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	02/27/2026

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 - Some	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 ensure three of three sampled residents (Resident 1, 6, and 54) were treated with dignity when:a. Certified Nursing Assistant (CNA) 6 left Resident 54's lower body exposed. b. CNA 12 stood over in front of Resident 1 while assisting Resident 1 to drink during lunch.C. Speech Therapist (ST) was standing while feeding Resident 6.These deficient practices resulted in Resident 54 feeling uncomfortable, cold and naked and had the potential to cause Resident 1, 6 and 54 feeling humiliated, negatively impacting the residents' psychosocial well-being. Findings: a. During a review Resident 54's admission Record (AR), the AR indicated Resident 54 was admitted to the facility on [DATE]with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness in the arm, leg, and face on one side of the body) following cerebral infarction (stroke – loss of blood flow to a part of the brain) and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the right and left ankle and left shoulder. During a review of Resident 54's Minimum Data Set (MDS – resident assessment tool), dated 1/24/2026, the MDS indicated Resident 54's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 54 was dependent (helper does all of the effort) with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview with Resident 54 on 2/24/2026 at 1:52 PM, CNA 6 was observed leaving Resident 54's room. Resident 54 was observed lying in bed uncovered only wearing a sweater over a shirt, a diaper and socks. The privacy curtain was not pulled all the way around to cover Resident 54's bed. The privacy curtain was only pulled so that the resident was not visible from the hallway. Resident 54 stated Resident 54 was not cold but felt uncomfortable lying in bed uncovered. During a concurrent observation and interview on 2/26/2026 at 10:23 AM with Resident 54 in the activities room, Resident 54 was observed sitting in the wheelchair covered in a blanket. Resident 54 stated Resident 54 was usually cold and did not like to be uncovered. Resident 54 stated when lying in bed, Resident 54 liked to be covered to stay warm. Resident 54 stated when left in only a shirt, underwear and no blanket, Resident 54 would feel naked. During an interview on 2/26/2026 at 10:39 AM with CNA 7, CNA 7 stated whenever CNA 7 had to step away for whatever reason while assisting a resident (in general), CNA 7 would cover the resident for dignity and respect, and made sure the resident was comfortable and with the call light available. (continued on next page)

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	During an interview on 2/26/2026 at 3:26 PM with the Director of Nursing (DON), the DON stated if the CNA (in general) was going to step away from the resident, the CNA should cover the resident. The DON also stated it was important to keep the residents covered for privacy. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 1/1/2012, indicated, Employees are to treat all residents with kindness, respect, and dignity and honor the exercise of resident's rights.These rights included, but are not limited to, a resident's right to.privacy and confidentiality. b. During a review of Resident 1's AR, the AR indicated, Resident 1 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (adult onset disorder characterized by difficulty in blood sugar control and poor wound healing, muscle weakness (generalized), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 1's MDS, dated [DATE], the MDS indicated Resident 1's cognitive skills were moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort to complete the activity) to eat and with oral hygiene. During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/2/2026, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a concurrent observation and interview on 2/24/2026 at 1 PM with CNA 10 in the Dining Room, Resident 1was sitting in a wheelchair while being fed by CNA 12 who sat across from Resident 1. CNA 12 stood up in front of Resident 1 every time CNA 12 had to hold and tip the milk for Resident 1 to drink. CNA 10 stated CNA 12 was not supposed to stand up and should sit at Resident 1's side while feeding Resident 1. During an interview on 2/25/2026 at 9:44 AM with CNA 12, CNA12 stated CNA 12 should have been at eye level with Resident 1 while CNA 12 fed Resident 1, for dignity. During an interview on 2/26/2026 at 11:27 AM with Registered Nurse (RN) 1, RN 1 stated staff (in general) should be sitting down at eye level with the resident (in general) during feeding for dignity issues. c. During a review of Resident 6's AR, the AR indicated Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dysphagia (difficulty swallowing) following cerebral infarction (loss of blood flow to a part of the brain) and flaccid hemiplegia (total paralysis of one side of the body characterized by muscles that are limp, floppy, and devoid of muscle tone) affecting the right dominant side. During a review of Resident 6's MDS, dated [DATE], the MDS indicated Resident 6 had impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for ADLs. During a concurrent observation and interview on 2/26/2026 at 7:47 AM in Resident 6's room, the ST was observed standing while feeding Resident 6. The ST stated the ST normally stands while feeding residents due to personal preference and residents have not asked the ST to sit down. The ST stated (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the ST attended an in-service on how to feed residents and had been instructed to sit while feeding residents. During an interview on 2/26/2026 at 8:12 AM with CNA 16, CNA 16 stated facility staff (in general) should sit down while feeding residents to ensure staff can see the residents' faces and make sure, they are not choking. During a review of the facility's P&P titled, Resident's Rights - Quality of Life, dated 3/2017, the P&P indicated each resident should be cared for in a manner that promotes and enhances the quality of life, dignity, respect, individuality and received services in a person-centered manner, as well as those that support the resident in attaining or maintaining his/her highest practicable wellbeing. The P&P indicated facility staff must treat cognitively impaired residents with dignity and sensitivity.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's policy and procedure (P&P) titled, Advance Directives, for two of two sampled residents (Resident 4 and Resident 35) when:1. Copies of Resident 4's and Resident 35's advance directives (AD-a legal document that provides instructions for medical care when a person can no longer decide on their own) were obtained and filed in Resident 4's and Resident 35's medical records.2. The Social Services Director (SSD) did not ensure the Durable Power of Attorney (DPOA, a legal document allowing another person to manage one's financial, legal, or medical affairs when one can no longer decide on their own) filed in Resident 35's medical records also covered medical or healthcare decisions.These failures had the potential to result in conflict regarding Resident 4's and Resident 35's choices regarding health care decisions and the residents' medical wishes not to be honored.Findings: a. During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on 1/13/2026 with diagnoses including fracture of lower end of right femur (a broken bone on the right thigh), subsequent encounter for closed fracture with routine healing (a follow up visit indicating the break is healing normally) and urinary tract infection (UTI- an infection in the bladder/urinary tract). During a review of Resident 4's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 1/15/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 1/20/2026, the MDS indicated Resident 4's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 4 required substantial to maximal assistance with eating, oral hygiene, and personal hygiene and was dependent on toileting, showering, and dressing. During a review of Resident 4's Social Services Assessment (SSA), dated 1/14/2026, the SSA indicated Resident 4 had an AD on file. The SSA indicated the AD was uploaded in Resident 4's electronic health record (EHR-a digital version of a patient's medical chart that stores health information). During an interview on 2/25/2026 at 12:30 PM with the Social Services Director (SSD), the SSD stated an AD indicated the residents' (in general) preferences regarding health decisions. The SSD stated Resident 4 should have an AD on file, but the AD was not in Resident 4's medical record. The SSD stated it was important to have Resident 4's AD on file to ensure Resident 4's health decisions were honored. b. During a review of Resident 35's AR, the AR indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral palsy (group of conditions that affect movement and posture caused by damage to the brain before birth) and unspecified severe protein-calorie malnutrition. During a review of Resident 35's H&P, dated 11/20/2025, the H&P indicated Resident 35 did not have the capacity to understand and make decisions. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills were severely impaired (never/rarely made decisions). The MDS indicated Resident 35 was dependent (helper does all the effort to complete the activity) for activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 35's AD was not completed. During a review of Resident 35's Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be provided to a person in an emergency), dated 9/19/2025, the POLST did not indicate if Resident 35 had an AD and who Resident 35's healthcare agent (proxy, person specifically appointed to make medical treatment decisions when a person can no longer decide on their own) was. The POLST indicated, POLST complements an Advance Directive and is not intended to replace that document (Advance Directive). During a review of Resident 35's DPOA, dated 12/13/1991, the DPOA indicated Resident 35 only granted Resident 35's responsible party (RP, a person who is responsible for guiding, informing, assisting, and advocating for residents in the healthcare system) the DPOA to manage Resident 35's financial affairs. The DPOA did not appoint Resident 35's RP to manage Resident 35's medical or healthcare affairs. During a concurrent interview and record review on 2/25/2026 at 12:30 PM with the SSD, Resident 35's SSA, dated 9/23/2025 and timed at 4:01 PM, was reviewed. The SSA indicated Resident 35 had an AD on file. The SSD stated an AD was a form that would assist residents (in general) to identify who the residents (in general) wanted to decide for them in the event they were not able to make medical decisions for themselves. The SSD stated the POLST was not intended to replace an AD. Resident 35's medical record was reviewed and an AD and/or a DPOA for healthcare was not found in Resident 35's medical record. The SSD stated the SSD and/or Admissions staff were responsible for providing education and acquiring the residents' (in general) AD upon admission. The SSD reviewed Resident 35's DPOA, dated 12/13/1991, and stated the DPOA only covered financial decisions and did not cover medical decisions. The SSD stated the SSD should have read Resident 35's DPOA to ensure the DPOA also covered medical decisions. During a review of the facility's P&P titled, Advance Directives, revised July 2018, the P&P indicated, Upon admission, the admission Staff or designee will obtain a copy of a resident's advance directive. A copy of the resident's advance directive will be included in the resident's medical record. An Advance Directive is defined as a resident's written preference regarding treatment options.Upon admission, the Admissions Staff or designee will provide written information to the resident concerning his or her right to make decisions concerning medical care.and the right to formulate advance directives.During the Social Services Assessment process, the Director of Social Services or designee will also ask the resident whether he or she has a written advance directive.If the resident has an Advance Directive, the Facility shall obtain a copy of the document and place it in the resident's medical record. The P&P indicated, the Interdisciplinary Team would review the advance directive with the resident or responsible party annually to ensure that the directive still reflects the wishes of the resident.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) for three of three residents (Resident 103, 13, and 67) as evidenced by:Failure to develop a CP for Resident 13's behavior of pulling and removing Resident 13's gastrostomy tube (GT - medical feeding tube inserted through the abdomen directly into the stomach to deliver nutrients, fluids, and medications.)Failure to develop a CP for Resident 67's personal preference to apply tape to the eyelids. Failure to develop a CP for Resident 103's admission to hospice care.These failures had the potential for Resident 103, 13 and 67 to not obtain their highest physical, mental and psychosocial well-being.Findings: A. During a review of Resident 13's admission Record (AR), the AR indicated Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including Parkinson's disease (brain disorder in which there is a lack of the chemical messenger dopamine, which helps control muscle movement; leads to muscle stiffness, weakness and trembling) with dyskinesia (difficulty in performing or controlling voluntary movements) with fluctuations, dysphagia (difficulty, discomfort or inability to swallow food or liquids) and encounter for attention to gastrostomy (the surgical creating of an opening in the abdominal wall into the stomach for drainage or a feeding tube.) During a review of Resident 13's Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 12/5/2025, the MDS indicated Resident 13 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for toileting and required partial/ moderate assistance (helper does less than half the effort) for mobility. During an interview on 2/26/2026 at 11:38 AM with Certified Nursing Assistant (CNA) 8, CNA 8 stated Resident 13 wore an abdominal binder and mitten restraints on both hands because Resident 13 had a history of pulling out Resident 13's GT. CNA 8 stated the abdominal binder and mitten restraints are worn while Resident 13 is in bed to prevent Resident 13 from removing the GT. CNA 8 was unsure how many times Resident 13 had pulled out the GT and was only aware of one incident. During an interview on 2/26/2026 at 11:59 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated in the past year, Resident 13 might have removed the GT four to five times. During an interview on 2/26/2026 at 12:14 PM with LVN 4, LVN 4 stated Resident 13 wore restraints because Resident 13 had a behavior or pulling out the GT. LVN 4 stated Resident 13 was strong and persistently attempted to remove the GT. During a concurrent interview and record review on 2/26/2026 at 12:37 PM with the Registered Nurse (RN) 2 Resident 13's CPs were reviewed. RN 2 stated Resident 13 had a history of pulling the GT many times. RN 2 stated prior to implementing mitten restraints, Resident 13 wore an abdominal binder to prevent pulling out the GT but Resident 13 was still able to reach underneath the abdominal binder to remove the GT. RN 2 stated the staff (general) did not develop a CP for Resident 13's behavior of removing the GT. RN 2 stated a CP should have been developed to inform the staff to monitor for the behavior and to indicate interventions and goals for Resident 13. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. During a review of Resident 67's AR, the AR indicated Resident 67 was admitted to the facility on [DATE] with multiple diagnoses including disorder of macular degeneration (gradual loss of vision due to deterioration of nerve tissue in the retina) and disorders of multiple cranial nerves (involve dysfunction of two or more cranial nerves, symptoms depend on the nerves involved ranging from vision changes and facial weakness to swallowing difficulties.) During a review of Resident 67's MDS dated [DATE], the MDS indicated Resident 67 had impaired cognition and required partial/ moderate assistance for toileting hygiene and bathing. During a review of Resident 67's Optometry Notes (ON) dated 1/26/2026, the ON indicated Resident 67 had complete ptosis (drooping of the upper eyelid) with lids taped up and to alternate two to three times per day. During an observation and interview on 2/26/2026 at 10:20 AM with Resident 67, Resident 67 was observed with tape placed vertically from the top of the right eyelid to Resident 67's forehead and the left eye was closed. Resident 67 stated the tape was used to keep Resident 67's right eye open because Resident 67 was unable to keep their eyes open themselves. Resident 67 stated it was their preference to use tape. During an interview on 2/26/2026 at 1 PM with RN 2, RN 2 stated Resident 67 did not have a CP in place for the tape placed on Resident 67's eyelids. RN 2 stated a CP should have been developed to ensure facility staff are checking Resident 67's skin integrity around the eyes and also due to the potential for infection. RN 2 stated it was also important to note that it was Resident 67's preference to have the tape on the eyelids. During an interview on 2/27/2026 at 8:57 AM with the Director of Nursing (DON), the DON stated the importance of a CP is to guide the nurses on how to give care and what needs to be done. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Planning, dated 9/7/2023, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being. C. During a review of Resident 103's admission Record (AR) indicated Resident 103 was admitted to the facility on [DATE] with diagnoses including anoxic brain damage (a severe condition caused by total lack of oxygen reaching the brain, leading to rapid brain cell death with widespread tissue damage), among other diagnoses. During a review of Resident 103's MDS, dated [DATE], the MDS indicated Resident 103's cognitive skills was severely impaired (never/rarely made decisions). During a review of Resident 103's Inter Disciplinary Team (IDT) Note, dated 1/20/2026, the IDT Note indicated Daughter is requesting hospice to get involved. MD and NP was notified of resident's condition and family request. New order received for hospice eval with Hospice company. New order noted and carried out. All Pertinent information faxed to hospice company. During a review of Resident 103's Order Summary, dated 1/21/2026, the Order Summary indicated, to admit the resident under the care of hospice on Routine level of care. DNR (Do Not Resuscitate), (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hospice, Dx: Cerebral atherosclerosis, Dementia. During a review of Resident 103's H&P, dated 1/22/2026, the H&P indicated the resident with history of cerebral atherosclerosis (a condition where hardened, narrowed, or clogged arteries in the brain (due to plaque buildup) reduce oxygen-rich blood flow) with vascular dementia (this lack of blood flow damages brain tissue, resulting in a decline in memory, thinking, behavior, and daily functioning), history of hyperlipidemia (the medical term for having too many fats (lipids) – specifically cholesterol and triglycerides – in your blood), history of anoxic brain injury (a severe condition caused by total lack of oxygen reaching the brain, leading to rapid brain cell death with widespread tissue damage), history of psychosis (a mental health symptom, not a specific illness, where a person loses touch with reality), who is declining, and has been referred for hospice services. During a review of Resident 103's H&P, dated 1/27/2025, the H&P indicated that Resident 103 does not have the capacity to understand and make decisions. During an interview on 2/27/2026 at 8:57 AM with the DON, the DON stated she cannot find a hospice care plan and must have missed that one. The importance of a care plan is to guide the nurses on how to give care and what to be done. Hospice company has their own care plans but it is practice for the facility to also make their own care plan. During a review of the facility's revised policy and procedure (P&P) titled, Person-Centered Care Planning revised 4/24/2025, the P&P indicated, 4. Comprehensive Care Plan a. The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: i. The services that re to be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being. ii. Any services that would otherwise be required under, but are not provided due to resident's exercise of rights, including the right to refuse treatment. During a review of the facility's revised policy and procedure (P&P) titled, Hospice Care of Residents revised 1/1/2012, the P&P indicated, III. If the resident and/or surrogate decision maker decides to utilize hospice care, the Attending Physician will be contacted to make a final determination. B. The Hospice and Facility will collaborate on a Care Plan for the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure appropriate and necessary care and services were provided for three of three sampled residents (Residents 58, 105 and 29) by failing to:A. Ensure Resident 58's physician order for Tresiba (a once-daily long-acting injectable insulin [a hormone that removes excess sugar from the blood] used to improve blood sugar control) contained administration parameters (specific instructions that must be followed when giving insulin).B. Ensure Resident 58's blood sugar levels were checked prior to administering Tresiba.These deficient practices had the potential to result in serious health complications for Resident 58.C. Ensure non-legend medications (medication that can be purchased over-the-counter [OTC] without a prescription) were not kept at Resident 105's and Resident 29's bedside without a physician's order and without following the facility's process for self-administration (the process where patients manage and take their own medications).This deficient practice had the potential to result in Resident 105 and Resident 29 misusing the OTC drugs posing a safety risk and had the potential for Resident 105 and Resident 29 to share the OTC drugs with other residents such as their roommates.Findings: a & b. During a review of Resident 58's admission Record (AR), the AR indicated the facility originally admitted Resident 58 on 5/6/2025 with a readmission date of 2/5/2026 with diagnoses including end stage renal disease (ESRD-irreversible kidney failure) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 58's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/5/2026, the H&P indicated Resident 58 could participate in plan of care. During a review of Resident 58's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 58's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 58 required setup or clean up assistance with eating, supervision or touching assistance with oral hygiene, partial to moderate assistance with personal hygiene, substantial to maximal assistance with upper body dressing, and was dependent on toileting, showering, and lower body dressing. During a review of Resident 58's Order Summary Report (OSR), dated 2/27/2026, the OSR indicated a physician order (PO), with a start date of 2/6/2026, to inject 70 units (unit of measurement) of Tresiba subcutaneously (just beneath the skin's surface) to Resident 58 one time a day for DM. The OSR indicated there was no PO to check Resident 58's blood sugar level before administration of Tresiba, when to hold the Tresiba, and what to do when Resident 58's blood sugar level was low. During a review of Resident 58's Medication Administration Record (MAR), dated 2/1/2026 to 2/28/2026, the MAR indicated brand name insulin degludec was administered to Resident 58 on 2/6/2026, 2/15/2026, 2/17/2026, 2/18/2026, 2/19/2026, 2/21/2026, 2/24/2026, and 2/25/2026. During a review of Resident 58's Care Plan Report (CPR), initiated on 2/8/2026, the CPR indicated Resident 58 was at risk for altered endocrine status (regulates hormone levels such as insulin) related to DM and gout (a joint condition that triggers sudden pain and swelling). The CPR goal was for Resident 58 to maintain normal blood glucose level until the next CPR review date of 3/2/2026. The CPR interventions included checking Resident 58's fasting blood sugar (blood sugar level after 8-12 hours of no food or no drink [except water]) as ordered by the physician. (continued on next page)

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Claremont Heights Post Acute	590 S. Indian Hill Blvd. Claremont, CA 91711

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/27/2026 at 10:56 AM with Licensed Vocational Nurse (LVN) 1, Resident 58's Blood Sugar Summary (BSS), printed on 2/27/2026, was reviewed. LVN 1 stated the BSS indicated Resident 58's blood sugar had only been checked four times (2/5/2026, 2/13/2026, 2/20/2026, and 2/25/2026) since Resident 58 was admitted on [DATE]. LVN 1 stated it was the policy of the facility to check residents' (in general) blood sugar level prior to administering long-acting insulin. LVN 1 stated it was important to check Resident 58's blood sugar prior to giving Tresiba to prevent medical complications such as hypoglycemia (low blood sugar). During an interview on 2/27/2026 at 11:05 AM with Resident 58, Resident 58 stated the staff (in general) did not always check Resident 58's blood sugar prior to administering Tresiba. Resident 58 stated Resident 58 was concerned because Resident 58 knew the staff were supposed to check blood sugar levels prior to administering Tresiba. During a concurrent interview and record review on 2/27/26 at 12:09 PM with Registered Nurse (RN) 1 and RN 2, Resident 58's current physician orders were reviewed. RN 1 and RN 2 stated Resident 58's Tresiba order did not include parameters such as checking blood sugar levels and if necessary, when to hold the medication. RN 1 and RN 2 stated there were no orders indicating Resident 58's blood sugar should be checked prior to administering Tresiba. RN 1 stated the doctor's communication phone and Resident 58's medical record did not indicate a doctor (in general) was notified of the Tresiba's missing parameters. RN 1 and RN 2 stated it was important to check Resident 58's blood sugar prior to giving Tresiba to ensure Resident 58 was appropriate to receive the medication. RN 1 and RN 2 stated it was important to obtain parameters for the Tresiba to ensure Resident 58 received proper medical care. During a review of the facility's Policy and Procedure (P&P) titled, Specific Medication Administration Procedures, updated June 2021, the P&P indicated, Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. c 1. During a review of Resident 105's AR, the AR indicated Resident 105 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and essential (primary) hypertension (HTN – high blood pressure). During a review of Resident 105's H&P, dated 2/18/2026, the H&P indicated Resident 105 had the capacity to understand and make decisions. c 2. During a review of Resident 29's AR, the AR indicated, Resident 29 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including 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 29's H&P, dated 8/26/2025, the H&P indicated Resident 29 could make needs known but could not make medical decisions. During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognitive skills for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 29 required partial/moderate assistance (helper does less than half the effort) to set up or clean-up assistance (helper sets up or cleans up; resident completes activity) for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	daily). During a concurrent observation and interview on 2/24/2026 at 9:53 AM with Resident 105, a twenty (20) oz (ounce – a unit of weight) bottle of Amlactin Daily Healing 12% Lactic Acid Lotion was on Resident 105's bedside drawer. Resident 105 stated Resident 105 got the Amlactin from a membership-only warehouse club that sells a wide variety of products and Resident 105 had the Amlactin for thirty (30) days. Resident 105 stated Resident 105's physician (unnamed) told Resident 105 to get the Amlactin. During a concurrent observation and interview on 2/24/2026 at 10:18 AM with Resident 29, a sixteen (16) oz Eucerin Original Healing Cream was on Resident 29's bedside drawer. Resident 29 stated Resident 29's family member (unnamed) gave the Eucerin to Resident 29 for Resident 29's dry skin and Resident 29 had the Eucerin for awhile. During a concurrent interview and record review on 2/26/2026 at 11:14 AM with Licensed Vocational Nurse (LVN) 3, Resident 105 and Resident 29's physician orders were reviewed. LVN 3 stated Amlactin was a medicated lotion and Eucerin was a dermatological skin care. LVN 3 stated Amlactin and Eucerin were OTC medications and should have been stored at the facility's medication cart unless there were physician orders for them to be stored at the bedside and for Resident 105 and Resident 29 to self-administer medications. LVN 3 stated the process for self-administration involved assessing the resident (in general), reviewing the care plan (provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), and obtaining a physician's order. LVN 3 stated it was important for residents' safety for OTC drugs not to be kept at the bedside to avoid the resident sharing the medication with other residents. LVN 3 stated there were no physician orders for Resident 105's Amlactin and Resident 29's Eucerin. During a concurrent interview and record review on 2/26/2026 at 11:27 AM with Registered Nurse (RN) 1, Resident 105 and Resident 29's medical records were reviewed. RN 1 stated Amlactin was a lactic acid lotion and Eucerin was a healing cream and were OTC topical creams. RN 1 stated residents were allowed to keep OTC drugs at the bedside, but residents had to be first evaluated if residents could administer own medication, had to have a physician's order for self-administration, and consented (gave permission) to self-administer, and was care planned. RN 1 stated Resident 105 and Resident 29 did not have physician orders or consents for self-administration of Resident 105's Amlactin and Resident 29's Eucerin. RN 1 stated staff should be inspecting resident's rooms for OTC drugs. During a review of the facility's P&P titled, Self-Administration of Medications, updated 11/2027, the P&P indicated residents who desired to self-administer medications were permitted to do so if the facility's interdisciplinary team had determined that the practice would be safe for the resident and other residents of the facility. The P&P indicated each resident was offered the opportunity to self-administer his or her medications during the routine assessment by the facility's interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process.

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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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure foods brought in from outside of the facility were stored properly for two of two sampled residents (Resident 105 and Resident 4), in accordance with the facility's policy and procedure (P&P) titled, Food Brought in by Visitors. This deficient practice placed Resident 105 and Resident 4 at risk for serious complications from food borne illnesses (any illness resulting from eating contaminated/spoiled foods).Findings: a. During a review of Resident 105's admission Record (AR), the AR indicated, Resident 105 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including heart failure (a heart disorder which causes the heart to not pump blood efficiently) and essential (primary) hypertension (HTN - high blood pressure). During a review of Resident 105's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 2/18/2026, the H&P indicated Resident 105 had the capacity to understand and make decisions. b. During a review of Resident 4's AR, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection) and unspecified protein-calorie malnutrition. During a review of Resident 4's H&P, dated 1/15/2026, the H&P indicated Resident 4 had the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 1/20/2026, the MDS indicated Resident 4's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 4 required substantial to maximal assistance with eating, oral hygiene, and personal hygiene and was dependent on toileting, showering, and dressing. During an observation on 2/24/2026 at 9:53 AM, inside Resident 105's room, an unlabeled 3-pound (lb - a unit of weight) container of green seedless grapes was found on Resident 105's dresser. During a concurrent observation and interview on 2/24/2026 at 10:28 AM with Registered Nurse (RN) 2, in Resident 105's room, RN 2 observed an unlabeled 3-pound container of green seedless grapes on Resident 105's dresser. RN 2 stated RN 2 did not know who the grapes belonged to and the grapes should have been labeled with resident's (in general) name and stored in the refrigerator for infection precautions. During a concurrent observation and interview on 2/24/2026 at 12:30 PM with Certified Nursing Assistant (CNA) 9, in Resident 4's room, an unlabeled/undated plastic grocery bag containing an undated plastic container with Spanish labeling was found inside Resident 4's bedside drawer. The undated plastic container with Spanish labeling contained three (3) cookies. CNA 9 stated CNA 9 did not know how old the food (cookies) was. CNA 9 stated foods brought in from outside were supposed to be labeled with resident's name, room number, date (received) and stored in the refrigerator, to know if the food not old. During an interview on 2/24/2026 at 1 PM with CNA 10, CNA 10 stated foods brought in from home were not supposed to be left inside the resident's room and should be labeled with the resident's name and date (received), and stored in the refrigerator for safety, because the food can get old. During an interview on 2/25/2026 at 12:55 PM with Resident 4's family member (FM), the FM stated the food in Resident 4's bedside drawer was brought in by the FM, and it was a papaya salad. The FM stated the facility did not inform the FM of the facility's policy regarding bringing food from home. During an interview on 2/26/2026 at 11:27 AM with RN 1, RN 1 stated staff (in general) were supposed to be informing resident's family regarding the facility's policy regarding bringing food from home. RN 1 stated staff (in general) should be checking resident's food from home for the resident's appropriate diet, label the food with resident's name, room number and date (received) and time to ensure safe consumption. During an interview on 2/26/2026 at 3:25 PM with Resident 105, Resident 105 stated Resident 105's son brought the grapes and cherries and should have been refrigerated to prevent bacteria to get in, and make Resident 105 sick. During a review of the facility's P&P titled, Food Brought in by Visitors, with an effective date of 5/22/2025, the P&P indicated, The facility staff will.provide resident/resident representative with this policy about the use and storage of foods (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	brought in by family/visitors.Place the food in a food container that is clearly labeled with the resident's name and date received and stored in a refrigerator designated for this purpose.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 infection prevention and control practices by failing to ensure two of two sampled residents' (Resident 105's and Resident 50's) personal care items were labeled and stored properly. This deficient practice had the potential to result in cross contamination (the process by which microorganisms are unintentionally transferred from one area/object to another with a harmful effect) and/or the development and transmission of disease (an illness or sickness) and infections for Resident 105 and Resident 50.Findings:a. During a review of Resident 105's admission Record (AR), the AR indicated Resident 105 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including heart failure (a heart disorder which causes the heart to not pump the blood efficiently) and essential (primary) hypertension (HTN - high blood pressure). During a review of Resident 105's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated [DATE], the H&P indicated Resident 105 had the capacity to understand and make decisions. During a review of Resident 105's Care Plan Report (CPR), initiated on [DATE], the CPR indicated a goal to reduce the risk of MDRO transmission. The CPR interventions included implementing EBP to prevent the spread of infections for specific care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. b. During a review of Resident 50's AR, the AR indicated Resident 50 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including sepsis (a life-threatening blood infection) and personal history of other infectious and parasitic (relating to organisms that depend on a host to survive and spread) diseases. During a review of Resident 50's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 50's cognitive skills (ability to think and process information) for daily decision making were intact. The MDS indicated Resident 50 required substantial/maximal assistance (helper does more than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 50's H&P, dated [DATE], the H&P indicated Resident 50 had the capacity to understand and make decisions. During an observation on [DATE] at 9:53 AM, Resident 105 and Resident 50's shared room had an EBP signage posted by the door and a white colored trimmed 3-drawer personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart outside of the room. There was an unlabeled 3-pound (lb - a unit of weight) container of green seedless grapes next to multiple unlabeled personal care items such as a deodorant, mouthwash, toothpaste, toothbrush and a wash basin with supply of diapers, stored on the shared dresser of Resident 105 and Resident 50, located across from Resident 105's bed. Resident 105 and Resident 50's shared restroom had an unlabeled pack of XL [NAME] Wipes (brand name) and two (2) unlabeled packs of equate (brand name) wipes on top of the toilet tank and a twenty point three (20.3) fl oz (fluid ounce - a unit of volume), extra repair (brand name) unscented body lotion, a seven point five (7.5) oz Tres Care (brand name) perineal/body wash + shampoo, four (4) fl oz DawnMist (brand name) baby lotion, one point five (1.5) oz freshmint (brand name) toothpaste, a bar of [NAME] spring (brand name) bath soap stored on the top of the pony wall (a short wall that separates the toilet and the shower in a bathroom). During a concurrent observation and interview on [DATE] at 10:28 AM with Registered Nurse (RN) 2 in Resident 105 and Resident 50's shared room, RN 2 observed an unlabeled 3-pound container of green seedless grapes next to multiple unlabeled personal care items such as a deodorant, mouthwash, toothpaste, toothbrush and a wash basin with supply of diapers, stored on the shared dresser of Resident 105 and Resident 50, located across from Resident 105's bed. In Resident 105 and Resident 50's shared restroom, RN 2 observed an unlabeled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pack of XL [NAME] Wipes (brand name) and two (2) unlabeled packs of equate (brand name) wipes on top of the toilet tank and a twenty point three (20.3) fl oz (fluid ounce - a unit of volume), extra repair (brand name) unscented body lotion, a seven point five (7.5) oz Tres Care (brand name) perineal/body wash + shampoo, four (4) fl oz DawnMist (brand name) baby lotion, one point five (1.5) oz freshmint (brand name) toothpaste, a bar of [NAME] spring (brand name) bath soap stored on the top of the pony wall. RN 2 stated Resident 105 and Resident 50, ideally, they share half of everything. RN 2 stated labeling resident's (in general) personal care items and storing the personal care items in resident's personal space was important to know who the personal care items belonged to and for infection control. During an interview on [DATE] at 3:06 PM with the Infection Preventionist (IP), the IP stated, resident's personal care items should be labeled with the resident's name and stored close to the resident's side of the room for infection control. The IP stated Resident 105 and Resident 50 could share the dresser as long as the personal care items were not mixed (separated).During an interview on [DATE] at 4:41 PM with Certified Nursing Assistant (CNA) 14, CNA 14 stated personal care items were essential and should be labeled with the resident's name and stored at the resident's bedside. CNA 14 stated labeling and storing personal care items at the resident's bedside was important to prevent residents from sharing, to avoid cross contamination, and for infection control. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program Description, dated [DATE], the P&P indicated the program encompassed employee health and patient safety through resident care practices. The P&P included goals such as to provide a safe, sanitary and comfortable environment, decrease the risk of infections to residents, visitors, guests and staff, monitor for evidence of infection/communicable disease and implement appropriate control measures, create a culture of safety in the facility to promote infection prevention as a focus and identify and correct problems related to infection prevention and control practices. The P&P indicated, the IP would monitor/audit procedures for proper infection prevention and control technique, as indicated and appropriate.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to ensure a safe and clean environment for one of one sampled resident (Resident 76) when the wall in Resident 76's room was observed with a red tinged substance.These failures resulted in Resident 76 living in an unclean environment and had the potential to result in psychosocial decline to Resident 76.Findings:During a review of Resident 76's admission Record (AR), the AR indicated the facility originally admitted Resident 76 on 2/10/22 with a readmission date of 3/10/2025 with diagnoses including nontraumatic intracerebral hemorrhage in cerebellum (a sudden bleed inside the part of the brain that controls balance and coordination) and acute (sudden) respiratory failure with hypoxia (a medical condition that happens when your lungs cannot get enough oxygen [colorless, odorless gas]).During a review of Resident 76's History and Physical (H&P), dated 3/11/2025, the H&P indicated Resident 76 could make needs known but could not make medical decisions.During a review of Resident 76's Minimum Data Set (MDS- a resident assessment tool), dated 2/13/2026, the MDS indicated Resident 76's cognitive (the ability to think and process information) skills for daily decision making were severely impaired (never/rarely makes decisions). The MDS indicated Resident 76 required partial to moderate assistance with upper body dressing, substantial to maximal assistance with eating, oral hygiene, showering, and lower body dressing, and was dependent on toileting and personal hygiene.During an observation on 2/24/2026 at 9:37 AM in Resident 76's room, the wall on the right side of Resident 76's bed was observed with a red tinged substance.During a concurrent interview and observation on 2/25/2026 at 2 PM with the Director of Staffing Development (DSD) the wall next to Resident 76's bed was observed. The DSD stated the substance on Resident 76's wall looked like old food. The DSD stated the dirty wall was potential for infection. Additionally, the DSD stated it was important to maintain a clean room for Resident 76 to ensure a comfortable and homelike environment.During an interview on 2/27/2026 at 12:33 PM with the Director of Nursing (DON), the DON stated the wall next to Resident 76's bed should be clean, The DON states it was important to provide Resident 76 with a clean room because Resident 76 deserved to have a clean and homelike environment.During a review of the facility's Policy and Procedure (P&P) titled, Resident Rooms and Environment, revised January 2012, the P&P's purpose indicated, To provide residents with a safe, clean, comfortable and homelike environment. The P&P's policy indicated, The facility provides residents with a safe, clean, comfortable, and homelike environment. The P&P's procedure indicated, Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: Cleanliness and order.During a review of the facility's P&P titled, Housekeeping-Resident Rooms, revised September 2016, the P&P's purpose indicated, To promote the quality of life for residents by providing clean and sanitary living spaces. The P&P's policy indicated, The housekeeping department coordinates the daily cleaning of all resident rooms. The P&P's procedure indicated, Quarterly (for long-term residents): All surfaces in the room, including all walls and ceilings are thoroughly cleaned.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide evidence that the use of physical restraints (any manual method, physical or mechanical device, equipment, or material that restricts the resident's freedom of movement or normal access to his/her body) for one of one sampled resident (Resident 13) was a measure of last resort to protect the safety of the resident.This deficient practice had the potential for Resident 13 to be restrained unnecessarily and could negatively impact Resident 13 mentally, psychosocially and increase the risk for impaired skin integrity.Findings: During a review of Resident 13's admission Record (AR), the AR indicated Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including Parkinson's disease (brain disorder in which there is a lack of the chemical messenger dopamine, which helps control muscle movement; leads to muscle stiffness, weakness and trembling) with dyskinesia (difficulty in performing or controlling voluntary movements) with fluctuations, adult failure to thrive (syndrome characterized by unintended weight loss, decreased appetite, poor nutrition, and physical activity and often accompanied by depression and cognitive decline) encounter for attention to gastrostomy (the surgical creating of an opening in the abdominal wall into the stomach for drainage or a feeding tube.)During a review of Resident 13's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 12/5/2025, the MDS indicated Resident 13 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for toileting and required partial/ moderate assistance (helper does less than half the effort) for mobility.During a review of Resident 13's Change of Condition Evaluation (COC) dated 1/30/2026, the COC indicated Resident 13 dislodged the gastrostomy tube (GT-soft, flexible tube inserted directly into the stomach) GT while in bed.During a review of Resident 13's Change in Condition Evaluation (COC) dated 2/12/2026, the COC indicated upon assessment, Resident 13 was noted with dislodged GT.During a review of Resident 13's Progress Notes (PN) dated 2/13/2026 at 9:53 AM, the PN indicated Resident 13 was awaiting GT reinsertion at bedside with after pulling out the GT. Resident 13 pulled out foley catheter that was in place to keep stoma (surgically created opening on the outside of the body that connects to an organ on the inside) from closing. Resident 13 was sent to a general acute care hospital (GACH) for further evaluation and treatment.During a review of Resident 13's Restrain-Physical (Initial Evaluation) [RPIE] dated 2/14/2026, the RPIE indicated the device in use at the time was bilateral mittens to prevent accidental GT dislodgment on the left and right hands due to interference with specific medical treatments. The RPIE further indicated an abdominal binder had worked in the past to control/limit the behavior/ issue prompting the need for restraint per the resident/family or next of kin. The RPIE indicated Resident 13 was still able to access the GT site even when wearing the binder. The RPIE indicated Resident 13's family requested the restraints.During a review of Resident 13's Care Plan (CP, a form where one can summarize a person's health conditions, specific care need, and current treatments) the CP indicated Resident 13 may have bilateral mittens on to prevent accidental GT dislodgement with interventions to monitor skin integrity every shift dated 2/14/2026. Resident 13's CP further indicated Resident 13 benefitted from use of abdominal binder to prevent GT dislodgement and to monitor skin integrity daily every shift. The CP interventions also included to monitor Resident 13's behavior, attempt to redirect attention if seen attempting to play with tubing dated 2/10/2026. The CP indicated Resident 13's goal was to not have GT dislodgement through the next review.During a review of Resident 13's Order Summary Report (OSR) dated with active orders as of 2/26/2026, the OSR indicated: may have bilateral mittens on to prevent accidental GT dislodgement with start date 2/14/2026. The OSR also indicated to monitor skin integrity every shift related to use of mittens with start date 2/14/2026.During an interview on 2/26/2026 at 11:59 AM with Licensed Vocational Nurse (LVN) 2, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 stated Resident 13 was impulsive and had pulled the GT four to five times in the past year. LVN 2 stated Resident 13's last removed the GT on 2/13/2026 and a foley catheter (thin, flexible tube usually used to drain urine from the bladder by way of the urethra) was inserted to prevent Resident 13's gastrostomy from closing but Resident 13 also pulled out the foley catheter before it could be replaced with another GT. LVN 2 stated Resident 13 was then taken to a general acute care hospital (GACH) on 2/13/2026 for GT reinsertion. During an interview on 2/26/2026 at 12:14 PM with LVN 4, LVN 4 stated Resident 13 had restraints due to pulling on the GT and Resident 13 was strong and persistent in the behavior. LVN 4 stated Resident 13 used the restraints all day and the physician order did not specify when to place the restraints and when to remove them. LVN 4 stated the purpose of specifying when Resident 13 needed the restraints was for resident safety and to prevent skin breakdown. LVN 4 stated while using restraints, the resident's skin should be checked every two hours but it was not documented.During an interview on 2/26/2026 at 12:37 PM with the Registered Nurse (RN) 2, RN 2 stated Resident 13 had a history of pulling the GT many times. RN 2 stated nurses (general) have a responsibility to make suggestions to the doctor for certain interventions and Resident 13's doctor was informed of Resident 13's behavior and approved the order for restraints. RN 2 stated Resident 13's order for restraints did not indicate the how long the restraints should be on and only indicated to monitor to prevent dislodgement every shift.During an interview on 2/26/2026 at 1:07 PM with the Director of Nursing (DON), the DON stated Resident 13's family requested to have the bilateral mitten restraints on because the restraints had been useful in the past at a different facility. The DON stated Resident 13 had pulled out the GT up to six times in the past year.During an interview on 2/26/2026 at 2:03 PM with the DON, the DON stated the facility attempted to monitor the behavior and redirect if Resident 13 was seen attempting to play with the tubing. The DON stated Resident 13 had a behavior of pulling on the GT for at least one year. The DON stated there had been no interdisciplinary department team (IDT) meeting about Resident 13's behavior. The DON stated there was no documentation to show interventions that were attempted prior to implementing restraints. The DON stated there was no documented evidence that the facility had used the least restrictive method of managing Resident 13's behavior. The DON stated the nursing staff (general) should document restrain monitoring, restraint application and assessment. The DON stated that when restraints are in use, there should be a plan to reduce the use of restraints as much as possible but there was no current plan in place to reduce use of the restraints. The DON stated if other methods of managing behavior are not used first, the facility could be restraining a person unnecessarily which could affect them mentally, psychosocially and could increase the risk for impaired skin integrity.During a review of the facility's policy and procedure (P&P) titled, Restraints, dated 3/27/2024, the P&P indicated the facility honors the resident's right to be free from any restraints that are imposed for reasons other than that of treatment of the resident's medical symptoms. Restraints require a physician order and are used as a last resort to be used only when deemed necessary by the IDT, and in accordance with the resident's assessment and Plan of Care. If restraints are used, the least restrictive alternative is used for the least amount of time, and only under carefully monitored circumstances. Every attempt will be made to avoid a decline in the resident's physical functioning.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of one sampled resident's (Resident 35's) Care Plan (CP - provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), was revised after Resident 35 had a significant weight loss (5% in 1 month or 10% in 6 months of total body weight). This deficient practice had the potential to result in the continued implementation of an ineffective or inadequate CP interventions to prevent Resident 35 from further unplanned weight loss. Findings: During a review of Resident 35's admission Record (AR), the AR indicated Resident 35 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including cerebral palsy (a group of conditions that affect movement and posture, caused by damage to the developing brain) and unspecified severe protein-calorie malnutrition. During a review of Resident 35's History & Physical Examination (H&P, physician's clinical evaluation and examination of the resident), dated 11/20/2025, the H&P indicated Resident 35 did not have the capacity to understand and make decisions. During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool), dated 12/17/2025, the MDS indicated Resident 35's cognitive skills (ability to think and process information) were severely impaired (never/rarely made decisions). The MDS indicated Resident 35 was dependent (helper does all of the effort) for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) including eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). The MDS indicated Resident 35 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. During a review of Resident 35's Nutritional Risk Assessment (NRA), dated 12/6/2025 and timed at 12:45 PM, the NRA indicated Resident 35 was at increased nutritional risk and had a fifteen (15) pound (lb- a unit of weight) weight loss in one (1) month and fourteen (14) lb weight loss in three (3) months. During a review of Resident 35's Change in Condition Evaluation (COC), dated 12/6/2025 and timed at 9:57 PM, the COC indicated Resident 35 had a weight loss of sixteen (16) lbs or one hundred thirty nine percent (139%) in one (1) month. During a review of Resident 35's Weights and Vitals Summary (WVS), dated 9/19/2025 to 2/23/2026, the WVS indicated Resident 35's weights as follows: 9/19/2025=114 lbs10/20/2025=115 lbs11/21/2025=109 lbs12/22/2025=99 lbs1/19/2026=100 lbs1/14/2025=97 lbs2/16/2026=98 lbs The WVS indicated Resident 35 had a significant weight loss of -14.04 % in the last 6 months. During a concurrent interview and record review on 2/26/2026 at 11:27 AM with Registered Nurse (RN) 1, Resident 35's AR, WVS and CP titled, [Resident 35] has nutritional problem or potential nutritional problem r/t (related to) ., date initiated 9/23/2025 were reviewed. RN 1 stated Resident 35 was on the skinny side, was at risk for malnutrition and weight loss. RN 1 stated Resident 35 had a significant weight loss. RN 1 stated a CP was how to take care of residents (in general) and consisted of a problem, interventions and goal. RN 1 stated Resident 35's CP was revised on 2/24/2026 and should have been revised when Resident 35 started losing weight in 12/2025. RN 1 stated revising Resident 35's CP timely was important to address the problem and update the plan of care since the initial CP was not effective. During a review of the facility's policy and procedure (P&P) titled, Person-Centered Care Planning, with revision date of 4/24/2025, the P&P indicated comprehensive care plans must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. During a review of the facility's P&P titled, Change in Condition, with revision date of 8/25/2025, the P&P indicated a change in weight (change = gain or loss) of five pounds or more within a 30-day period or 10% or more in the past 6 months was a change in condition and the care plan must be updated to reflect the resident's current status, if applicable.

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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 interview and record review, the facility failed to ensure the nursing staff had the appropriate competencies and skills sets necessary to care for residents' needs and related services when the facility:a. Failed to provide documentation indicating nursing staff (general) had been trained in the use of physical restraints (any manual method, physical or mechanical device, equipment, or material that restricts the resident's freedom of movement or normal access to his/her body) while one of one sampled residents (Resident 13) used bilateral mitten restraints (specialized glove that covers the fingers and palm designed to limit the ability to grip or pull at medical lines and devices) and an abdominal binder (compressive, elastic garment worn to reduce access to medical devices.b. Failed to ensure one of three Certified Nursing Aides' (CNA 15) employee personnel file had documentation of a recent background check (a screening process used by employers to verify a candidate's history) upon hire and a current CPR (cardiopulmonary resuscitation - an emergency treatment that's done when someone's breathing or heartbeat has stopped) certification. These deficient practices had the potential for nursing staff to be inadequately trained in the use of physical restraints and had the potential for nursing staff to provide unsafe and inadequate care to Resident 13. These deficient practices also had the potential for the facility to hire a CNA who had a criminal background and was not trained in CPR which could compromise the residents' safety.Findings: a. During a review of Resident 13's admission Record (AR), the AR indicated Resident 13 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing) and encounter for attention to gastrostomy (the surgical creating of an opening in the abdominal wall into the stomach for drainage or a feeding tube). During a review of Resident 13's Minimum Data Set (MDS – a resident assessment tool), dated [DATE], the MDS indicated Resident 13 had severely impaired cognition (ability to understand and process information) and was dependent (helper does all of the effort) on staff for toileting hygiene. The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and/or contact guard assistance as resident completes activity) for personal hygiene. During a review of Resident 13's Order Summary Report (OSR), with active orders as of [DATE], the OSR indicated a physician order (PO), dated [DATE], that Resident 13 may have bilateral mittens on to prevent accidental gastrostomy tube (G-tube, a feeding tube inserted through the abdomen that brings nutrition directly to the stomach) dislodgement. During a concurrent observation and interview on [DATE] at 9:09 AM with the Director of Staff Development (DSD) in Resident 13's room, Resident 13 was observed with bilateral mitten restraints and an abdominal binder. The DSD stated Resident 13 had a behavior of pulling out the gastrostomy tube and wore the mittens and abdominal binder to prevent Resident 13 from reaching and pulling out the gastrostomy tube. During an interview on [DATE] at 11:38 AM with Certified Nursing Assistant (CNA) 8, CNA 8 stated CNA 8 received an in-service about restraints the week prior from the Director of Staff Development before the start of CNA 8's shift to care for Resident 13. CNA 8 stated the DSD informally instructed (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 8 how to correctly place mitten restraints so they're not too tight and how to remove them. During an interview on [DATE] at 11:59 AM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated LVN 2 had received an in-service on restraints before but could not recall who led the in-service or when it took place. During an interview on [DATE] at 12:14 PM with LVN 4, LVN 4 further stated LVN 4 had received an in-service on restraints in the past but could not remember when. LVN 4 stated the topic of restraints was not covered during the facility's annual skills fair that took place the week prior. During an interview on [DATE] at 1:12 PM with the DSD, the DSD stated the DSD had not given any in-services on restraints in the past month that the DSD had been employed as the Director of Staff Development. During a review of the Facility Assessment (FA), dated [DATE], the FA indicated the facility held an annual nursing skills competency fair from [DATE] to [DATE]. The FA indicated the nursing skills competency fair covered the following topics: wound care, medication pass, foley catheters, Hoyer lift, transfers, oxygen, nebulizers, peri care, Heimlich maneuver, vital signs, ambulation, position on side, low air loss mattress (LALM), feeding, international dysphagia diet standardization initiative (IDDSI), and diet textures. During an interview on [DATE] at 2:38 PM with the Director of Nursing (DON), the DON stated the DON had been employed at the facility for less than one year and had not conducted any in-service on restraints to licensed staff and did not have any documentation to show that staff had been previously trained in the use of restraints. During a review of the facility's policy and procedure (P&P) titled, Training Requirements, dated [DATE], the P&P indicated the facility must develop, implement, and maintain an effective training program for new and existing staff, individual providing services under a contractual agreement, and volunteers, consistent with their expected roles. The facility must determine the amount and types of training necessary based on a facility assessment and special needs of the residents. b. During a concurrent interview and record review on [DATE] at 11:41 AM with the DSD, CNA 15's employee personnel file was reviewed. CNA 15's background check was dated [DATE]. The DSD stated CNA 15 was hired on [DATE]. The DSD stated background checks were conducted prior to employment to ensure the candidate was eligible for the job applied for and to check for criminal background. The DSD stated a criminal offense could have happened, we don't know all the information, between CNA 15's hiring date of [DATE] and the background check dated [DATE]. CNA 15's CPR card on file indicated the CPR certification was from BLS National CPR Foundation, dated [DATE] and was valid for two (2) years. The DSD stated CNAs (in general) at the facility were required to be CPR certified and CNA 15's CPR card was expired, and a current card should have been on file. The DSD stated having a current CPR card on file was important as part of the facility's requirement to work at the facility. During a concurrent interview on [DATE] at 2:05 PM with the DSD and the Training Instructor (TI), the TI stated the TI came to the facility to provide the CPR class and CNA 15 took the CPR class on [DATE]. The TI stated CNA 15's current CPR card was an e-card (electronic card sent over the internet) sent directly to CNA 15 by the TI. The DSD stated CNA 15's current CPR card, dated [DATE], should have been filed in CNA 15's employee file. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure (P&P) titled, Hiring and Employment Verification, effective date [DATE], indicated ongoing monitoring of all licenses and certifications would be re-verified prior to expiration and the DSD would maintain a tracking system to alert for renewals The P&P indicated copies of all verified licenses and certifications would be kept in the employee's personnel file and the facility would maintain records of all verifications and screenings including license and certification verification to be updated regularly and retained throughout the employee's tenure.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure one of three Certified Nursing Assistant's (CNA 15's) performance review was completed at least once every 12 months. This deficient practice resulted in the facility not assessing and evaluating the necessary skills and competencies of CNA 15 and placed residents assigned to CNA 15 at risk for inadequate and unsafe care.Findings: During a concurrent interview and record review on 2/27/2026 at 11:41 AM with the Director of Staff Development (DSD), CNA 15's employee personnel file was reviewed. The DSD stated CNA 15 was hired on 2/8/2015 and the last performance review on CNA 15 on file was dated 6/8/2024. CNA 15's Employee Performance Review (EPR), dated and signed 6/8/24 was reviewed. The EPR was incomplete. The DSD stated completing a performance review annually was important to ensure CNAs (in general) were aware of how the CNAs were doing with their skills and what to improve on to ensure the CNAs provided quality of care. During a review of the facility's Employee Handbook (EH), edition dated January 2024, the EH indicated employees may receive periodic performance reviews and would generally be conducted by their supervisor. The first performance evaluation may be after completion of the Introductory Period and after that review, performance evaluations may be conducted annually, on or around their anniversary date. The EH indicated performance evaluations were designed to help employees become aware of progress, areas for improvement and objectives or goals for future work performance.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were not left at the bedside for one of one sampled resident (Resident 73) when Resident 73's Calcium Carbonate oral chewable tablet (generic for Tums, over the counter medication containing calcium carbonate designed to relieve heartburn, sour stomach, acid indigestion and upset stomach) was found on Resident 73's bedside table on 2/24/2026.This failure had the potential for Resident 73 to choke or take more medication than prescribed.Findings:During a review of Resident 73's admission Record (AR), the AR indicated Resident 73 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (total paralysis) and hemiparesis (weakness) following cerebral infarction (condition where blood flow to a part of the brain is blocked or reduced, causing brain tissue to die due to lack of oxygen) affecting left non-dominant side. During a review of Resident 73's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 1/19/2026, the MDS indicated Resident 73 had intact cognition (ability to understand and process information) and required supervision or touching assistance (helper provides verbal cues and/or touching/ steadying and /or contact guard assistance as resident completes activity) for toileting and personal hygiene.During a concurrent observation and interview on 2/24/2026 at 10:13 AM with Certified Nursing Assistant (CNA) 8 in Resident 73's room, a large, white, round pill imprinted with G 127 was observed in a medicine cup on top of Resident 73's bedside table. CNA 8 stated the medication was Tums and CNA 8 knew it was Tums because Resident 73 took it every day.During a concurrent observation and interview on 2/24/2026 at 10:24 AM with Licensed Vocational Nurse (LVN) 5 in Resident 73's room, a large, white, round pill imprinted with G 127 was observed in a medicine cup on top of Resident 73's bedside table. LVN 5 stated LVN 5 had not administered that medication to Resident 73 today and did not know how long the medication had been left on Resident 73's bedside table. LVN 5 stated medications are not kept at the bedside because they needed to be administered by the nurse unless the residents had been approved by the doctor to self-administer. LVN 5 stated Resident 73 did not have approval to self-administer medications. LVN 5 stated medications are not safe to leave at the bedside and a resident could choke or end up taking a different dose than what is ordered and become unstable.During a review of Resident 73's Order Summary Report (OSR) dated with active orders as of 2/25/2026, the OSR indicated calcium carbonate oral tablet, give one tablet by mouth every six hours as needed for heart burn with start date of 6/2/2025.During an interview on 2/26/2026 at 8:44 AM with Resident 73, Resident 73 recalled the Tums left on the bedside table and stated Resident 73 had asked for the medication the night before to have it nearby. Resident 73 stated Resident 73 sometimes woke up with acid reflux (common condition where stomach acid flows back up into the throat causing a burning sensation in the chest) at nighttime and wanted the medication just in case.During an interview on 2/26/2026 at 12:58 PM with Registered Nurse (RN) 2, RN 2 stated it was never acceptable to keep medication at the bedside unless an assessment was completed indicating the resident could self-administer medication. RN 2 stated leaving medication at the bedside could lead to someone being over medicated or another resident could enter the room and take the medication that was not prescribed to them.During an interview on 2/26/2026 at 1:05 PM with the Director of Nursing (DON), the DON stated Resident 73 should not have had medication at the beside for safety reasons and if a staff member does not watch the resident take their medications, the resident could choke.During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated 8/2019, the P&P indicated B. only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications and C. all medications dispensed by the pharmacy are stored in the box, bag or other container with the pharmacy label.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's protocol for antibiotic stewardship for one of one sampled resident (Resident 106). Resident 106 was screened for pneumonia (an infection that causes the lungs to fill with fluid or pus) and prescribed levofloxacin (a strong broad-spectrum antibiotic used for bacterial infections like pneumonia) without meeting the necessary criteria.This deficient practice had the potential for Resident 106 to develop antibiotic resistance.Findings:During a review of Resident 106's admission Record (AR), the AR indicated Resident 106 was admitted to the facility on [DATE] with multiple diagnoses including quadriplegia (partial or total paralysis of all four limbs and the torso), pneumonia, and solitary pulmonary nodule (area of abnormal growth on the lungs).During a review of Resident 106's Patient Report (PR) dated 2/24/2026, the PR indicated Resident 106's chest x-ray (noninvasive imaging test that uses a small amount of radiation to create pictures of the heart, lungs, airways, blood vessels, and chest bones) results and indicated opacities (area of increased density) in the right upper lung, concerning for pneumonia.During a review of Resident 106's OSR, the OSR indicated a physician order for levofloxacin tablet 500 milligrams (mg- unit of weight) give 1 tablet by mouth in the evening for pneumonia for 5 days with start date 2/25/2026.During a review of Resident 106's Progress Notes (PN) dated 2/25/2026 at 9:31 AM, the PN indicated abnormal x-ray results: opacities in the right upper lung. The PN further indicated Resident 106's chest x-ray results were provided to Medical Doctor (MD) 2 and MD 2 prescribed levofloxacin tablet 500 mg, give 1 tablet by mouth in the evening for pneumonia for five days, orders carried out. The PN indicated upon assessment Resident 106 stated complicated pneumonia upon admission caused right upper pain to chest and Resident 106 felt short of breath at times.During a review of Resident 106's Order Summary Report (OSR) with active orders as of 2/27/2026, the OSR indicated Resident 106 was capable of making healthcare decisions.During a concurrent interview and record review on 2/27/2026 at 8:11 AM with the Infection Preventionist (IP), Resident 106's Surveillance Data Collection Form (SDCF) dated 2/26/2026, was reviewed. The SDCF indicated under Respiratory Tract Infections: Pneumonia, that all three criteria must be present:1. Interpretation of chest radiograph as demonstrating pneumonia or the presence of new infiltrate2. At least one of the following respiratory sub-criteria:New or increased coughNew or increased sputum productionO2 saturation <94% of room air or a reduction in O2 saturation of >3% from baselineNew or changed lung examination abnormalitiesPleuritic chest painRespiratory rate of ˆ 25 breaths/ min3. At least one of McGeer's constitutional criteria (table 1)The IP stated the checkmarks indicated what criteria applied to Resident 106. The IP stated the SDCF had one checkmark under number 1 and the IP stated Resident 106 had pleuritic chest pain and check marked 2e. The SDCF indicated the treatment for pneumonia was levofloxacin 500 mg, give one tablet by mouth in the evening for pneumonia with start date 2/25/2026. The IP stated MD 2 ordered the levofloxacin based on Resident 106's x-ray results on 2/24/2026.During a concurrent interview and record review on 2/27/2026 at 11:00 AM with the IP, Resident 106's SDCF was reviewed. The IP stated the SDCF used McGeer's criteria (standardized, evidenced based definitions used for surveillance of infection in longer term care facilities to distinguish true infections from non-infectious, age-related symptoms) to determine if residents (general) met the criteria of an infection and need for an antibiotic. The IP stated McGeer's criteria is based on signs of symptoms of the infection as well as labs and imaging depending on the type of infection. The IP stated based on Resident 106's SDCF, Resident 106 did not meet McGeer's criteria. The IP stated if a resident does not meet McGeer's criteria, the doctor should be informed so the doctor could decide whether to continue with antibiotics. The IP stated the IP did not inform MD 2 that Resident 106 did not meet McGeer's criteria and MD 2 should have been notified so that MD 2 could make an informed decision. The IP stated if the doctor does not have all the information, the doctor could be prescribing unnecessary antibiotics which could lead to antibiotic (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	02/27/2026

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resistance.During an interview on 2/27/2026 at 2:43 PM with the Director of Nursing (DON), the DON stated a resident's (general) doctor should be informed if the resident does not meet McGeer's criteria to ensure the resident does not get unnecessary medication. The DON stated if the resident receives an antibiotic that is not needed, it could lead to antibiotic resistance.During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship dated 5/20/2021, the P&P indicated the IP is responsible for tracking the following antibiotic stewardship processes: C. whether or not the resident's condition met McGeer's Criteria when the antibiotic was ordered.