a fall mat was located on the right side of the bed. During a concurrent interview and record review on 1/23/2026 at 4:39 PM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated Resident 2's [at risk for falls] CP indicated bilateral fall mats. LVN 1 stated Resident 2 needed fall mats on both sides of Resident 2's bed to prevent injuries in the event of a fall. During a concurrent observation and interview on 1/23/2026 at 4:49 PM with the Director of Nursing (DON), the DON stated fall mats needed to be in place on both sides [of Resident 2's bed]. The DON entered Resident 2's room and found the left fall mat placed against the wall toward the right side of Resident 2's bed. The DON stated the fall mat needed to be in place to prevent injury in case of a fall. During a review of the facility's Policy and Procedure (P&amp;P) titled Person Centered Care Planning dated 5/22/2025, the P&amp;P indicated the facility must develop and implement a comprehensive person-centered care plan.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 055344
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