

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Claremont Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 219 E. Foothill Blvd Pomona, CA 91767	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678</p> <p>Based on interview and record review, the facility failed to revise the plan of care for one of three sampled residents (Resident 1), who was at high risk for falls, following episodes of getting up unassisted on 4/8/2025.</p> <p>This deficient practice had the potential to increase Resident 1's risk for falls and injury.</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of history of falling, right femur (thigh bone) fracture (break in the bone), and encounter for orthopedic (the branch of medicine dealing with the correction of deformities of bones or muscles) after care, dementia (progressive state of decline in mental abilities), osteoarthritis (OA- a progressive disorder of the joints caused by a gradual loss of cartilage [connective tissue that protects the joints/bones])abnormalities of gait (manner of walking) and mobility (ability to move freely), and generalized muscle weakness.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 4/1/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, remember and make decisions) for daily decision making. The MDS indicated Resident 1 required supervision (helper provides verbal cues and or touching as resident competes activity) for oral and personal hygiene, partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs) for upper body dressing, and substantial/maximal assistance (helper does more than half the effort to lift or hold trunk or limbs) for showering/bathing, rolling left and right, sitting to lying on the bed, lying to sitting on side of the bed, and toilet transfer. The MDS indicated Resident 1 had not attempted to transfer to and from a bed to a wheelchair, sit to stand, or walk ten feet due to medical condition or safety concerns. The MDS indicated Resident 1 had a fall in the last month prior to admission, surgical repair of the hip, required pain assessment interview, and had not had any pain in the last five days of the assessment.</p> <p>(continued on next page)</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
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Care Plan (CP) titled, Care Plan Report, initiated 3/28/2025, the CP indicated Resident 1 was at risk for falls related to impaired balance and mobility and decreased endurance. The CP interventions indicated for staff to ensure Resident 1's call light was within reach, encourage Resident 1 to use the call light to call for assistance as needed, may have low bed with bilateral floor mats for safety precautions, and may have pressure pad alarm in wheelchair and bed to alert staff of resident attempting to get up unassisted.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) for April 2025, the MAR indicated Resident 1 had two episodes of attempting to get up unassisted from Resident 1's wheelchair on 4/8/2025.</p> <p>During an interview on 5/6/2025 at 12:40 PM with the MDS Nurse, the MDS Nurse stated no CP had been updated since 4/4/2025 for Resident 1 getting up unassisted to ensure Resident 1's safety and apply new interventions.</p> <p>During an interview on 5/6/2025 at 1:36 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 1 had a Care Plan for falls which should have been updated to include more frequent monitoring such as every hour as opposed to two hours since Resident 1 was at high risk for falls and kept getting up unassisted on 4/8/2025. LVN 2 stated not having a CP and updated interventions would not allow nurses to meet resident's needs and could contribute to a decline in resident's health. LVN 2 stated Resident 1's CP should have updated interventions to the CP to avoid missed diagnosis and delayed treatment.</p> <p>During an interview on 5/7/2025 at 2:04 PM with the Assistant Director of Nursing (ADON), the ADON stated it was important for licensed nurses to update and create care plans to meet resident's needs by implementing interventions to each resident's care area, prevent further decline, missed diagnosis, delayed treatment, and identify any new issues that require intervention.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Fall Management System, revised October 2024, the P&P indicated, It is the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs. The P&P indicated, Residents with high risk factors identified on the Fall Risk Evaluation will have an individualized care plan developed that includes measurable objectives and timeframes. The care plan interventions will be developed to prevent falls by addressing the risk factors and will consider the particular elements of the evaluation that put the resident at risk. The P&P indicated, Resident's care plan will be updated.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678</p> <p>Based on interview and record review, the facility failed to assess and manage reported pain for one of three residents (Resident 1) as indicated in Resident 1's care plan and the facility's policies and procedures titled, Pain Recognition and Management, and Pain Management, by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Licensed Vocational Nurse (LVN) 1 assessed and documented Resident 1's pain location. 2. Ensure Resident 1 received pain medication when Resident 1 complained of persistent pain to Resident 1's right lower extremity (RLE- right leg, including hip, thigh, knee, calf, and foot) on 4/7/2025. <p>These deficient practices had the potential for Resident 1 to experience unrelieved/uncontrolled pain that could result in physical, mental, and emotional distress.</p> <p>Cross Reference F842</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of history of falling, right femur (thigh bone) fracture (break in the bone), and encounter for orthopedic (the branch of medicine dealing with the correction of deformities of bones or muscles) after care, dementia (progressive state of decline in mental abilities), osteoarthritis (OA- a progressive disorder of the joints caused by a gradual loss of cartilage [connective tissue that protects the joints/bones]) abnormalities of gait (manner of walking) and mobility (ability to move freely), and generalized muscle weakness.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 4/1/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, remember and make decisions) for daily decision making. The MDS indicated Resident 1 required supervision (helper provides verbal cues and or touching as resident competes activity) for oral and personal hygiene, partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs) for upper body dressing, and substantial/maximal assistance (helper does more than half the effort to lift or hold trunk or limbs) for showering/bathing, rolling left and right, sitting to lying on the bed, lying to sitting on side of the bed, and toilet transfer. The MDS indicated Resident 1 had not attempted to transfer to and from a bed to a wheelchair, sit to stand, or walk ten feet due to medical condition or safety concerns. The MDS indicated Resident 1 had a fall in the last month prior to admission, surgical repair of the hip, required pain assessment interview, and had not had any pain in the last five days of the assessment.</p> <p>During a review of Resident 1's Care Plan (CP) titled Care Plan Report, dated 3/28/2025, the CP indicated Resident 1 had pain of the right femur due to a recent right femur fracture and surgical intervention following a fall. The CP interventions indicated for staff to administer analgesia (absence of pain) medication as per physician orders and give one-half (1/2) hour before treatments or care, anticipate need for pain relief, and respond immediately to any complaint of pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Physician Order (PO), dated 3/28/2025, the PO indicated Resident 1 had an order for licensed staff to monitor Resident 1's pain level using zero (0) to 10 pain scale (0 = no pain, 1 to 3 = mild pain, 4 to 6 = moderate pain, and 7 to 10 = severe pain) every shift.</p> <p>During a review of Resident 1's PO, dated 3/31/2025, the PO indicated Resident 1 had an order for Hydrocodone-Acetaminophen (medication to treat moderate to severe pain) oral tablet 5-325 milligram (mg- a unit of mass) give one (1) tablet by mouth every six hours as needed (PRN) for moderate to severe pain from all sources.</p> <p>During a review of another Resident 1's CP titled, Care Plan Report, dated 4/4/2025, the CP indicated Resident 1 was at risk for hip fracture complications due to impaired mobility. The CP interventions indicated for staff to monitor/document/report to the doctor signs and symptoms (s/sx) of hip fracture complications such as unrelieved pain, impaired mobility, and pain after exercise or weight bearing.</p> <p>During a review of Resident 1's Physical Therapy (PT- treatment that helps improve how the body performs physical movements) Treatment Encounter Notes (PT TEN) dated 4/7/2025, timed at 2:38 PM, completed by Physical Therapist 1 (PT 1- a healthcare provider who helps improve how the body performs physical movements), the PT TEN indicated Resident 1 complained of discomfort on Resident 1's left lower extremity despite being pre-medicated. The PT TEN indicated PT 1 informed LVN 4 and agreed to monitor Resident 1.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) for April 2025, the MAR indicated no documented evidence Resident 1 received Hydrocodone-Acetaminophen before or after the therapy session on 4/7/2025. The MAR indicated no documentation the licensed nurse assessed Resident 1 having any pain on 4/7/2025.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) for April 2025, the MAR indicated Resident 1 was administered Hydrocodone-Acetaminophen 5-325 mg for complaints of pain (pain location was not indicated) on the following dates and times:</p> <ul style="list-style-type: none"> a. On 4/9/2025 at 10:32 AM for pain level of 8 out of 10. b. On 4/14/2025 at 8:56 AM for pain level of 8 out of 10. c. On 4/14/2025 at 8:09 PM for pain level of 7 out of 10. d. On 4/16/2025 at 8:20 AM for pain level of 7 out of 10. e. On 4/17/2025 at 8:18 AM for pain level of 7 out of 10. <p>During a concurrent interview and record review on 5/6/2025 at 12:40 PM with the MDS Nurse, Resident 1's MAR for April 2025 was reviewed. The MDS Nurse stated the MAR did not indicate Resident 1's pain location when the licensed nurse (LVN 1) administered pain medication to treat Resident 1's complaint of moderate to severe pain on 4/9/2025, 4/14/2025, 4/16/2025, and 4/17/2025. The MDS Nurse stated it was important for licensed nurses to document thoroughly such as the location of resident's pain to provide appropriate care, treatment, and notify the doctor if necessary.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/6/2025 at 3:19 PM with LVN 4, Resident 1's medical record and MAR for April 2025 were reviewed. LVN 4 stated LVN 4 was Resident 1's licensed nurse on 4/7/2025 during the 7 am to 3 pm shift. LVN 4 stated LVN 4 could not remember being informed by PT 1 about Resident 1 having pain and giving Resident 1 pain medication. LVN 4 stated there were no documented interventions, assessments, nor pain relief provided to Resident 1 on 4/7/2025. LVN 4 stated the MAR indicated the licensed nurse (LVN 1) administered Hydrocodone to Resident 1 on 4/9/2025 at 10:32 AM, 4/14/2025 at 8:56 AM and 8:09 PM, 4/16/2025 at 8:20 AM, and 4/17/2025 at 8:18 AM but there was documentation of Resident 1's pain location therefore the location of the pain was unknown.</p> <p>During an interview on 5/7/2025 at 10:09 AM with LVN 1, LVN 1 stated when a resident (in general) reported pain, LVN 1 should ask the location, intensity, and onset of the pain, and what triggered the resident's pain. LVN 1 stated when LVN 1 administered Hydrocodone to Resident 1 on 4/9/2025, 4/14/2025, 4/16/2025, and 4/17/2025, LVN 1 failed to document the location of Resident 1's pain which put Resident 1 at risk for missed or delayed diagnosis, inappropriate treatment, ineffective pain relief, and delay in timely interventions which can further worsen any injury residents may have. LVN 1 stated she could not recall by memory where Resident 1's pain was located.</p> <p>During an interview on 5/7/2025 at 11:59 AM with PT 1, PT 1 stated that she provided therapy to Resident 1 on 4/7/2025 which consisted of the right leg range of motion, as well as the left leg range of motion while Resident 1 laid down on Resident 1's bed. PT 1 stated PT 1 provided hip and knee flexion, with hip abduction (the movement of a limb away from the midline of the body) and adduction (the movement of a limb towards the midline) to the left leg/left hip. PT 1 stated PT 1 only took care of Resident 1 that day, and her memory was blurry regarding actual events which was why she relied heavily on her thorough documentation to recall events that day. PT 1 stated based on her assessment and documentation, Resident 1 was able to roll to his right side while lying in bed, and partially roll to his left side, progressing to sitting on edge of bed with assistance. PT 1 stated during the session, Resident 1 refused to attempt standing or getting out of bed and began to exhibit agitation. PT 1 stated Resident 1 wanted to go back to bed as Resident 1 complained of discomfort on his left lower extremity despite being pre-medicated prior to therapy and was guarding his left leg due to complaints of persistent pain. PT 1 stated Resident 1 was unable to describe or quantify Resident 1's pain level at that time. PT 1 stated PT 1 walked over to the nurse's station to inform the licensed nurse (LVN 4) of Resident 1's discomfort to Resident 1's left lower extremity and LVN 4 agreed to monitor Resident 1. PT 1 stated PT 1 could not recall how Resident 1 was showing agitation other than refusing to continue the therapy session. PT 1 stated there was a possibility PT 1 may have written the wrong laterality (preference for using one side of the body over the other) of Resident 1's pain location.</p> <p>During an interview on 5/7/2025 at 12:45 PM with LVN 2, LVN 2 stated when residents (in general) report pain, licensed nurses should assess origin of pain, when the pain started, and depending on the pain level should give pain medication as needed, reassess the resident for effectiveness of pain medication, and document findings on the MAR. LVN 2 stated if the interventions were not effective, licensed nurses should document the reason, notify the doctor and family, and ask for X-rays (type of medical imaging that creates pictures of bones and soft tissues) or any type of diagnostic testing to rule out any unknown injuries.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 5/7/2025 at 2:04 PM with the Assistant Director of Nursing (ADON), the ADON stated licensed nurses were to communicate with staff and respond to any complaints of pain by assessing the resident's pain level, location of pain, pain intensity, new onset of pain, determining if pain was long-term, and check the resident's physician orders for any medication and/or treatment available to treat the resident's pain. The ADON stated it was important to follow up on the resident's pain levels and reassess the pain to determine if the treatment was effective and to ensure the facility was meeting the resident's needs. The ADON stated failure to properly assess the resident's complaint of pain can result in untreated pain, delayed or missed interventions, decline in physical function, and complications from over or under medication.</p> <p>During a review of an electronic mail (e-mail) titled, Documentation Clarification, dated 5/7/2025, timed at 3:01 PM, emailed by PT 1, the e-mail indicated PT 1 provided a written statement to clarify Resident 1's PT TEN dated 4/7/2025. The e-mail indicated per PT 1, PT 1 made an incorrect entry when PT 1 incorrectly documented Resident 1 complained of persistent pain on Resident 1's left lower extremity (LLE) instead of RLE. The email indicated per PT 1, Resident 1's pain location on 4/7/2025 was on the RLE.</p> <p>During a review of the facility's P&P titled, Pain Recognition and Management, revised 1/2022, the P&P indicated, It is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan . The P&P indicated the care plan will reflect the location and type of pain, pharmacological, and non-pharmacological interventions, with evaluation and revision as indicated.</p> <p>During a review of the facility's P&P titled Pain Management the P&P dated 10/2024, the P&P indicated, The resident will be assessed for pain . On admission with a pain-related diagnosis, or if pain is indicated through the Nursing Admission Assessment . Upon development of new symptoms of acute pain . Complete the Pain Management Review assessment . Complete appropriate physical assessment to determine any physical changes or manifestations as needed. The P&P indicated, Monitor pain status and treatment effects on a regular basis, e.g., during routine medication pass . Consult physician for additional interventions if pain is not relieved by currently ordered treatment modalities and comfort measures. The Care Plan will include pharmacological and non-pharmacological interventions, with evaluation and revision as needed.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48678</p> <p>Based on interview and record review, the facility failed to maintain complete and accurate medical records for one of three sampled residents (Resident 1) by failing to:</p> <ol style="list-style-type: none"> 1. Ensure Physical Therapist (PT- a healthcare provider who helps improve how the body performs physical movements) 1 and PT 2 accurately documented Resident 1's pain location in Resident 1's Physical Therapy Encounter Notes (PT TEN) dated 4/7/2025 and 4/14/2025. 2. Ensure Licensed Vocational Nurse (LVN) 1 assessed and documented Resident 1's pain location in Resident 1's medical record. 3. Ensure staff documented the rationale for initiating a room transfer for Resident 1 on 4/7/2025 in Resident 1's medical record. <p>These failures resulted in Resident 1's medical record to contain inaccurate and incomplete information and had the potential to affect Resident 1's care.</p> <p>Cross Reference F697</p> <p>Findings:</p> <p>During a review of Resident 1's Admission Record (AR), the AR indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of history of falling, right femur (thigh bone) fracture (break in the bone), and encounter for orthopedic (the branch of medicine dealing with the correction of deformities of bones or muscles) after care, dementia (progressive state of decline in mental abilities), osteoarthritis (OA- a progressive disorder of the joints caused by a gradual loss of cartilage [connective tissue that protects the joints/bones])abnormalities of gait (manner of walking) and mobility (ability to move freely), and generalized muscle weakness.</p> <p>During a review of Resident 1's Minimum Data Set (MDS- resident assessment tool), dated 4/1/2025, the MDS indicated Resident 1 had moderately impaired cognition (ability to think, remember and make decisions) for daily decision making. The MDS indicated Resident 1 required supervision (helper provides verbal cues and or touching as resident competes activity) for oral and personal hygiene, partial/moderate assistance (helper does less than half the effort to lift, hold, or support trunk or arms and legs) for upper body dressing, and substantial/maximal assistance (helper does more than half the effort to lift or hold trunk or limbs) for showering/bathing, rolling left and right, sitting to lying on the bed, lying to sitting on side of the bed, and toilet transfer. The MDS indicated Resident 1 had not attempted to transfer to and from a bed to a wheelchair, sit to stand, or walk ten feet due to medical condition or safety concerns. The MDS indicated Resident 1 had a fall in the last month prior to admission, surgical repair of the hip, required pain assessment interview, and had not had any pain in the last five days of the assessment.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 1's Physician Order (PO), dated 3/31/2025, the PO indicated Resident 1 had an order for Hydrocodone-Acetaminophen (medication to treat moderate to severe pain) oral tablet 5-325 milligram (mg- a unit of mass) give one (1) tablet by mouth every six hours as needed (PRN) for moderate to severe pain from all sources.</p> <p>During a review of Resident 1's PT TEN dated 4/7/2025, timed at 2:38 PM, completed by PT 1, the PT TEN indicated Resident 1 complained of discomfort on Resident 1's left lower extremity (LLE- left leg, including the thigh, knee, calf, ankle, and foot) despite being pre-medicated. The PT TEN indicated PT 1 informed the licensed nurse (LVN 4) and agreed to monitor Resident 1.</p> <p>During a review of Resident 1's Medication Administration Record (MAR) for April 2025, the MAR indicated no documented evidence Resident 1 received Hydrocodone-Acetaminophen before or after the therapy session on 4/7/2025. The MAR indicated no documentation the licensed nurse assessed Resident 1 having any pain on 4/7/2025.</p> <p>During a review of Resident 1's MAR for April 2025, the MAR indicated Resident 1 was administered Hydrocodone-Acetaminophen 5-325 mg for complaints of pain (pain location was not indicated) on the following dates and times:</p> <ul style="list-style-type: none"> a. On 4/9/2025 at 10:32 AM for pain level of 8 out of 10. b. On 4/14/2025 at 8:56 AM for pain level of 8 out of 10. c. On 4/14/2025 at 8:09 PM for pain level of 7 out of 10. d. On 4/16/2025 at 8:20 AM for pain level of 7 out of 10. e. On 4/17/2025 at 8:18 AM for pain level of 7 out of 10. <p>During a review of Resident 1's PT TEN dated 4/14/2025, timed at 3:12 PM, completed by PT 2, the PT TEN indicated Resident 1 was pre-medicated prior to the therapy session and Resident 1 continued to complain of pain on left hip and left lower extremity during bed mobility exercises.</p> <p>During a concurrent interview and record review on 5/6/2025 at 12:40 PM with the MDS Nurse, Resident 1's MAR for April 2025 was reviewed. The MDS Nurse stated the MAR did not indicate Resident 1's pain location when the licensed nurse (LVN 1) administered pain medication to treat Resident 1's complaint of moderate to severe pain on 4/9/2025, 4/14/2025, 4/16/2025, and 4/17/2025. The MDS Nurse stated it was important for licensed nurses to document thoroughly such as the location of resident's pain to provide appropriate care, treatment, and notify the doctor if necessary.</p> <p>During an interview on 5/6/2025 at 2:50 PM with the Social Services Director (SSD), the SSD stated the SSD had written down the date when Resident 1 was moved from Room A to Room B on 4/7/2025, but the SSD failed to document the reason for the room transfer. The SSD stated the SSD could not recall by memory why the facility decided to move Resident 1 to another room.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 5/6/2025 at 3:19 PM with LVN 4, Resident 1's medical record and MAR for April 2025 were reviewed. LVN 4 stated LVN 4 was Resident 1's licensed nurse on 4/7/2025 during the 7 am to 3 pm shift. LVN 4 stated LVN 4 could not remember being informed by PT 1 about Resident 1 having pain and giving Resident 1 pain medication. LVN 4 stated there were no documented interventions, assessments, nor pain relief provided to Resident 1 on 4/7/2025. LVN 4 stated the MAR indicated the licensed nurse (LVN 1) administered Hydrocodone to Resident 1 on 4/9/2025 at 10:32 AM, 4/14/2025 at 8:56 AM and 8:09 PM, 4/16/2025 at 8:20 AM, and 4/17/2025 at 8:18 AM but there was documentation of Resident 1's pain location therefore the location of the pain was unknown.</p> <p>During an interview on 5/7/2025 at 10:09 AM with LVN 1, LVN 1 stated when a resident (in general) reported pain, LVN 1 should ask the location, intensity, and onset of the pain, and what triggered the resident's pain. LVN 1 stated when LVN 1 administered Hydrocodone to Resident 1 on 4/9/2025, 4/14/2025, 4/16/2025, and 4/17/2025, LVN 1 failed to document the location of Resident 1's pain which put Resident 1 at risk for missed or delayed diagnosis, inappropriate treatment, ineffective pain relief, and delay in timely interventions which can further worsen any injury residents may have. LVN 1 stated she could not recall by memory where Resident 1's pain was located.</p> <p>During an interview on 5/7/2025 at 11:59 AM with PT 1, PT 1 stated that she provided therapy to Resident 1 on 4/7/2025 which consisted of the right leg range of motion, as well as the left leg range of motion while Resident 1 laid down on Resident 1's bed. PT 1 stated during the session, Resident 1 refused to attempt standing or getting out of bed and began to exhibit agitation. PT 1 stated Resident 1 wanted to go back to bed as Resident 1 complained of discomfort on his left lower extremity despite being pre-medicated prior to therapy and was guarding his left leg due to complaints of persistent pain. PT 1 stated PT 1 walked over to the nurse's station to inform the licensed nurse (LVN 4) of Resident 1's discomfort to Resident 1's left lower extremity and LVN 4 agreed to monitor Resident 1. PT 1 stated there was a possibility PT 1 may have written the wrong laterality (preference for using one side of the body over the other) of Resident 1's pain location.</p> <p>During an interview on 5/7/2025 at 12:19 PM with Resident 1's Family Representative (FR), the FR stated that FR 1 agreed to the facility's recommendation to move Resident 1 from Room A to Room B due to Resident 1's roommate requiring to be isolated. The FR was not sure why the roommate required isolation.</p> <p>During an interview on 5/7/2025 at 2 PM with the Admissions Coordinator (AC), the AC stated the facility's process for initiating a room transfer for residents was to document the reason for the transfer and notify the family representative. The AC stated Resident 1's family had requested a room change; however, the facility failed to ask the family and document a rationale for the room transfer and neither the AC nor the SSD could remember why the facility moved Resident 1 from Room A to Room B.</p> <p>During an interview on 5/7/2025 at 2:04 PM with the Assistant Director of Nursing (ADON), the ADON stated it was important for licensed nurses to ensure any resident (in general) pain assessment was accurate, consistent, and thoroughly documented to ensure proper pain management and continuity of care by rating pain level, asking pain location, aggravating and relieving factors, onset of pain, duration, characteristics, and treatment. The ADON stated failure to properly assess and document the resident's complaints of pain could result in untreated pain, delayed or missed interventions, decline in physical function, and complications from over or under medication.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Claremont Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 219 E. Foothill Blvd Pomona, CA 91767	
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of an electronic mail (e-mail) titled, Documentation Clarification, dated 5/7/2025, timed at 3:01 PM, emailed by the facility, the e-mail indicated PT 1 provided a written statement to clarify Resident 1's PT TEN dated 4/7/2025 completed by PT 1. The e-mail indicated per PT 1, PT 1 made an incorrect entry when PT 1 incorrectly documented Resident 1 complained of persistent pain on Resident 1's LLE instead of right lower extremity (RLE- right leg, including the thigh, knee, calf, ankle, and foot). The e-mail indicated per PT 1, Resident 1's pain location on 4/7/2025 was on the RLE.</p> <p>During a review of an e-mail titled, Resident 1, dated 5/14/2025, timed at 8:21 PM, emailed by the facility, the e-mail indicated PT 2 provided a written statement to clarify Resident 1's PT TEN dated 4/14/2025 completed by PT 2. The e-mail indicated per PT 2, PT 2 made an error in PT 2's documentation of Resident 1's pain location. The e-mail indicated per PT 2, Resident 1's pain location on 4/14/2025 was on the RLE and not on the LLE.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Social Services Program, revised October 2024, the P&P indicated, The Social Services staff is responsible for . Maintaining regular progress and follow up notes indicating the resident's response to the care plan and interventions . maintaining contact with resident's family members, significant others, or responsible party, and involving them in resident's care plan ., The P&P indicated, The Social Services staff provides .comprehensive documentation of social service assessment and intervention for each resident .</p> <p>During a review of the facility's P&P titled, Charting and Documentation, revised 10/2024, the P&P indicated, Disciplines contributing to the record includes but is not limited to . nursing . social service .physical therapy . The P&P indicated, The resident's clinical record is an account of treatment, care, response to care, signs, symptoms and progress of the residents' condition. It also includes data needed for identification and communication with family/responsible party.</p>		